Delhi Medical Council

368, 3rd Floor, Pathology Block,
Maulana Azad Medical College,
Bahadur Shah Zafar Marg,
New Delhi-110002

DMC/14/2/Comp.167/2005/ 12th August, 2005

Shri Gaurav Duggal
D-76, GF,
South City-2,
Gurgaon – 122001

Complainant

Vs.

1. Dr. Noshir Shroff
Shroff Eye Centre
A-9, Kailash Colony,
New Delhi – 110 048

2. Dr. Sanjeev Nangia
Shroff Eye Centre
A-9, Kailash Colony,
New Delhi – 110 048

3. Medical Superintendent
Shroff Eye Centre
A-9, Kailash Colony,
New Delhi – 110 048

4. Medical Superintendent
National Heart Institute
49, Community Centre,
East of Kailash
New Delhi – 110 065

Respondents

ORDER

The Delhi Medical Council examined a complaint of Shri Gaurav Duggal, forwarded by Directorate of Health Services, alleging medical negligence on the part of the respondents 1 to 4, in the treatment administered to the complainant's daughter, late Simran Duggal at Shroff Eye Centre and subsequently at National Heart Institute, New Delhi, resulting in her death on 14.8.2002. The Delhi Medical Council perused the complaint, replies of the respondents 1 to 4, medical records of Shroff Eye Centre and National Heart Institute. The following were heard in person :-

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-	Shri Gaurav Duggal	
-	Smt. Nidhi Duggal	mother of the deceased
-	Dr. Noshir Shroff	Ophthalmologist
-	Dr. Sanjeev Nangia	Anaesthesiologist
-	Dr. S.K. Kochhar	Medical Superintendent, Shroff Eye Centre
-	Dr. A.C. Ghosh	Medical Superintendent, National Heart Institute
-	Dr. A.P. Arora	Consultant, Cardiologist, National Heart Institute
-	Dr. A.V. Sharma	Ex-Consultant, Anaesthesiologist, National Heart Institute

Briefly stated the facts of the case are that Late Simran Duggal (referred hereinafter as the patient), a 4 year old girl with a history of bronchial asthma was taken for cataract surgery on 8.8.2002 at Shroff Eye Centre. The patient developed severe Bradycardia after administration of Scoline (an anaesthetic agent) by Respondent No. 2. Subsequently she was shifted to National Heart Institute for further management, where, after battling with her condition, she expired on 14.8.2002.

In the pre-operative check-up performed by Respondent No. 2 before surgery, the child did not have broncospasm and her chest was reported to be clear. The Pediatrician had also given clearance for the operation. The Respondent No. 2 used inhalation induction (oxygen, nitrous oxide and halothene) and scoline as the muscle relaxant. The doses of these agents used were correct. The patient developed bradycardia (decrease in heart rate) for which atropine injection was administered. Since there was no improvement, a repeat dose of atropine was administered. There was no improvement in the heart rate, the ECG showed wide QRS complexes suggestive of ventricular tachycardia. A DC shock was given. Arterial blood gas analysis was performed which revealed hyperkalmia. This was treated with Inj. glucose, insulin and calcium. The patient was stabilized and subsequently managed on a ventilator at National Heat Institute where she succumbed to her condition six days later on 14.8.2002. The Respondent No. 2 used a technique that is standard, well described and is commonly practice. The decrease in heart rate observed after administration of scoline is a well-known complication, which is treated by atropine. The same was done in this patient. Unfortunately, the accompanying hyperkalmia complicated the condition of the patient. Hyperkalmia is also well-known complication of Inj. scoline,

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but the Potassium level rise by about 0.5 to 1 mEq/l (normal level of Potassium is 3.5 to 4.5 mEq/l). The severe hyperkalmia observed in this patient (8 mg/l) is seen after scoline, in some myopathies, which may be occult. The treatment of hyperkalmia was also carried out appropriately in this patient. Whether this patient had occult myopathy or not is very difficult to comment upon. It is the opinion of the Delhi Medical Council that Respondent No. 2 had used standard anaesthetic technique with correct doses and had detected the complications (which are known to occur) in time and administered the recommended treatment. The chain of events leading to the death of the patient can only be described as unfortunate and not negligence on the part of Respondents No.1 to 4.

Complaint stands disposed.

By the order of and in the name of
Delhi Medical Council

(Dr. S.K. Khattri)
Secretary

Copy to :-

1) Shri Gaurav Duggal, D-76, GF, South City-2, Gurgaon – 122001 – 16522

2) Dr. Noshir Shroff, Shroff Eye Centre, A-9, Kailash Colony, New Delhi – 110 048 – 16523

3) Dr. Sanjeev Nangia, Shroff Eye Centre, A-9, Kailash Colony, New Delhi – 110 048 - 16524

4) Medical Superintendent, Shroff Eye Centre, A-9, Kailash Colony, New Delhi – 110 048 – 1652

5) Medical Superintendent, National Heart Institute, 49, Community Centre, East of Kailash, New Delhi – 110 065 – 1652

6) Directorate of Health Services, Govt. of NCT of Delhi, Swasthya Sewa Nideshalaya, Bhawan, F-17, Karkardooma, Delhi – 110032 – With reference to letter No. F.23/84/04/DHS/NH/31579 dated 5th October, 2004 – 1652

(Dr. S.K. Khattri)
Secretary