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

PROCESS

This matter was initiated by a letter from the complainant received on January 30, 2023. A response from Dr. Puppala was received on January 31, 2023.

Dr. Puppala is a family physician licensed to practice medicine in Nova Scotia.

The complainant lives in Sydney, Nova Scotia and she is the mother of the patient about whom the complaint relates.

Investigation Committee II, formed in accordance with the *Medical Act* of Nova Scotia, 2011, was responsible for the investigation of this complaint.

In addition to correspondence from the complainant and registrant, the Committee considered:

- The patient's medical chart as provided by Dr. Puppala;
- An investigator's interview with complainant, the patient and an individual who accompanied the patient to his visits with Dr. Puppala; and
- An interview with Dr. Puppala on July 18, 2023.

SUMMARY

Key points as reported by the Complainant

The complainant states her son developed a cough and a lump in his neck in November 2020 that would not go away. He did not have a family doctor. His godfather asked if Dr. Puppala (his family doctor) could assess her son regarding this issue.

In February 2021, her son had an initial appointment with Dr. Puppala. He was given puffers and told he would be sent for more tests.

In June 2021, her son went for a CT scan. The family was never told the results. They called and asked for almost a year to get results. They were unable to get the information about the CT scan. The complainant and her entire family, and the patient's godfather were inquiring as to the status of the lumps, and any tests that needed to be done. Phone calls had not been returned from Dr. Puppala's office. Dr. Puppala's office had become a "black hole" from which no help or information flowed.

The complainant states that her son's godfather attended several of his own appointments with Dr. Puppala as his primary physician and none of the concerns about her son were ever discussed, not even an offhand comment about lymphoma.

Her son saw Dr. Puppala after the CT scan to get disability forms filled out. Nothing was mentioned about the CT scan during that appointment.

Since her son has autism, his mother acted as his advocate. She ultimately spoke to her family physician to obtain results and discovered that her son had lymphoma. It is Stage 4.

The complainant went to see Dr. Puppala after the CT result was known, and Dr. Puppala said that he thought the lymph nodes were a reaction to the vaccine. The patient had not been vaccinated at the time. He received his Covid vaccines July 2, 2021, August 24, 2021. The complainant states that if Dr. Puppala had used her son's health card number (to search records) or asked any probing questions, it would have led to the discovery that her son had not been vaccinated, and at the time did not meet the necessary requirements for his age group to even be vaccinated.

The complainant states Dr. Puppala's supposition that her son was suffering from asthma was also not substantiated, as evidenced in his own charts, that his lungs were clear and the Flovent was ineffective. This line of thought would have led to a whole host of testing and medicine changes, which were not attempted.

The most insulting thing is that even after the diagnosis of malignant lymphoma Dr. Puppala did not reach out, did not offer assistance or concern.

The complainant believes Dr. Puppala did not read the report and did not follow up on it. He was more concerned with his burgeoning cosmetic surgery business to address the medical needs of his actual patients. He also failed to fill out her son's disability paperwork correctly.

Key points as reported by the Registrant

The patient is in his mid-twenties and has "high-end autism". Dr. Puppala saw initially him on February 2, 2021. The patient was accompanied by a family friend who was his long-term patient. During the appointment, the family friend asked Dr. Puppala to examine the patient, who had been suffering from a cough for several months and did not have a family doctor.

Dr. Puppala diagnosed the patient with asthma and started him on a trial of puffers. He did not have any past medical history or records to refer to. After the initial appointment in February, Dr. Puppala advised the patient to return for a follow-up appointment in one month if he was not better.

The patient's next appointment was on May 5, 2021. At this time, he had not improved clinically in relation to asthma but did not have any other symptoms of lymphoma which include night sweats, weight loss, fevers, fatigue, or generalized pruritus. The patient did have supraclavicular lymph node swelling on the left side of the neck. This prompted Dr. Puppala to order blood work and a CT scan out of concern to rule out malignancy. He asked the patient to return in two to

three months or as needed if he was not better.

The CT results showed enlarged supraclavicular, mediastinal, and internal mammary lymph nodes, which could be a sign of lymphoma. There was no swelling of the spleen or liver.

