

**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. Getachew Demem Mazengia (CPSO# 90248)  
(the Respondent)**

**INTRODUCTION**

The Patient attended the Emergency Room (ER) eight days postpartum as she was experiencing a hemorrhage. The Respondent (General Practice) provided care to the Patient in the ER.

The Complainant, who is the Patient's family member, 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 care the Respondent provided to the Patient for a postpartum hemorrhage. Specifically, the Respondent:**

- **failed to perform a physical assessment, including assessment of vaginal bleeding when the Patient presented to the ER;**
- **ignored the Patient's requests to be examined;**
- **failed to complete an adequate history; and**
- **failed to appropriately treat the Patient's postpartum hemorrhage.**

**COMMITTEE'S DECISION**

A General Panel of the Committee considered this matter at its meeting of May 27, 2020. The Committee required the Respondent to attend at the College to be cautioned in person with respect to the assessment and management of postpartum hemorrhage in the ER.

In the present case, the Committee also required the Respondent to provide the Committee with a written report on postpartum hemorrhage, including taking a relevant history; completing an appropriate physical examination and subsequent assessment; identifying differential diagnoses, and appropriate initial treatments of postpartum hemorrhage as well as appropriate resuscitation of hypotension, and to review the College policies *Medical Records Documentation* and *Physician Behaviour in the Professional Environment*.

## **COMMITTEE'S ANALYSIS**

The Committee was concerned with the Respondent's care and management of the Patient when she attended the ER with a postpartum hemorrhage. In the Committee's view, the Respondent failed to appropriately assess the Patient until she became hypotensive, and his records were also inadequate and did not contain sufficient details.

The Respondent took a very cursory history regarding blood loss, and only did an abdominal examination with no comment regarding the uterine size or tone. The Respondent did not examine the pad and/or bed to assess the amount of bleeding. When the Respondent assessed the Complainant, he should also have noted the drop in her blood pressure since her arrival and he should have done a complete examination, including a pelvic examination.

With regard to management of the Patient's bleeding, the Respondent's oxytocin order was unusual in that he ordered an infusion at a high dose and made no attempt to give an oxytocin bolus.

Once the Patient's blood pressure dropped dramatically about two and half hours after admission, the Respondent recognized significant bleeding was occurring. However, from the Patient and Complainant's description the Respondent's management of the resuscitation was chaotic until the on-call obstetrician arrived. Even giving two units of un-crossmatched blood, as was done here, is unusual. If the Respondent's initial assessment had been more thorough the severity of the Patient's issue would have been identified sooner.

The Respondent admits to yelling when he required help with the resuscitation and joking with another physician who attended to assist. The Committee reminded the Respondent that it is important that physicians are professional and empathetic in their communications, keeping in mind the situation of the patient and the family.

After reviewing the Respondent's letter to the College, the Committee also was concerned that he lacked insight into the deficiencies in his care in this case, including he failed to recognize his responsibility in completing an adequate initial assessment.