COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA
SUMMARY OF DECISION OF INVESTIGATION COMMITTEE "II"

Re: Dr. Venkata Karthik Rao Puppala, Licence No: 015158
Date: March 4, 2024
Decision: Consent to Reprimand

Dr. Puppala is a family physician licensed to practice medicine in Nova Scotia. The complainant brought a complaint before the College relating to Dr. Puppala's treatment of her son.

The complaint

The complainant's son is an adult with autism. He had a cough and a lump in his neck that would not go away. The complainant's son did not have a family doctor so his neighbour, who is Dr. Puppala's patient, asked Dr. Puppala to see him. Dr. Puppala examined him, did not note a lump but did suspect asthma. Dr. Puppala gave him a puffer and asked him to come back if it did not help.

A couple of months later, the family friend brought the patient back to see Dr. Puppala because his symptoms had not improved. Dr. Puppala noted the patient had a hard lump and lymph node swelling on the side of his neck. Dr. Puppala ordered bloodwork, a CT scan and states he asked the patient to return in two to three months if he had not improved.

The patient went for a CT scan but neither the patient, his mother nor the family friend received the results. The family friend had a number of appointments with Dr. Puppala on his own, but he and Dr. Puppala did not discuss the patient.

Dr. Puppala did receive the results of the CT scan and bloodwork. The results showed some signs of lymphoma and contained a comment saying:

> *IMPRESSION:*
> *Left supraclavicular, mediastinal and right internal mammary lymphadenopathy from lymphoma.*

Dr. Puppala decided to act conservatively as he had seen numerous cases of enlarged lymph nodes in patients following their COVID vaccination and assumed the patient had received his vaccine.

Dr. Puppala did not see the patient again until six months later. The family friend brought the patient in to have Dr. Puppala fill out forms for autism support. Neither the patient, the family friend nor his mother were aware of the CT scan results before this appointment to fill out the forms.

At that visit, the patient still had the lump in his neck and that, coupled with the results of the CT scan, prompted Dr. Puppala to order a biopsy. Unfortunately, the biopsy was not performed on

the scheduled date as the patient did not get to the appointment. Dr. Puppala did not follow up with the patient, the family friend or the patient's mother about the missed appointment.

The patient's mother ultimately spoke with her own family doctor about her son, and he was diagnosed with stage 4 lymphoma.

The investigation

An Investigation Committee of the College was assigned to investigate this complaint. Investigation Committees are appointed by the College's Council and are made up of practicing physicians and public members. These Committees operate independently from the College and conduct their investigations under the authority of the Nova Scotia Medical Act and Medical Practitioner's Regulations...

The Committee appointed an investigator who interviewed Dr. Puppala, the complainant, the patient and the patient's family friend. The Committee reviewed the transcripts of these interviews and also interviewed Dr. Puppala a second time. The Committee also reviewed the patient's medical records.

Dr. Puppala told the Committee that in hindsight, he should have acted on the CT results and given the option to the patient whether to do the biopsy right away or watch and wait. Dr. Puppala also said that, in hindsight, he should have further investigated why the patient did not show up for his biopsy.

Dr. Puppala also said, in hindsight, because he was not fully aware of the dynamics and family situation, he should have put something in place to ensure things were understood. The Committee is concerned Dr. Puppala failed to put anything in place to mitigate the risks associated with treating the patient who was brought to him by a family friend and who clearly had challenges navigating his care and treatment.

In accordance with the College's *Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment,* a physician should determine a patient's capacity to give consent. A physician, in assessing a patient's mental capacity, should attempt to obtain the patient's agreement to participate, and assess their capacity to understand information relevant to the topic at hand, the decisions to be made, the risks and benefits of actions that may be undertaken, and ability to understand his or her choices.

When Dr. Puppala was concerned the patient might not have capacity, the next step should have been to obtain consent from a substitute decision maker ("SDM") on behalf of the patient. There were no discussions between Dr. Puppala and the complainant regarding the patient's capacity to consent to treatment, or whether she, as his mother, was the patient's SDM. To the Committee's knowledge, the family friend was not the patient's SDM, and there is no record on the patient's chart indicating he was.