Blood work was also done in June 2021, and it showed increased neutrophils but low lymphocytes. No liver enzyme elevation and normal lactate dehydrogenase. His ferritin was normal stating that there was no inflammation going on in the body.

Nobody followed up on the patient and his cough symptoms until November 29, 2021. This follow-up was only scheduled because the patient needed paperwork for disability. His symptoms had not worsened or changed, nor did he have any weight loss during this period.

Dr. Puppala states he did not discuss the patient's health or care during any of the family friend's own appointments before they returned in November, or after that date as well.

Upon filling out the disability paperwork, Dr. Puppala asked about the patient's symptoms and did not receive any significant source of concern from him or the family friend. But on noticing the patient's persistent lymphadenopathy and having the CT scan results of possible lymphoma, he ordered a biopsy for the patient and specifically told the family friend to follow-up, to rule out lymphoma. Dr. Puppala states he understands that this information was not communicated properly to the patient's mother or the family members because unfortunately, the patient did not show up for the appointment on January 13, 2022.

The patient's mother came to the office in July 2022 and said that the patient had been diagnosed with cancer. She threatened to sue Dr. Puppala if something happened to her son.

Dr. Puppala was not aware of his lymphoma diagnosis because they did not register Dr. Puppala in the hospital records/system as his family doctor.

Dr. Puppala states that during 2021, Dr. Puppala saw numerous cases of axillary and mediastinal lymphadenopathy secondary to COVID vaccination. In the patient's case, due to limited medical history and exposure to him, he decided to treat conservatively and pursued the possibility of lymphoma with a percutaneous biopsy if he had persistent symptoms.

Nova Scotia started rolling out its first COVID vaccine in January 2021. Healthcare workers and people at risk were one of the first to receive it. The patient's age group had the vaccine around May - June 2021. His immunization records are not shared with his family doctor or any person that seeks to access it. There is no central database to access vaccine information by family doctors or any health providers. It must be shared by the patient during their visit. When Dr. Puppala saw the CT scan result in June 2021, he had no means to determine if he had his immunization or not.

Dr. Puppala understands that the patient's family, his mother, caregiver, and his godfather were inquiring about his health care concerns. He states his office has not had any appointments made or canceled or no shows during this time. He states his office promptly returned any phone calls that were made for appointments. Any information that needed to be accessed

would have been arranged by making an appointment or just walking in.

Dr. Puppala states that when the patient's lungs were examined and were clear in February 2021, this does not negate the diagnosis of asthma. According to history, the patient only had shortness of breath with exertion which goes with the diagnosis of asthma. Wheezing might not be audible during normal times. He could be completely normal during examination with clear lungs but still have symptoms of asthma when he is exposed to allergies or exercise induced.

Dr. Puppala promptly corrected the paperwork for the patient's autism support and faxed it accordingly.

Preliminary Investigation

Pursuant to Section 88 (1) of the *Medical Practitioners Regulations*, an investigator was appointed to conduct a preliminary investigation of this complaint. An investigator conducted interviews with the complainant, the patient, the family friend and Dr. Puppala, and drafted a (Preliminary) Investigative Report.

CONCERNS/ALLEGATIONS OF COMPLAINANT

The complainant alleges Dr. Puppala:

- lost a chance at an early detection of lymphoma;
- blamed the COVID vaccine for the lump, even though the patient was not vaccinated;
- failed to follow up; and
- did not complete disability work correctly.

DISCUSSION

The Committee reviewed the complaint, response, and medical record. The Committee considered investigator interviews of Dr. Puppala, the complainant, the patient and the family friend. The Committee interviewed Dr. Puppala.

Initial visit

Dr. Puppala reiterated in his interview with the investigator how in February 2021, the patient was coughing and had no other symptoms and had no nodes in his neck. Dr. Puppala maintains he told the patient to follow up in a month.

The Committee confirmed the medical record noted the patient presented in February to "establish care" and had an ongoing cough. His lungs were clear on auscultation, but he had redness in his ears. Dr. Puppala prescribed Flovent for asthma and the plan was to follow-up in 1-2 months or as needed.

