EDITORIALS

Fire in a hospital

SANJAY NAGRAL

Consultant surgeon, Department of Surgical Gastroenterology, Jaslok Hospital and Research Centre, GD Deshmukh Marg, Mumbai 400 026 Department of Surgery, KB Bhabha Municipal General Hospital, Bandra, Mumbai 400 050 INDIA e-mail: sanjay.nagral@gmail.com

On December 9, 2011, in a shocking and gruesome incident, perhaps the worst of its kind in India, a massive fire broke out at the AMRI Hospitals, a large private speciality institution in Kolkata and consumed 93 lives (1). Hapless patients in wards and intensive care were suffocated and charred to death as local fire containment measures were nonexistent and fire fighters could not enter the narrow lane leading to the hospital .There was a huge media outcry over the incident and finger pointing by local politicians. As a fallout of the incident, six directors of the hospital, including two senior doctors and four others who happen to be leading Kolkata industrialists, were arrested for abetment. The hospital's licence was cancelled, the government ordered an 'enquiry', compensation was awarded to the victims' families and a review of fire safety in hospitals across the country was ordered. For a few days after the story the media did 'exposes' on fire safety measures in other hospitals in the country. The state of poor safety measures became "breaking news". Soon the story receded into the background, and gradually disappeared. In short, everything proceeded according to a predictable script. If it isn't already, everything will soon be back to business as usual, perhaps even at AMRI.

Why then, should a journal devoted to medical ethics resurrect and analyse what is purportedly just a tragic accident? Is it really a healthcare issue, or nothing but another example of poor safety standards prevalent in all sectors in India? Is a fire in a hospital, howsoever tragic and shocking, any different from other such incidents in theatres, markets and residential complexes that strike us with terrible regularity? To be fair, there is ample evidence that as a nation, and perhaps even as a culture, we have a certain indifference to safety in any sphere of life. For example, the fact that we have one of the highest road accident death rates in the world partly reflects our casual attitude towards road safety. We also have the dubious distinction of having among the largest numbers of train accidents, building collapses and industrial accidents. There is no doubt that substantial blame does lie with the regulatory agencies which are supposed to monitor safety measures in any institution, healthcare or otherwise. But it would be simplistic to look at the AMRI incident as yet another example of the poor safety regulation and preparedness that is all pervading in our society.

It may be worth scratching below the surface to examine whether safety in healthcare institutions is just a matter of poor planning and regulation, or whether it reflects a deeper systemic malaise that needs dissection because it has implications for day-to-day healthcare. It should be a given that since the core function of hospitals is to look after the sick and, in a sense, vulnerable population, those who run them need to have a heightened sensitivity to safety. Whether it is the food served, the ventilation, or the hygiene, hospitals need to ensure that these don't aggravate already existing illness and disease amongst its occupants. So, though it is important for all modern buildings and public places to have mechanisms for fire safety, for a hospital to ignore and flout them is particularly disturbing and deplorable. And this is precisely what AMRI seems to have done.

The burgeoning speciality private hospital sector in India projects itself as 'modern' and 'hi- tech' offering 'world class' care. In fact, this is how it sells itself to the middle and upper middle class consumer. The complete retreat of public institutions has thus resulted in pushing a large proportion of the population into seeking healthcare in these institutions, which are expensive and unaffordable, but fulfil the need of a certain class. What seems clear though is that these institutions, whilst recreating a 'world class' ambience and facade, have not adopted the stringent safety practices that institutions in the developed world usually follow. A classic example of this is an area which perhaps takes more lives on a day-to-day basis in healthcare institutions but is not seen as an acute disaster or crisis. This is the emerging problem of hospital-acquired infections. These are infections with antibiotic resistance that patients admitted to hospital acquire from the hospital environment. A large part of this problem can be prevented with simple and effective infection control protocols. These include measures like mandatory hand washing practices by healthcare staff, and proper ventilation, waste disposal and antibiotic protocols. Most private hospitals in India have as yet not adopted these practices. Some pay lip service to them because of the newfound necessity for 'accreditation', due to pressure from the insurance sector. However, they do not actually implement them on a day-to-day basis. Others completely ignore the existence of this problem. When such a fundamental issue of basic safety, central to healthcare practice, is ignored, to talk about fire safety seems almost irrelevant and esoteric.