Flowing from this issue is the issue around the sharing of the patient's personal health information with the family friend, in the absence of him being designated as his SDM. While the Committee is satisfied that consent may be implied here because it was the complainant who asked the family friend to take the patient to appointments, and the patient did not object to the

family friend being present, it remains concerned that any such consent was not confirmed with the patient, or the patient's family or SDM and documented and included in the patient's medical record.

The Committee remains concerned about the overall content of Dr. Puppala's medical records for the patient. It was not clear from the records whether Dr. Puppala told the patient and the family friend to arrange follow-up, or whether it was he who would schedule follow-up with the patient. It was not documented that Dr. Puppala had considered a differential diagnosis of a vaccine related lymphadenopathy in consideration of the enlarged node.

In accordance with section 99(5)(f) of the *Medical Practitioners Regulations*, the Committee determined there is sufficient evidence, that if proven, would constitute professional misconduct.

The Committee then considered whether the circumstances warrant imposing a licensing sanction. In doing so, the Committee reviewed Dr. Puppala's complaint history with the College.

In four prior complaints, the College did not take disciplinary action against Dr. Puppala but did caution him about the completeness of his medical records, his communication skills, the need to properly manage and integrate information from specialists into the care plan and for failing to effectively communicate the care plan to the patient's family.

Dr. Puppala's four previous cautions are not disciplinary sanctions, nor is there proof of the underlying events leading to those cautions. However, these cautions make the misconduct in this case, if proven, more serious.

The Committee is satisfied that because Dr. Puppala has been warned on prior occasions to improve his record keeping and communication skills, and to appropriately manage a patient's care by integrating care from specialists (in the patient's case, Dr. Puppala received an opinion from a Radiologist), his conduct in this case warrants imposing a licensing sanction.

The Committee turned its mind to what type of licensing sanction is warranted.

Dr. Puppala is an experienced physician. The patient is a relatively young man, with at a minimum, communication, and self-advocacy issues, and noted to have ASD. It appears Dr. Puppala did not follow up on this diagnosis to consider how it might impact the care he was providing to the patient.

Dr. Puppala missed an opportunity to follow up with the family friend and the patient regarding the June 2021 CT that noted the lymphoma, and then failed to investigate why the patient did not show up for his January 2022 biopsy. These two instances may have contributed to the delay in the patient receiving his lymphoma diagnosis and associated treatment.

The Committee does appreciate Dr. Puppala has acknowledged his shortcomings regarding the patient's care. The Committee accepts Dr. Puppala felt he had to provide the patient with care because he was the patient's family friend. While it is to be commended that he agreed to help the patient via the family friend, this arrangement was not without significant foreseeable risks.

Taking all these considerations into account, the Committee has determined that a Reprimand is the appropriate sanction.

The decision

In accordance with clause 99(5)(f) of the *Medical Practitioners Regulations,* the Committee has determined there is sufficient evidence that, if proven, would constitute professional misconduct, incompetence or conduct unbecoming, warranting a licensing sanction. This means the Committee was satisfied if this matter was referred to a formal hearing process, there would be a finding of professional misconduct or incompetence.

Rather than refer the file to this process, the Committee is permitted to ask the physician to agree to the reprimand it would have otherwise sought though the hearing process.

Pursuant to clause 99(7)(a)(i) of the *Medical Practitioners Regulations*, and with Dr. Puppala's consent, Dr. Puppala is reprimanded for failing to:

- proactively follow up with a vulnerable patient and his family or caregivers in a timely fashion regarding a suspected lymphoma concern noted on a CT;
- investigate why a vulnerable patient did not show up for a scheduled biopsy for a suspected lymphoma; and
- determine whether a patient has capacity to navigate their own care, and the capacity to consent to sharing their confidential health information with persons who are not substitute decision makers and who attend appointments as a support person or advocate, and to document same.

As a part of Dr. Puppala's Reprimand, he also agrees to pay a portion of the costs incurred by the College for the investigation of this complaint. This is not a fine

All decisions remain permanently on the record of the College and can be referenced by an investigation Committee in the event of any future complaints made against the physician.

A Certificate of Professional Conduct is often required when a physician applies for or renews a license in another jurisdiction and will reflect all prior decisions.