In his interview with the Committee, Dr. Puppala said to his knowledge the family friend and the patient made a follow-up appointment in one month, as they were leaving, but subsequently that was cancelled (not by him) and rescheduled, more than once.

It is not clear to the Committee whether the family friend and the patient communicated the follow-up plan to the complainant, the patient's mother, and whether that was the expectation or Dr. Puppala's instruction.

May 5, 2021, subsequent visit

Dr. Puppala stated in his investigator interview that when the patient came in for his next appointment on May 5, 2021, he was provided with limited information about how the patient had been since their first visit. Upon examination, Dr. Puppala found a hard lump. Dr. Puppala was concerned the left supra-clavicle could be a sentinel node from an underlying malignancy. He ordered a CT. He cannot recall exactly what he said to the family friend as to why he was ordering the CT. He may have said he was, "looking for cancer" but may have only said he needed to do further investigations. He says he tells patients he will call them to come in if something is "wrong" on their CT.

During his interview with the Committee, Dr. Puppala stated he could not recall the conversation at this appointment but did say he was "worried about cancer".

During his interview with an investigator, the patient said he could not remember a lot about his appointments with Dr. Puppala. He recalls how he went with the family friend because Dr. Puppala was the family friend's doctor. He did recall that after he had a CT scan, he never heard anything more.

The May 5, 2021, medical record indicates the Flovent did not help, and the cough was continuing. The patient's lungs were clear, but Dr. Puppala noted a supraclavicular adenopathy. The noted plan was to check labs and have a chest CT and it was advised they follow up in 2-3 months or as needed. It is not clear to the Committee whether the follow-up plan was communicated to the family friend and the patient, or whether the family friend and the patient communicated the follow-up plan to the complainant.

June 7, 2021, CT Results

During his interview with an investigator, Dr. Puppala stated he read the CT result/report on June 7, 2021. He stated it demonstrated the issue was "mostly mediastinal" and nothing abdominal, so he was not concerned that it was a sentinel node indicating malignancies. He thought the patient might have vaccine-related adenopathy, because at that time, he had seen a lot of health care workers who had these. The CTs and biopsies of those healthcare workers/patients came back normal.

The Committee reviewed the CT findings which indicated:

FINDINGS:

Parotid, submandibular and thyroid gland within normal limits. No pathologically enlarged lymph nodes in the neck. No neck mass. Pharynx and larynx are within normal limits. Enlarged left supraclavicular lymph node measuring 3.1 x 2.6 cm. Enlarged mediastinal lymph nodes, largest of the right paratracheal lymph node mass is 6.2 x 5.6 m causing compression and stretching of the SVC but no thrombosis. No hilar or axillary lymphadenopathy. No pleural or pericardial effusion. Also seen enlarged right internal mammary lymph node. Lung fields shows no mass or airspace consolidation. In the visualized upper abdomen spleen size upper limit of normal at 13.8 cm. No definite enlarged upper abdominal lymph nodes seen. No aggressive bony lesions.

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

Dr. Puppala indicated he did not want to "jump into the conclusion that it could be malignant" and "cause anxiety in this child". He decided if the lump did not go away, he would bring him in, and they would do a biopsy.

During his interview with the Committee, Dr. Puppala said when he got the patient's bloodwork back, it was "basically anemia". His platelets were normal and the white blood cells were about 12,000, and it was neutrophil predominant, and leukocyte depleted. Lymphocytes were only 20,000 and usually, "they go up to 30 to 45,000". There was no auto morphology or peripheral smear. The ferritin was normal, iron stores were low and the LFTs were normal. LDH was normal and if the blood cells had been rupturing because of incomplete malformations the lymphocytes and LDH would be elevated. Dr. Puppala noted this usually happens in the late stages of lymphomas, but most of the numbers were normal, "and it was kind of reassuring". The electrolytes were normal, and the thyroid was normal.

Dr. Puppala acknowledged he did not have any explanation for the anemia, but thought that because the patient's iron level was low, he was iron deficient from not eating a healthy diet and living a sedentary lifestyle, influenced by ASD (autism spectrum disorder). Dr. Puppala did not have collaborative reports to go back to that would indicate he needed to investigate further.

