SUMMARY

DR. LUIS HENRIQUE PEROCCO BRAGA (CPSO# 83041)

1. Disposition

On June 20, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required urologist Dr. Braga to appear before a panel of the Committee to be cautioned with respect to wrong-sided surgery (including consent, imaging, and communications with the patient and family) and responsiveness to the patient's unexpected post-operative pain.

2. Introduction

A family member of the patient complained to the College that Dr. Braga operated on the patient's left ureter instead of right ureter to remove a kidney stone, failed to communicate with the family post-operatively, failed to see the patient post-operatively despite the patient's pain, initially failed to disclose the adverse event to the patient or the family, and caused the patient physical and psychological trauma having long-term effects.

Dr. Braga responded by acknowledging the error that occurred, explaining how it happened, and reviewing the steps he has taken to ensure a similar error does not occur again.

3. Committee Process

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

Dr. Braga acknowledges performing surgery on the wrong ureter in this case. He also appears to recognize that his initial communications post-operatively with the patient and her family were poor, and he further acknowledges not personally attending the patient for significant post-operative pain to the operated side after the first, wrong-sided surgery.

Dr. Braga returned the patient to the operating room to remove the incorrectly placed left ureteric stent, remove the right-sided ureteric stone, and place a right ureteric stent. He later had a discussion with the patient's family, admitted his error, apologized, and explained what happened.

This error should not have occurred and was entirely preventable. Dr. Braga, through a surgical pause and other quality assurance process changes, should have identified the error before any harm came to the patient. While recognizing that Dr. Braga has responded appropriately to the complaint and has no history with the College, the significant error led the Committee to impose a caution.