The issue of regulation of the private sector in India has been the focus of much discussion and debate over the last few decades. Whilst, on one hand, health activists have struggled for greater regulation, the state has been half-hearted in implementation of its own legislations (2). Often, powerful lobbies of medical professionals have scuttled any substantial attempts to implement regulatory laws. Whilst individual cases of medical negligence continue to hit the headlines, litigation has increased and 'accreditation' is the new buzzword, serious regulation is still elusive. In the context of this tragedy, this issue could, once again, have become the focal point of the public debate. Alas, but not surprisingly, the mainstream media chose to ignore this and focus only on symbolic arrests and a blame game. On the other hand, political formulations traded charges with each other.

Some other questions that emerge out of this churning are equally disturbing and befuddling. Why is the safety quotient so low in our society both in general, and in healthcare? Should our natural instinct for self preservation not make us sensitive to basic safety issues? Are there some socioeconomic and cultural factors at work here which numb us to safety? And shouldn't an industry like healthcare which is critically dependent on outcomes and results for its growth in a fairly competitive environment be intrinsically sensitive to safety concerns? To phrase it differently, won't hospitals which show a record of safety actually do well in their business, and therefore naturally adopt these practices? This idea which seems so obvious doesn't seem to have support even amongst other industries. For example, car manufacturers have always projected the look of their product rather than its safety features. The construction industry almost never talks about the earthquake-resistant capability of its projects. No airline ever projects its safety record as a way to attract passengers. It seems that safety doesn't necessarily sell and is thus given short thrift by industry. Perhaps, even the elite consumer is ambivalent to safety concerns.

It doesn't need deep philosophical study to appreciate that we live in an age where the illusory look and image is what sells and can substitute for standards and performance. And in that narrow sense, the healthcare industry is playing a game that works. It is another matter that in the context of healthcare this compounds one tragedy with another. The hapless victims at AMRI and their families have faced an unprecedented triple whammy of tragedies: first being pushed into private healthcare by a public health system that has been systematically dismantled; second, their severe illness needing hospitalisation, and third, a sudden manmade disaster that took away their lives whilst they were battling the first two afflictions.

References

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Putting patients first: draft guidelines for compensation for research-related injury in clinical trials in India

GAGANDEEP KANG

Professor and Head, The Wellcome Trust Research Laboratory, Department of Gastrointestinal Sciences, Christian Medical College, Vellore, Tamil Nadu 632 004 INDIA
e-mail: gkang@cmcvellore.ac.in

With the recent highlighting of ethical issues in several clinical trials, and the increase in awareness among parliamentarians, there has been some concern about the conduct of trials in India. The areas of concern include ensuring that consent is truly informed, and monitoring participant safety, the occurrence of deaths, and the payment of compensation. On November 18, 2011, the draft of the Drugs and Cosmetics (3rd Amendment) rule, 2011, was published (1) in the Gazette of India, with a plan for implementation 45 days after publication. In addition, the draft guidelines for compensation were posted for comment by the Indian Council of Medical Research (ICMR), where bioethicists have been responsible for developing and updating the *Ethical guidelines for biomedical research on human participants,* last revised in 2006. These guidelines state that research participants who suffer an injury as a result of participation in research are entitled to compensation for impairment or disability (2). It is commendable that the Government of India through the Ministry of Health and Family Welfare is taking steps to safeguard the rights of research participants and emphasise the responsibility of sponsors, investigators and institutional ethics committees engaged in conducting or reviewing clinical research in India. The proposed rules include several provisions for ensuring that study participants who suffer injury, permanent injury, or their heirs in case of the participants death, will be entitled to timely and just compensation. These rules highlight the need to ensure that research participants' needs in case of injury, are given primacy, as they should be.

Unlike the basic principles of autonomy, justice, beneficence and non-maleficence that underlie the practice of biomedical ethics worldwide, there have been contrasting views in the area of biomedical research, on the needs of participants and the