Dr. Puppala told the Committee he was not sure the Radiologist could comment that this was lymphoma, because that requires a histologic diagnosis (a diagnosis that requires an examination of biopsied tissue by a pathologist) and he was, "kind of puzzled with that". Dr. Puppala thought it could be a vaccine related injury (he assumed the patient would have been a priority for vaccination because of his ASD) or the patient might have had COVID, and might have reactive lymphadenopathy, which any upper respiratory tract illness could have caused.

November 29, 2021, visit

Dr. Puppala reiterated in his interview with the investigator that when the family friend brought the patient in for an appointment in November 2021, they came in to get paperwork completed. At the time, the patient was still not feeling better, so Dr. Puppala ordered a biopsy. He states he

told them the lump was the same size, was not going away and could be cancerous. This appointment was the last he heard from anybody regarding the patient. He assumed the lump had gone away.

Dr. Puppala confirmed that at this November 2021 appointment, the family friend and the patient would not have been aware of the June 2021 CT scan results.

Dr. Puppala stated during his interview with the investigator (and affirmed to the Committee) that during the November 2021 appointment, he said to the family friend, "it's looking hard, I don't think it's a normal lymph node, it could be malignant, it has to be followed through". He said he had the impression the family friend heard what he said and understood it.

Dr. Puppala told the Committee he recalls the family friend coming to his own appointment, after the biopsy had been ordered, without the patient accompanying him, and asking him about the CT scan result or the biopsy result. He remembers telling the family friend that biopsies were taking a long time to come back since COVID because of the pathologists getting backed up. Dr. Puppala thinks the family friend presumed it was the CT scan that was taking a long time to come back, and Dr. Puppala thought the patient already went for biopsy and that is what the family friend was asking him about.

During his interview, the patient could not recall if Dr. Puppala stated at the November 2021 appointment that he was going to send in a request for him to have a biopsy. The family friend stated Dr. Puppala "never told him anything". It was not clear to the Committee what, if anything, the family friend, or the patient communicated to the complainant after the November 2021 appointment.

The Committee confirmed the November 2021 medical record captured that the plan was to order a biopsy to "rule out malignancy" as the "CT suggested lymphadenopathy in the mediastinum". They were advised to follow up in 2-3 months, or as needed. The Committee observed the biopsy requisition indicated there was a "hard swelling in the left supraclavicular area of the neck/Rule out malignancy". The Committee observed the CT requisition has a phone number listed for the patient that is not the number that is on the College complaint form for the patient, or for his mother, the complainant.

Dr. Puppala initially told the investigator that when he looked at the missed biopsy (appointment) notification from Radiology in January 2022, he thought, "Well, the lymph nodes must have gone back to normal because the patient did not show up", but later said that because the notification was not time stamped, he was not sure he had seen it.

Dr. Puppala told the Committee he thinks the missed biopsy notification came to his office and that his secretary uploaded it to his EMR and did not alert him as to what happened.

In June 2022, the patient's mother met with Dr. Puppala. She said her son has cancer. She stated her doctor was surprised that the June 2021 CT scan that stated "lymphoma" was not followed-up on. Dr. Puppala apologized for acting conservatively, thinking the lump could be vaccine related. The complainant states if Dr. Puppala had told the family friend he thought the lump was vaccine related, they could have ruled that out, as the patient was not vaccinated. The Committee

observed it is unclear whether the family friend was aware of the patient's vaccination status, but notes it appears no one was ever asked. The Committee noted that in his interview with the investigator, Dr. Puppala said he had also told the complainant, "We thought the lymph nodes went away, that's why you missed your appointment".

The Committee noted if Dr. Puppala did not see the missed appointment notification this raises communication and clinic operations concerns. If he saw the notification and assumed the patient was a no-show because he was better, that assumption, coupled with not following up, was risky.

Documentation and Consent

The Committee observed Dr. Puppala stated in his interview with the investigator that the family friend would come to his own scheduled appointment and upon arrival would say that the appointment was for his friend, the patient. Dr. Puppala states he was "put in a situation" where he felt he should treat the friend. Dr. Puppala understood from the family friend that the patient did not have a family doctor. Dr. Puppala understood there were no medical records which could be transferred to him.

