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. Constantine Temba M'Cwabeni (CPSO #60612)
(the Respondent)

INTRODUCTION

The Complainant arrived at the emergency room (ER) with a chief complaint of back pain. The Respondent assessed her at 16:00, at which time she also reported pain in her left hand and left shoulder. He ordered pain medication and x-rays of the Complainant's left hand and shoulder and of her lower back. The Respondent discharged the Complainant at approximately 18:10 with instructions to follow up with her family physician and return to the ER if she had any new concerns.

One week after the ER visit, the Complainant presented to her family physician with ongoing pain and was diagnosed with discitis and a mycotic aneurysm.

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned about the Respondent's care and conduct in the ER. Specifically, the Respondent:

- **Did not treat the Complainant with respect**
- **Failed to adequately investigate the Complainant's infection**
- **Failed to treat cellulitis and a blood clot.**

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of May 2, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to the lack of comprehensive history and physical examination and inadequate documentation. In addition, the Committee requested that the Respondent provide the Committee with a written report, approximately 2-4 pages in length, with respect to the presentation of discitis.

COMMITTEE'S ANALYSIS

Failed to adequately investigate the Complainant's infection

- The Committee was concerned that both the Respondent's assessment of the Complainant and his note of the encounter were extremely poor. The Complainant had been in the ER days earlier and been diagnosed with cellulitis and had a positive staph blood culture, but the Respondent did not mention this in his note. There was no indication that he was aware of the Complainant's recent ER history.

- The Respondent did not document an examination of the hand, arm or shoulder. He indicated that he did not document an examination of the Complainant's hand because it appeared to be completely normal, but this led the Committee to question why he felt the need to order an x-ray of the hand.

- There was no mention in the Respondent's note of pertinent red flags with regard to back pain (including bowel and bladder function and radiculopathy), nor was there indication from the documentation that the Respondent conducted an adequate examination. The Respondent noted only: "wriggling around in pain and tender LS spine." The Respondent did not document the precise site of the Complainant's pain, nor did he reexamine the Complainant once her pain had settled (if indeed it did settle).

- The x-ray of the Complainant's back showed interval development of an L2 fracture, but the Respondent did not note this in the chart or take any action. There was little indication in the record that he explored other causes of the Complainant's pain, such as infection. Laboratory testing (rather than plain x-rays only) might have helped in the process of diagnosis. The Respondent did not note the Complainant's history of recent spinal injections or her recent wrist cellulitis and positive blood culture. These were both pieces of information that might have led him to consider infection as a cause of her current problems. According to the documentation, he did not do an abdominal examination or consider an aortic aneurysm as a possible cause for her symptoms.

The Committee took no further action on the concern respecting the Respondent's communication with the Complainant. The Committee stated its expectation that physicians communicate with patients in a professional manner at all times.

The Committee decided to take no action on the Complainant's concern that the Respondent failed to treat cellulitis and a blood clot, as there was no indication from the medical record that the Complainant had either of those issues when the Respondent assessed her in the ER.

Given its concern about the Respondent's failure to conduct an adequate history and physical examination of a patient with a serious clinical condition, and his failure to consider and

document a proper differential for back pain, the Committee decided to caution the Respondent as set out above, and also request homework related to the presentation of discitis.