**SUMMARY**

**DR. PETER DE MAIO (CPSO# 86122)**

## 1. Disposition

On November 17, 2017, the Inquiries, Complaints and Reports Committee (the Committee) ordered diagnostic radiologist Dr. De Maio to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. De Maio to:

- attend a medical record-keeping course

- review and provide written summaries of the College's *Medical Records* and *Consent to Treatment* policies.

## 2. Introduction

A patient complained to the College that Dr. De Maio failed to perform an angiogram/ angioplasty in a competent manner, failed to consider complications with the procedure when she complained about severe pain and altered sensation in her left leg, and allowed her to be discharged from the hospital while she was still in pain and requiring pain medication.

Dr. De Maio responded that he performed a technically challenging procedure competently. Specifically, Dr. De Maio explained that he decided to puncture the artery in the patient's left groin when he found he could not safely treat the narrowed arteries through a puncture in the right groin. Dr. De Maio also indicated that, upon learning of the patient's reports of pain and altered sensation, he carefully examined her leg and performed an ultrasound (and that none of his investigations revealed any evidence of a puncture site complication). Finally, Dr. De Maio advised that the nurses discharged the patient in accordance with the hospital's discharge policy, and that while he did not re-evaluate the patient after his initial post-procedure examination, he was not aware that she was experiencing persistent symptoms at the time she

was discharged.

## 3. Committee Process

A Surgical 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

While the Committee was satisfied that Dr. De Maio performed the patient's procedure in a competent and proper manner, the Committee had concerns about the fact that Dr. De Maio did not document any pre-procedure consent discussions he might have had with the patient outlining the potential risks and complications of the procedure. Among other things, the Committee noted that the College's policy, *Consent to Treatment*, provides that a legible, understandable and contemporaneous note in the patient's record regarding consent to treatment is the best evidence a physician has to demonstrate that the requirements of the *Health Care Consent Act, 1996* have been satisfied.

Similarly, the Committee concluded that while nursing notes documented Dr. De Maio's post-procedure care, Dr. De Maio failed to personally document anything about this encounter with the patient – including his considerations, the results of his assessment, or his clinical decisions –despite the fact that he was examining a limb-threatening concern.

Regarding the patient's discharge, the Committee was satisfied that overall, the patient met the criteria. The Committee did not fault Dr. De Maio for not reassessing the patient prior to discharge given that nurses did not contact him to do so and under the circumstances, it was

reasonable for Dr. De Maio to follow hospital protocol and delegate responsibility for patient discharge to the PACU nursing staff.

*This summary was amended following an appeal heard by the Health Professions Appeal and Review Board ("HPARB"), a decision by HPARB dated August 17, 2017, and the Committee's consideration of the matter on November 17, 2017.*