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. Kamal Mattar (CPSO #85480)
(the Respondent)

INTRODUCTION

The Respondent first saw the Patient in April 2017, when the Patient reported experiencing hematuria and other urinary symptoms. The Complainant, the Patient's family member, 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 that the Respondent exhibited unprofessional behaviour, and failed to properly care for the Patient's prostate issues before and after surgery. Specifically, the Respondent:

- **Did not investigate hematuria, opting instead to use a catheter and tell the family to "wait for surgery";**
- **Denied that there was a mass found on two separate ultrasounds, and discharged the Patient home twice;**
- **Told the family his "job was done" and that it "was up to [them]" to figure out why the Patient was swollen; and,**
- **Did not disclose the results of a positive biopsy until asked by the family.**

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of July 5, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to thoroughly reviewing test results and following up appropriately on findings. The Committee also accepted an undertaking signed by the Respondent.

COMMITTEE'S ANALYSIS

Re: investigating hematuria, opting to use a catheter, and telling the family to "wait for surgery", and re: saying his "job was done" and that it "was up to [them]"to the Patient and his family

- The medical record showed that the Respondent did investigate the Patient's hematuria. However, the Committee was concerned that the Respondent failed to

identify or follow up on the Patient's positive urine cytology for bladder cancer. Further, the Committee was concerned that the Respondent seemed to have limited insight in this regard. Even if the Respondent missed that first test, all the Patient's subsequent findings and clinical deterioration were characteristic of an advanced tumor.

- Overall, it took the Respondent far too long to understand the significance of the Patient's clinical condition and findings. This led the Committee to the decision that the Respondent requires further knowledge and education with regards to the investigation and management of bladder cancer, particularly since he practises urology (where bladder cancer is expected to be a main competency). Further, given the Respondent's lack of insight, the Committee felt it would be appropriate to caution the Respondent in person, as outlined above.

In regards to the ultrasounds and discharging the Patient, the ultrasounds did show prostate enlargement, but it is not clear if this was ever communicated to the Patient. It appears that the Complainant was not aware, but the Committee could not determine if the Respondent failed to communicate the results, or whether the Patient simply did not tell her. As a result, the Committee took no further action in this regard.

In regards to the biopsy results, the Respondent explained that it was his intention to inform the Patient and Complainant of the results at their postoperative visit, as at that time the prostate tumor did not require any other investigation or follow-up. While the tumor did not require further investigation, the Committee was of the view that it would have been wise for him to inform the Patient of his cancer diagnosis when he first became aware of it, but did not take any action on this element of the complaint.