

## **SUMMARY**

### **DR. MATTHEW DENNIS DI SILVESTRO (CPSO# 83851)**

#### **1. Disposition**

On January 22, 2016, the Inquiries, Complaints and Reports Committee (“the Committee”) required Orthopaedic Surgeon Dr. Di Silvestro to appear before a panel of the Committee to be cautioned with respect to failing to document the postoperative care provided and failing to assess a patient when their condition deteriorated. The Committee also required Dr. Di Silvestro to write a report on the recognition and management of post-operative bowel obstruction, including Ogilvie syndrome, and postoperative delirium.

#### **2. Introduction**

A family member complained to the College regarding the postoperative care Dr. Di Silvestro provided, including that Dr. Di Silvestro failed to assess the patient after being informed of significant changes in the patient’s condition; failed to assess the patient and/or document an assessment while he was the most responsible physician; provided verbal orders without assessing the patient; failed to communicate with the family when the patient’s condition deteriorated; and demonstrated unprofessional behaviour when he stated that a colleague “stuck me with all these patients to round on while he is on holidays.”

Dr. Di Silvestro took over postoperative care two days after the patient had hip replacement surgery and was the most responsible physician for six days. Unfortunately, the patient’s condition deteriorated and the patient passed away six days after surgery.

Dr. Di Silvestro told the College that he assessed the patient on early morning rounds but failed to document his assessments. Dr. Di Silvestro acknowledged that he failed to maintain appropriate notes of his assessments with the patient. He is committed to improving his recordkeeping and so he attended the University of Toronto’s Medical Recordkeeping course in September 2015. He did order appropriate treatments and investigations based on his assessments. He was not aware the family was concerned or he would have spoken with them.

The patient's condition was not critical until five days after the surgery, when he consulted with the Internal Medicine service.

He acknowledges making a comment about being left to care for many patients over the long weekend. He regrets and apologizes for making this statement. He always strives to communicate in a professional and compassionate manner, and he is sorry that he failed to do so in this case.

### 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, as well as College policies and relevant legislation.

### 4. Committee's Analysis

The Committee is very concerned about Dr. Di Silvestro's failure to assess the patient and/or to document his assessments and the postoperative care provided. There is nothing in the record to support that Dr. Di Silvestro assessed the patient, as neither Dr. Di Silvestro nor the nurses documented any in person visits, only the verbal orders were documented by the nurses, and so the Committee is unable to know with certainty if assessments were performed in person.

The medical record is a important document, which records events and decisions that assist physicians in managing a patient's care. The Committee expects all physicians to be familiar with all of the prescribed components of medical records, which appear in sections 18 and 19 of Ontario Regulation 114/94 made under the *Medicine Act*, 1991. As indicated in the College's policy on *Medical Records*, thorough and legible notes are a crucial component of good medical care, and are an important measure of the quality of care received by a patient.

The Committee is also very concerned that Dr. Di Silvestro failed to assess the patient when the patient's condition deteriorated, and to appropriately follow up on nursing, laboratory and family reports of worrisome signs and symptoms. Dr. Di Silvestro should have questioned why this patient was still in hospital days longer than the average length of stay after similar surgery and unable to walk, and then conducted a thorough physical examination and ordered additional investigations.

Though the patient's clinical course was slowly progressive until four days after surgery, if Dr. Di Silvestro had done proper daily assessments, he should have recognized concerns and considered a possible bowel obstruction or Ogilvie Syndrome, and ordered appropriate investigations and treatment.

For example, two days after the surgery the nurses noted that the patient's abdomen was bloated and tender. Dr. Di Silvestro should have ordered further investigations at that time. If Dr. Di Silvestro had given early attention to this patient, it may have prevented the rapid progression that began four days after surgery, which Dr. Di Silvestro also ignored until it was too late.

Four days after surgery, the nurses documented that the patient had a large firm abdomen and reduced bowel sounds, if Dr. Di Silvestro concluded based on an x-ray that the patient developed a bowel obstruction at that time, he then failed to properly assess this diagnosis and order appropriate investigations.

Five days after surgery, the nurses paged Dr. Di Silvestro, who then ordered inappropriate, ineffective and possibly dangerous treatment without seeing or assessing the patient (including by providing Lasix when the patient's creatinine levels were elevated and without knowing the patient's blood volume status.) As well, there was no evidence that Ancef was the appropriate antibiotic to order under the circumstances.

Aside from cautioning Dr. Di Silvestro for the above issues, the Committee also advises Dr. Di Silvestro regarding his communications. As the most responsible physician he should communicate with the patient's family about their condition and document the discussion. Dr. Di Silvestro should ensure that he communicates with patients, their family and colleagues in a professional, respectful and empathetic manner going forward.