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**THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA**
**INVESTIGATION COMMITTEE**

**CENSURE – IC5295**
**DR. BERHANU BALCHA**

On November 15, 2022, in accordance with subsection 102(2)(d) of *The Regulated Health Professions Act* ("RHPA), the Investigation Committee ("the Committee") of CPSM censured Dr. Balcha with respect to his care and conduct relating to the management of one of his patients as it pertains to her metastatic cancer recurrene. The concerns are that Dr. Balcha failed to meet the standard of the profession and displayed a lack of judgment in respect to his care and conduct in the following respects:

- Failed to refer Patient X for yearly mammograms as advocated by her oncologist in 2015, particularly in the context of her history of invasive ductal breast cancer.
- Failed to respond to progressing abnormalities at multiple points in time indicating metastatic disease as the clinical situation unfolded.
- Failed to appropriately document in Patient X's record sufficient information pertaining to her medical care in a legible and cohesive manner such that appropriate follow-up would ensue.

## I. PREAMBLE

Accurate, comprehensive, and timely diagnosis is central to patient care and a major determinant of health outcomes. The diagnostic process requires that a physician meet their patient's problem with an acceptable level of clinical reasoning skills and diligent information gathering. Physicians must be rigorous in their appreciation of the information gathered and the synthesis of pertinent information in the clinical context. A reasonable standard of care is characterized as a threshold of competency that all physicians within a given field are expected to meet.

Medical care provided must be accurately and adequately documented to ensure continuity of care and follow up by that physician, and such that other care providers can rely on the record to inform their care of the patient should the need arise. Details in the record must be sufficient to reasonably allow other health care providers to understand the nature of the care provided. This includes meeting CPSM's requirements and the standard of the profession for the creation and maintenance of adequate records. Record keeping requirements are addressed in Bylaw #11, Sections 2 and 27, which were in effect at the relevant time. The requirements have not changed but are noted in the Record Keeping document of the CPSM Standards of Practice of Medicine.

## II. THE RELEVANT FACTS ARE:

The Committee assessed the facts as follows:

1. Some details underlying this censure have been removed or anonymized to avoid providing identifying information about third parties.

2. X, who was born in 1950, was a long-term patient of Dr. Balcha's family medicine practice.

3. She had a history of invasive ductal breast cancer that was diagnosed in 2008 and treated with surgery, radiation, and chemotherapy. Her adjuvant therapy concluded in 2013.

4. The Committee considered the care Dr. Balcha provided as documented in a handwritten paper chart from 2015 onward. There were some legibility issues, and the chart contained scant information. Dr. Balcha provided a verbatim transcript to assist with interpretation of his notes.

5. On March 16, 2015, X had her final assessment by her oncologist, who was retiring in June. The plan going forward included that she follows up with her family physician, including yearly mammograms until age 70 and routine annual bloodwork. X was further advised to see her family physician regarding an episode of numbness to the right side of her body that occurred the day before.

6. Visits in 2015 and 2016 with Dr. Balcha were largely about diabetes and hypertension monitoring.

7. In October and December 2016, X complained to Dr. Balcha of numbness to the right side of her face and right shoulder, but no assessment of these complaints is documented.

8. In April 2017, her numbness issues continued, and Dr. Balcha referred X to a neurologist, Dr. D, whom she saw multiple times in follow up to various tests that were done.

9. Dr. D referred her for an MRI and then for a CT/angiogram. The CT/angiogram notes incidental pulmonary nodules. There were also enlarged right supraclavicular lymph nodes. A dedicated CT of the thorax was recommended for further assessment.

10. On July 11, 2017, Dr. D faxed a letter to Dr. Balcha detailing the concerns and indicating X's request to involve Dr. Balcha in further investigation and management.

11. It is apparent on the face of all diagnostic reports that were forwarded from Dr. D to Dr. Balcha, and they formed part of Dr. Balcha's medical record. The pulmonary nodules are highlighted with an * in the report by Dr. D and Dr. D notes he called X and will see her on July 10 regarding same. Dr. D also noted that the nodules were probably related to her history of breast cancer.

12. On July 12, 2017, X was seen by Dr. Balcha and his notes indicate that a discussion occurred regarding diabetes control, the numbness, and Dr. D's recommendation to change medications. The record also notes "*lung nodule – may need CT*". No CT was ordered at this time.

13. On September 13, 2017, a follow up visit with X occurred regarding the nodule on the lung. Dr. Balcha noted that "*unable to see specialist soon; Book CT*." A CT scan requisition was completed the same day, indicating a history of breast cancer and the multiple nodules seen in the chest. On October 2, 2017, a CT chest was done. The notes are as follows:
    Impression:
    1. sclerotic osseous metastatic disease.
    2. Numerous bilateral pleural and pulmonary parenchymal nodules. Given the findings elsewhere, this likely represents metastatic disease as well. There are no pleural effusions at this time.
    3. Mildly large right hilar lymph node, concerning for nodal metastatic disease.
    4. A CT of the abdomen/pelvis is recommended to assess for intra-abdominal metastatic disease.

15. Dr. Balcha was out of the office between September 28 and November 29, 2017. While Dr. Balcha states a colleague was reviewing his patients' results during this timeframe, that same colleague denies that he was covering for this particular patient. This is indicative that there was no system in place to ensure proper coverage while Dr. Balcha was scheduled to be absent for that two-month period.