During his interview with the Committee, Dr. Puppala said that if the patient was brought up in any of the appointments that were the family friend's appointments and the patient was not present, he would not document anything in the patient's chart or in the family friend's chart because it was a "pass by comment" not relevant to the family friend. When speaking to the family friend and the patient during appointments, Dr. Puppala states the family friend would look at him with a "blank stare".

The Committee is concerned that the family friend bringing the patient to see Dr. Puppala, sometimes within an appointment he scheduled for himself, was not without risks regarding communication and follow-up. It was also risky for Dr. Puppala to rely on the family friend to accurately communicate information to the complainant, and it is acknowledged by the complainant that her son has communication issues himself. The complainant was upset Dr. Puppala never communicated anything to her, but it is unclear whether Dr. Puppala was told he had to communicate with her, or whether the family friend was the sole point of contact.

Dr. Puppala stated in his interview with an investigator that if he realized the patient was somebody who could not follow through [on follow-up] or who would "fall through the cracks", he would have "made arrangements". The family friend was hearing impaired, and the patient could not advocate for himself and if Dr. Puppala "had more familiarity" he would have "made a buffer to prevent those things from happening".

In his interview with the Committee, Dr. Puppala said that he did not think the patient had the capacity to make clinical decisions for himself or to receive medical information directly from Dr. Puppala due to his "high end autism" which the family friend "maybe did say" [he had].

The Committee struggled to reconcile these two comments. Dr. Puppala implied he had not realized the patient was someone who could not follow through on things, but at the same time, was concerned the patient might not have capacity, and knew he could not advocate for himself.

The Committee also recalled Dr. Puppala stated during his interview with the investigator that during a November 2021 appointment he had the impression the family friend heard what he said and understood it (regarding the hard lymph node), but he also stated that the family friend would look at him with a "blank stare" during appointments. The Committee is concerned it is possible the family friend may not have understood what Dr. Puppala was telling him about the hard node.

Analysis

Dr. Puppala states that in hindsight he should have acted on the June 2021 CT results and given the option to the patient whether to do the biopsy right away or watch and wait. Dr. Puppala also states that unfortunately the patient did not, "come in within the usual time" and acknowledges he should have made a note to file to recall the patient to discuss those CT findings and further options.

The Committee remains concerned that the CT result clearly rang alarm bells where it indicated, "*IMPRESSION: Left supraclavicular, mediastinal and right internal mammary lymphadenopathy from lymphoma".* Coupled with the patient's bloodwork results, Dr. Puppala should have been quite concerned by this Radiology impression, especially considering the patient's age.

The Committee considered Dr. Puppala's statement he was not sure the Radiologist could comment it was lymphoma, because that requires a histologic diagnosis. Dr. Puppala thought it could be a vaccine related injury, but the Committee observed he did not follow up on his interim differential diagnosis to confirm the patient's vaccine status. He did not make a note at the May 2021 visit to recall the patient to discuss his CT results, and when he read the results in June 2021, he did not follow up with the patient and the family friend. The Committee is concerned that if the family friend had not brought the patient back in for an appointment in November to get paperwork completed, the concerns noted in the June 2021 CT might have completely fallen off Dr. Puppala's radar.

Dr. Puppala also states that in hindsight, he should have further investigated why the patient did not show up for his biopsy. The Committee remains concerned Dr. Puppala appeared to have no mechanism in place to ensure the patient's care plans were being facilitated. He acknowledged he was concerned the patient did not have capacity to direct his own health care.

Dr. Puppala states that in hindsight, not being totally aware of the dynamics and family situation, he should have put something in place to ensure things were understood. The Committee remains concerned Dr. Puppala did have reservations about the patient's ability to navigate his care and treatment on his own but failed to put anything in place to mitigate the associated risks.

This issue of the patient and capacity remains concerning. 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.

If Dr. Puppala was concerned the patient might not have capacity, the next step would be 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 was the patient's SDM. To the Committee's knowledge, the family friend was not the patient's SDM, and there is no record of the same on the patient's chart.

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.

