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. Mahmud Kara (CPSO #59474)
(the Respondent)

INTRODUCTION

The Respondent carried out a breast augmentation procedure on the Complainant in March 2021. As part of her surgical package, complimentary facial services and scar reduction treatment was included.

The Respondent took a leave of absence and then subsequently closed his practices in the summer of 2021 and as a result, he did not provide the Complainant with the complimentary services agreed to.

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

COMPLAINANT'S CONCERNS

The Complainant is concerned about the care and conduct of the Respondent, after undergoing breast augmentation on March 3, 2021. Specifically, the Respondent:

a) **failed to attend any preoperative appointments;**
b) **failed to properly perform her surgery, as she remains uncomfortable, in pain, and can feel 'hard clusters of something' now eight months post-surgery;**
c) **failed to insert the appropriately sized implant, leaving her with a D cup size rather than the requested C or B cup size;**
d) **failed to provide an in person follow up exam to discuss her concerns regarding her recovery, despite her multiple requests;**
e) **failed to attend follow up appointments, which had been scheduled by his office;**
f) **failed to provide the scar treatment and facial services that were included in her postoperative package;**
g) **inappropriately had his office staff advise to send all postoperative pictures to a cell phone number; and,**
h) **inappropriately closed his practice without notice and appropriate follow up.**

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of May 8, 2023. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to:

1. His failure to abide by obligations and responsibilities regarding temporary absences or closing of a medical practice while ensuring continuity of patient care, including not communicating with patients and not following the College policy, *Closing a Medical Practice*.

2. His failure to adequately perform or document preoperative appointments and discussion and postoperative care.

3. His failure to ensure proper delegation, including explicit communication of delegates' obligations and responsibilities.

The Committee also decided to accept an undertaking that is now posted on the public register.

COMMITTEE'S ANALYSIS

Failed to provide the scar treatment and facial services that were included in the Complainant's postoperative package (f)
- and -
Inappropriately closed his practice without notice and appropriate follow up (h)

As part of this investigation, the Committee retained an independent Assessor who specializes in plastic surgery. The Assessor expressed the view that, contrary to the College's policy, *Closing a Medical Practice,* the Respondent did not have a proactive plan for his office's closure and did not take reasonable steps to ensure his patients' ongoing care. In this way, the abrupt closure of the Respondent's practice and his out-of-hospital facility did not meet the standard of care.

The Committee concurred with this view and decided to caution the Respondent regarding this aspect of his care and to accept the undertaking.

Failed to attend any preoperative appointments (a)
- and -
Failed to do in-person follow-up examination to discuss the Complaint concerns (d)
- and -
Failed to attend follow-up appointment as scheduled by his office (e)

The Committee was also concerned about the Respondent's medical record keeping and his delegation of pre- and post-operative care. In this case, the Respondent's failed to adequately document his involvement in the Complainant's pre-operative care. Additionally, the Respondent had only very brief interactions with the Complainant both at the pre- and post-operative stage and delegated much of the Complainant's care and assessment to his nursing staff. This is inadequate care which could put patients at risk.

As such, the Committee determined that it was appropriate to caution the Respondent in person, with respect to these failings.

Inappropriately had his office staff advise to send all postoperative pictures to a cell phone number (g)

The Respondent told the College that his staff was not approved to request information in this manner. However, the Assessor indicated that a physician is responsible for ensuring that clinic policies and procedures are upheld by all staff. The Committee was satisfied that their concern regarding this issue would be addressed by accepting the undertaking from the Respondent.

Failed to properly perform the Complainant's surgery, as she remains uncomfortable, in pain, and can feel 'hard clusters of something' now eight months post-surgery (b)
- and -
Failed to insert the appropriately sized implant (c)

The Committee took no action with respect to these areas of concern.