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 November 2017. The Complainant was dissatisfied with the results and a mastopexy was conducted in October 2018. The Complainant continued to express dissatisfaction with the result and declined further appointments with the Respondent.

The Respondent took a leave of absence and then subsequently closed his practice in the summer of 2021.

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 with her bilateral breast augmentation that was performed by the Respondent in 2017, which required revision and has left her in pain, discomfort, insecurity from the inferior malposition. Specifically, the Respondent:

- **failed to insert the implant size she had consented to, in that she requested 'moderate profile' but 'full projection' was used;**
- **recommended inappropriately sized implants, which has left her with extremely wide cleavage;**
- **failed to provide appropriate postoperative follow-up care in that she was only seen for one appointment, despite her calling/reaching out; and,**
- **failed to provide her with a copy of her medical records, despite the two requests she made to the Respondent's email address.**

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 document discussions with patients regarding consent to treatment, planned operative management, the risks and benefits of the procedure, and the goals and expectations.

2. His failure to adequately perform or document preoperative examinations and discussion and post-operative care.

3. 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.

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

COMMITTEE'S ANALYSIS

Failed to insert the implant size the Complainant had consented to
- and -
Recommended inappropriately sized implants
- and -
Failed to provide appropriate postoperative follow-up care

The Committee was concerned about the Respondent's medical record-keeping, particularly his failure to adequately document his examination, decision-making, consent discussions, and the focus of his care.

The Respondent's medical record-keeping should have been more thorough. For example, the record for the initial consultation was extremely sparse and did not indicate that the Respondent had a thorough discussion regarding the risks and benefits of the planned procedure as well as how the procedure might meet the goals and expectations of the Complainant. While the informed consent signed by the Complainant is thorough and does indicate that the Complainant elected for larger implants than recommended by the Respondent, the record of the consent discussion in the consultation note is both brief and vague, providing no details about what the Respondent discussed regarding implant sizing. There was also no record in the Complainant's chart of follow-up care provided to the Complainant following her November 2017 procedure, even though the Respondent advised that there would have been at least one appointment.

Based on the above, the Committee decided to require the Respondent to appear before a Panel of the Committee to be cautioned with respect to these failings and to accept the undertaking.

Failed to provide the Complainant with a copy of her medical records, despite the two requests she made to the Respondent's email address

The College policy, *Closing a Medical Practice,* states that physicians must proactively plan for unexpected practice closures so that their practice is managed appropriately and in compliance with this policy. The policy also states that physicians must ensure that patients have continued access to their medical records following practice closure.

The Respondent did eventually provide the Respondent with her medical records, but not within the period indicated within the College's policy, *Medical Records Management.* Nor did he facilitate timely communication with the Complainant regarding her request.

The Committee's concern on this issue was heightened by the fact that the Respondent was the subject of numerous other complaints regarding the closure of his practice. The Committee is concerned with the Respondent's adherence to the *Closing a Medical Practice* policy, over a year and a half after his practice closure, even with the knowledge of the multiple complaints which have been made regarding this aspect of his care.

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