**SUMMARY**

**DR. KAMAL MATTAR (CPSO# 85480)**

## 1. Disposition

On August 17, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required urologist Dr. Mattar to appear before a panel of the Committee to be cautioned with respect to his failure to attend a seriously ill patient in response to a nurse's communication of concerns.

## 2. Introduction

A family member of the deceased patient (who was in hospital following surgery for bladder cancer) complained to the College that Dr. Mattar, who was the urologist on call at the hospital, did not attend the patient when his condition was deteriorating, despite repeated calls from nursing staff. The patient died approximately two and half hours after the nurse's second call to Dr. Mattar. The patient's family member also had a number of questions related to hospital policy related to the Intensive Care Unit (ICU) and documentation of the patient's discharge summary.

Dr. Mattar responded that the patient's Most Responsible Physician did not give him any information with regards to the patient's condition, that the symptoms which nurses reported in the telephone call were minor and normal for a patient who had undergone that type of major surgery, and that he does not attend the emergency room for those types of symptoms.

## 3. Committee Process

A Surgical Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee applies legislation and regulations, and refers to policies that the College has developed, which reflect

the College's professional expectations for physicians practising in Ontario. College policies may be accessed on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

## 4. Committee's Analysis

The Committee shared the concern of the patient's family member that Dr. Mattar did not attend in person to assess the patient despite a telephone call from nursing staff that expressed indications that the patient's condition was deteriorating, as documented in the nursing notes. The Committee disagreed with Dr. Mattar's statement that the patient's symptoms were minor. The Committee stated that, overall, Dr. Mattar should have demonstrated a higher index of suspicion that something was wrong with the patient, especially after the concerning call from nursing staff.

Given the Committee's concern about Dr. Mattar's failure to attend the patient in this case, the Committee decided to caution Dr. Mattar.

*This summary was amended following an appeal heard by the Health Professions Appeal and Review Board (HPARB), a decision by HPARB dated June 26, 2018, and the Committee's consideration of the matter on August 17, 2018.*