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. Shahab Nahvi (CPSO# 95512)
(the Respondent)

INTRODUCTION

The Patient had a slip and fall accident after consuming alcohol and attended the Emergency Room (ER) via ambulance, where he was assessed and discharged home. Several hours after his discharge, the Patient fainted and hit the right side of his face. He again attended the ER (at a different hospital) and was assessed by the Respondent. A CT scan was performed and was normal. The Patient was diagnosed with a concussion and discharged home. The next morning the Patient continued to experience symptoms and a physician neighbour assessed him and told him to attend the hospital for further testing. An MRI of the neck was done and showed a burst fracture to C-6. The Patient subsequently underwent surgery to repair the fracture.

The Patient's family member, the Complainant, contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct, as follows:

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

- **failed to recognize the signs and symptoms of a spinal injury;**
- **failed to properly assess, diagnose, and treat the Patient's injuries and symptoms; and**
- **acted in an indifferent and dismissive manner, and failed to listen to the Patient or his family, which put the Patient's life in danger.**

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of June 18, 2020. The Committee required the Respondent to attend at the College to be cautioned in person on the full assessment of a patient presenting with syncope (fainting), in the setting of a recent trauma and neurological symptoms, including a complete assessment of the head and neck and proper documentation of the assessment.

The Respondent also provided an undertaking to the College which included professional education in medical record-keeping and the assessment of acute cervical spine trauma.

COMMITTEE'S ANALYSIS

The Committee found it difficult to ascertain the extent of the physical examination the Respondent performed in this case given the poor quality of the records. The Respondent's handwritten records were difficult to decipher, and the content was limited. There was no proper, detailed history and inadequate documentation about the physical examination that the Respondent performed. The only notation relating to a neurological examination states "no focal sign", with no specifics given about the neurological examination and no information in the record to suggest that the possibility of a spinal cord injury was appropriately considered. The records do not support the Respondent's contention that he performed a thorough, appropriate assessment of the Patient.

The Respondent did not obtain the pertinent history regarding the mechanism of the Patient's fall, or the Patient's symptoms of numbness after the fall (or if he did obtain such details he did not appropriately consider them). The detailed report from the final ER that the Patient attended (where he had his MRI) notes that following the initial fall the Patient had numbness in both legs and worsening gait, and after the second fall he was stumbling and had weakness in both hands with radicular pain into both hands radiating from the neck. These symptoms of numbness and loss of strength are very concerning and should have caused the Respondent to consider further investigations.

This was the Patient's second ER presentation with a history of syncope in the setting of recent trauma and neurological symptoms, and the Committee would have expected the Respondent to have a much lower threshold in terms of ordering investigations to more thoroughly assess the Patient's signs and symptoms. In addition, given that the effects of the alcohol the Patient had consumed would have worn off by the time of this second ER visit, there was an even better opportunity to evaluate his symptoms. The fact that the family friend quickly noted concerns upon assessing the Patient would suggest that the findings were more apparent than suggested in the Respondent's correspondence to the College.

Given the issues regarding the Respondent's assessment and management, including his record-keeping, that were raised in the investigation, an undertaking was obtained, as set out above, and the Committee decided to require the Respondent to attend at the College to be cautioned in person.

As for the Respondent's manner towards the Patient, the Committee took no action.