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 on the Complainant in March 2021.

The Respondent took a leave of absence and then subsequently closed his practices 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 the care and conduct of the Respondent after undergoing breast augmentation surgery on March 3, 2021. Specifically, the Respondent inappropriately closed his practice without providing notice or follow-up care and he has not provided the scar treatment and postoperative care as was promised to the Complainant.

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 post-operative 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

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 he made little or no attempt to help the Complainant receive medical care from another surgeon. 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 in regard to this aspect of his care and to accept the undertaking.

The Committee was also concerned about the Respondent's performance of post-operative care and his delegation of pre- and post-operative care. In this case, 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. All post-operative care for the Complainant was done virtually. She was not scheduled to see the Respondent in person until six months following the surgery, which did not occur due to the Respondent's practice closure. This is inadequate care which could put patients at risk.

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