

**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 had a slip and fall accident after consuming alcohol and attended the Emergency Room (ER) via ambulance, where he was assessed by the Respondent 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). 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;**
- **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; and**
- **discharged the Patient without adequate testing which led to him suffering a second fall and exacerbation of his injuries.**

## **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 head and neck injuries in the setting of trauma, including a detailed neurological examination, and appropriate 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 very little documentation about the physical examination that the Respondent performed. There was no mention of a specific neurological examination, and no information in the record to suggest that the possibility of a spinal cord injury was appropriately considered. The records did 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 history of numbness in both lower extremities immediately after the fall. In light of the Patient's intoxication, there was the possibility of hidden injuries and a higher index of suspicion was warranted. In addition, a longer period of observation would have been appropriate, followed by a thorough re-examination, properly documented. While the Respondent stated that he followed the Canadian cervical spine and CT head rules, the documentation did not support that contention.

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.