The Committee considered Dr. Puppala's failure to follow-up with the family friend and the patient regarding the June 2021 CT results, and his subsequent failure to investigate why the patient did not show up for his biopsy appointment, as well as the content of his medical record contents. The patient has lymphoma, for which treatment was required.

In accordance with section 99(5)(f) of the *Medical Practitioners Regulations*, the Committee has 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, which contains the following:

- In 2021, Dr. Puppala was Cautioned for failing to appropriately manage a patient's care across the continuum. He was cautioned to integrate information from specialists into the care plan and to effectively communicate the care plan to the patient's family. He was also cautioned to maintain up-to-date medical records. In that matter, the Committee felt a licensing sanction was not warranted as it was reassured Dr. Puppala would be receptive to education regarding improving his communication skills with patients and other healthcare providers. He was ordered to participate in Communication Skills

training regarding having difficult conversations with patients or colleagues.

- In 2021, Dr. Puppala was also Cautioned to have open lines of communication with pharmacists and to respond in a collegial manner to ensure the safety of his patients from a medication standpoint.

- In 2017, Dr. Puppala was Cautioned to ensure he performs a thorough history, physical, and orders appropriate investigations based on the presenting complaint.

- In 2015, the Committee Cautioned Dr. Puppala to improve his medical record keeping to a level that meets the expected standard of the profession.

The Committee observed Dr. Puppala has been previously Cautioned regarding the contents of his medical records. He has been Cautioned about his communication skills. He has been Cautioned to appropriately manage a patient's care across the continuum by integrating 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 because Dr. Puppala was warned four times that his communication, record keeping, and integration of specialists' care needed improvement. Despite these Cautions and despite having taken a Communications Skills training course, the problems persist, resulting in a delayed diagnosis for a patient who is not able to advocate for himself.

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 professional misconduct in this case warrants imposing a licensing sanction.

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

The leading judicial authority for sanctioning principles followed by Professional Regulators is *Jaswal v. Newfoundland (Medical Board),* 1996 CanLII 11630 (NL SC). It sets out thirteen non-exhaustive factors to consider. These include:

- the nature and gravity of the proven allegations;
- the age and experience of the offending physician;
- the previous character of the physician and in particular the presence or absence of any prior complaints or convictions;
- the age and mental condition of the offended patient;
- the number of times the offence was proven to have occurred;
- the role of the physician in acknowledging what had occurred;

- whether the offending physician had already suffered other serious financial or other penalties as a result of the allegations having been made;
- the impact of the incident on the offended patient;
- the presence or absence of any mitigating circumstances;
- the need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper practice of medicine;
- the need to maintain the public's confidence in the integrity of the medical profession;
- the degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct; and
- the range of sentence in other similar cases.

The Committee is satisfied lymphoma is a significant illness with serious potential complications and outcomes.

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 contributed to the delay in the patient receiving his lymphoma diagnosis and associated treatment. The impact is significant. Dr. Puppala's failure to proactively communicate back to the patient, a vulnerable person, and to the family friend and the complainant, could shake the public's confidence in the practice of medicine because the expectation is that one's treating physician will follow-up with you when a concerning test result is received, and ensure any follow-up testing is arranged and completed.

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 godson of his patient, the family friend. While it is to be commended that he agreed to help the patient via the family friend, this set-up was not without significant foreseeable risks.

The Committee also appreciates that while the patient's family, his mother, caregiver, and his godfather were apparently inquiring about the patient's health care concerns, Dr. Puppala states his office did not have any appointments made by family members to discuss the patient. He states his office promptly returns phone calls made to request appointments. The Committee is satisfied that whatever was happening or not happening regarding the patient's family attempting to make appointments, it was Dr. Puppala who should have reached out to follow up.

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

The Committee was not concerned that Dr. Puppala failed to complete the patient's disability paperwork correctly because the issues were rectified by Dr. Puppala.

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.

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 costs in the amount of $2500 as a contribution toward the costs of the investigation.

All decisions remain permanently on the record of the College and can be referenced in the event of any future complaints made against the physician. Likewise, a Certificate of Professional Conduct will reflect all prior decisions.