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 bilateral brachioplasty and mastopexy on the Complainant. He subsequently performed fleur-de-lis circumferential belt lipectomy on the Complainant, but she developed wound dehiscence that required vacuum-assisted closure (VAC) and repair.

The Respondent planned to perform revision surgery in November 2019 but recommended that the Complainant reach a body mass index (BMI) of 33 before the surgery. The Complainant paid the Respondent in advance for leg lift surgery.

The Respondent took a leave of absence from his practice in July 2021 and subsequently closed his plastic surgery clinics. He did not perform the Complainant's leg lift surgery.

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 in regard to the arm lift, breast lift and 360-degree body lift he performed. Specifically, the Respondent:

- **Failed to appropriately perform the Complainant's arm lift, which left permanent creases on each arm**
- **Failed to appropriately perform the Complainant's breast lift, which left her right breast puckered under the nipple and with a 'dog ear' to the back of her right armpit**
- **Inappropriately performed a 360-degree body lift on the Complainant, given that she was not an appropriate candidate for the procedure at the time**
- **Failed to properly perform the Complainant's body lift, as it lasted for approximately 12 hours, resulted in wound complications, left her body disfigured and left a large pouch of skin on her lower abdomen that hangs down her right side**
- **Failed to provide appropriate treatment for the Complainant's dehisced wound, in that he sent her home wrapped with diapers, he indicated that appropriate**

treatment could be provided by community nurses, surgical intervention was delayed, his communication with community nurses was lacking, and he lacked experience with wound VAC dressing

- **Failed to obtain proper consent from the Complainant in that he did not inform her about the risk of death and did not inform her that she would have achieved better results if she had lost weight prior to her surgeries**
- **Failed to provide the Complainant with a refund for her leg lift surgery, despite her multiple requests.**

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of August 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 the obligations and responsibilities regarding temporary absences or closing of a medical practice to ensure continuity of patient care, including communicating with patients and his failure to follow College policy, *Closing a Medical Practice*
2. His failure to document discussions with patients regarding consent to treatment, being sure to document the discussions of planned operative management, the risks and benefits of the planned procedure and the goals and expectations
3. His failure to appropriately triage patients to ensure they are suitable for planned office procedures, including reviewing medical conditions, such as high BMI, which are contraindications for cosmetic surgery
4. His failure to adequately perform or document post-operative care, including antibiotic management.

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

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who specializes in plastic surgery. The Assessor opined that the Respondent did not display a lack of knowledge, skill or judgement in regard to the surgical procedures he carried out on the Complainant. The Committee decided to take no action on that aspect of the complaint.

The Respondent refunded the Complainant for the leg surgery she paid for. The Committee decided to take no action on this area of concern.

Patient triage

The Committee was of the view that the Respondent's decision to operate on a patient with a BMI of 33 might have meant that there was a reduced chance of the surgery being successful. The Committee decided to address the deficiencies in the Respondent's triaging of patients and patient selection through the caution.

Antibiotic management

The Assessor raised concerns about the Respondent's management of the Complainant's infections, including that he prescribed Keflex on three occasions when the swabs were positive for organisms that were not sensitive to Keflex. The Committee decided to caution the Respondent regarding this aspect of his post-operative care and documentation.

Consent

It was concerning to the Committee that there was little documentation to suggest that the Respondent ensured he put the surgical risks into context for the Complainant during the pre-operative visits. The Committee considered this to be a significant deficiency in the Respondent's care and documentation that should be addressed in the caution.

Closing the medical practice

The Assessor expressed the view that, in failing to provide the Complainant with all of her post-operative appointments and failing to assist her in getting care elsewhere once he closed his practice, the Respondent's overall treatment of the Complainant did not meet the standard of care. The Committee concurred with this view and decided to caution the Respondent in regard to this aspect of his care and to accept the undertaking.