SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee
(the Committee)
(Information about the complaints process and the Committee is available at:
https://www.cpso.on.ca/Public-Information-Services/Learn-About-Our-Complaints-Process**)**

Dr. Jaswinder Bhalla (CPSO# 94886)
(the Respondent)

INTRODUCTION

The Complainant, a woman in her 30s, became a patient in the Respondent's practice in 2014. She had a medical history of breast cancer and fibroids, and a surgical history including lumpectomy and myomectomy.

The Complainant attended the Respondent in April 2015 for assessment and treatment of back pain. In August 2015, the Complainant attended a hospital Emergency Room (ER), was diagnosed with metatastic breast cancer, and received urgent thoracic spine radiotherapy to prevent a spinal cord lesion.

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

COMPLAINANT'S CONCERNS

The Complainant is concerned about the care provided by the Respondent at her clinic in 2015. For example, she:

- **ran her hands down the Complainant's back when she complained of back pain, and advised her to exercise**
- **failed to perform further tests and investigations when the Complainant's pain did not subside**
- **refused to perform an internal examination to check the Complainant's fibroids as recommended by her gynaecologist, telling her to book an appointment for a Pap smear.**

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of February 21, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to failure to appropriately investigate new back pain in a patient with known past breast cancer, and with respect to her poor medical records. The Committee also accepted an undertaking from the Respondent to engage in education, practice under supervision, and undergo a reassessment approximately six months following the period of education and supervision.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who specializes in family medicine. The Assessor opined that the Respondent's care failed to meet the standard of practice when the Complainant attended with back pain in 2015, and when she attended for a gynaecologic examination and Pap smear in 2014.

The Respondent ran her hands down the Complainant's back when she complained of back pain, and advised her to exercise; and
The Respondent failed to perform further tests and investigations when the Complainant's pain did not subside

The Respondent's assessment, documentation and plan at the April 2015 visit where the Complainant reported back pain did not meet the standard of the profession. The Respondent failed to take a full history, which should have included the Complainant's history of breast cancer treated with a lumpectomy. The Respondent did not order any further tests or investigations, as she should have in light of the Complainant's medical history. Further, her chart notes were poor and she did not document a specific plan for the Complainant. The Respondent also noted no differential diagnosis for new back pain in a young patient with a known history of breast cancer.

The Respondent refused to perform an internal examination to check the Complainant's fibroids as recommended by her gynaecologist, telling her to book an appointment for a Pap smear

At the Complainant's first visit in August 2014, the Respondent documented the Complainant's history, including her history of fibroids followed by a myomectomy. The Respondent documented "book pap" indicating that she advised the Complainant to return for a Pap smear.

The Complainant returned for the Pap test in September 2014. The Assessor was critical of the care at the September 2014 visit, commenting that, "When Pap/gyne exam is done in lieu of a full physical in a healthy woman of a certain age, it should include a breast exam. When there is a past history of breast cancer it should be mandatory." The Committee agreed that the Respondent's care at the September visit was not sufficiently thorough.

Concerns about the Respondent's clinical care will be addressed by the educational and supervisory components of the Respondent's undertaking. In addition, the Committee wished to discuss care in this specific case with the Respondent when she attends to be cautioned.