SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Panayiotis Iracleous (CPSO #82933)
(the Respondent)

INTRODUCTION

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concern about the Respondent's care of the Patient, whom the Respondent saw at the Emergency Department (ER) for shortness of breath. Two days after the Respondent assessed him, the Patient was taken by ambulance back to the ER after collapsing at home. In the ER, attempts to resuscitate the Patient were unsuccessful. The Patient's death was investigated by the coroner, who determined that the cause of death was pulmonary embolism due to deep vein thrombosis of the leg with a genetic blood-clotting disorder.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent failed to adequately investigate and treat the Patient's reports of shortness of breath and chest pain during a visit to the ER.

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of December 17, 2020. The Committee required the Respondent to attend at the College to be cautioned in person with respect to medical record-keeping (in particular, both content and legibility) and appropriate assessment of acute shortness of breath (including the importance of ordering electrocardiogram or ECG as part of the assessment) in a patient with risk factors presenting to the ER. The Committee also directed that the Respondent enter into an undertaking with the College to undergo a period of clinical supervision, professional education, a reassessment, and monitoring by the College.

COMMITTEE'S ANALYSIS

- The Committee found significant and concerning shortcomings in the Respondent's care of the Patient. In particular, the Respondent's chart for the Patient was scant and illegible. The Committee noted that the COVID-19 pandemic should not be an excuse for physicians to fall below a reasonable standard of care in documentation.

- The Committee also noted that the Respondent did not sufficiently review the Patient's chart and failed to discover significant information related to the Patient's medical history of significant risks for blood clots.

- The Respondent indicated that he always considers life-threatening conditions when assessing patients with shortness of breath but the Committee noted that the chart does not have any documentation to reflect the Respondent's thinking or substantiate that he considered any of the differential diagnoses (myocardial infarction, pulmonary embolism, respiratory infections) in the Patient's case. The Committee was also concerned that the Respondent did not order an ECG for the Patient, in light of his known cardiac risk factors of age and sex.

- The Committee took into consideration the Respondent's history of prior complaints which involved similar concerns to the present complaint. The similarities to the present complaint concerned the Committee.

- In view of the identified shortcomings in management in the Patient's care and the tragic outcome, the Committee determined that it was appropriate to caution the Respondent in person, as outlined above. The Committee also directed an undertaking to remediate and improve the Respondent's practice going forward.