16. The CT scan report was received on October 3rd by Dr. Balcha's office. It appears to have been reviewed (initialed) by Dr. Balcha as portions of the conclusions of the report have been underlined or checked off, but it is unclear when it was reviewed.

17. On December 6, 2017, Dr. Balcha saw X for a visit at which time he noted there to be no issues with her diabetes and "CT scan report not available." Dr. Balcha recommended a follow-up in 3 months and there is no evidence of any action taken to follow-up regarding the CT scan report.

18. At X's next visit on February 14, 2018, Dr. Balcha documented that the CT scan was obtained (presumably from October 2, 2017), there were "mets to bones" which he discussed with X. It was only at this time that Dr. Balcha ordered an abdomen/pelvic CT. No referrals to oncology were made.

19. On March 26, 2018, the CT for the abdomen and pelvis was done. The requisition noted a clinical history of breast cancer with bone metastases and lymphadenopathy, rule out rectal metastases. The results indicated worsening osseous metastatic disease, thickening of the stomach and pulmonary nodules. No referrals were made to oncology thereafter. Dr. Balcha instead referred her to a gastroenterologist which resulted in a gastroscopy.

20. On August 10, 2018, X attended to Dr. Balcha for a visit, and he noted her to be experiencing musculoskeletal pain that was potentially secondary to breast cancer bone metastases. He provided her with Tylenol 3 and a note to be off work. Dr. Balcha did not refer her to CancerCare Manitoba at this visit, nor in the visits that followed in March and April 2019.

21. A mammogram was done in July 2019 at Dr. Balcha's request. No malignancy was noted. On August 28, 2019, X attended to his office complaining of shortness of breath as well as a lump behind her left ear. A history of dyspnea is documented, and a physical exam was done. A chest x-ray was done the following day and received by Dr. Balcha on August 30, 2019. It showed a large right sided pleural effusion and pulmonary nodules suspicious for metastatic disease. Dr. Balcha signed off on the x-ray report that same day but did nothing to follow up.

22. On October 16, 2019, X was still experiencing shortness of breath. A follow-up x-ray was done on October 18 and received the same day. It notes progressive metastatic disease with progressive pleural effusion and nodules. It was at this time that Dr. Balcha referred X to a respirologist, whom she attended on November 12, 2019.

23. A pleural tap done by the respirologist, Dr. H, who confirmed the presence of cancer, and a referral was made to CancerCare Manitoba by Dr. H.

24. Dr. Balcha's records indicate that on November 20, 2019, he referred X to CancerCare Manitoba and documented it to be at Dr. H's recommendation.

25. On January 3, 2020, X was assessed by CancerCare Manitoba, and it was confirmed that she has stage 4/metastatic breast cancer.

26. X's oncologist has reviewed the above-mentioned tests done in 2017 and confirmed that they are indicative of the return of stage 4/metastatic cancer.

27. On January 15, 2020, X attended to Dr. Balcha for the last time with 3 family members present. Dr. Balcha's notes indicate metastatic breast cancer and that she was seeing CancerCare Manitoba. He further noted that the malignant pleural effusion was being drained, she was still short of breath, and she should follow up as necessary.

28. While the specifics of Dr. Balcha's discussions with X are unknown, X has advised that she was unaware that there were concerns about a recurrence or spread of her cancer until she met with Dr. H in November 2019.

## III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. BALCHA'S CONDUCT IN:

1. Failing to refer X for yearly mammograms as advocated by her oncologist in 2015, particularly in the context of her history of invasive ductal breast cancer.

2. Failing to appropriately document X's record with sufficient information pertaining to her medical care in a legible and cohesive manner that would ensure appropriate follow up.

3. Failing to take appropriate steps to treat X's condition as follows:
    a. Dr. Balcha took no action to arrange a dedicated CT chest that was recommended in June 2017 until September 13, 2017. No referral was made to CancerCare Manitoba at that time.
    b. Dr. Balcha was out of the office between September 28 and November 29, 2017 and failed to ensure proper coverage was in place for his patients, including the review of X's CT scan report, while he was absent for that 2 month period.
    c. On October 2, X had a dedicated CT chest where metastatic disease was noted, and a dedicated abdominal/pelvic CT was recommended. When X attended to Dr. Balcha in December 2017, his notes indicate that the results of the CT done on October 2 were not available when the report indicates it was received by his office on October 3rd. There is nothing indicating that Dr. Balcha followed up on that report at that time and it is unknown when he reviewed the results.
    d. On February 14, 2018, X attended to Dr. Balcha at which time a discussion was documented about the report including "mets to bones" and he ordered a CT of the abdomen and pelvis. Once again, Dr. Balcha made no referrals to CancerCare Manitoba for X.
    e. On March 26, 2018, a CT of the abdomen and pelvis was done. The results noted multiple progressive abnormalities, though secondary to breast cancer bone metastases. Dr. Balcha made no referrals to CancerCare Manitoba at this visit, nor in the visits that followed in March and April 2019.
    f. On August 29, 2019, X had a chest x-ray done as a result of attending to Dr. Balcha's office with complaints of shortness of breath. Despite the x-ray showing a large right-sided pleural effusion and pulmonary parenchymal metastatic nodules being suspected, Dr. Balcha signed off on the report and did nothing to follow up. No action was taken until another chest x-ray in October 2019 prompted referral to a respirologist.

## IV. ORDERS

The Committee directed, pursuant to subsection 104(2) of the RHPA, that this censure and a description of the circumstances that led to it be made available to the public. Dr. Balcha paid the costs of the investigation in the amount of $4,680.