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 Patient in December 2019. The Patient expressed dissatisfaction with the results of her procedure and the Respondent offered to do a complimentary revision procedure in the fall of 2021.

The Respondent took a leave of absence and then subsequently closed his practices in the summer of 2021 and the revision surgery did not occur.

The Patient contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct.

COMMITTEE'S DECISION

A panel of the Committee considered this matter at its meeting of November 20, 2024. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to his failure to:

- perform a thorough in-person assessment of pre-operative patients;
- document the plan of care and consent discussions; and,
- ensure continuity of care when closing a medical practice.

COMMITTEE'S ANALYSIS

Failed to provide comprehensive preoperative consultations, in that the majority of these took place with his assistant
- and -
Failed to provide the Patient a sufficient explanation of the surgical procedure and postoperative care

As part of this investigation, the Committee retained an independent Assessor who specializes in plastic surgery. The Assessor opined that the Respondent's documentation did not meet the expected standards and that the absence of a

documented, thorough in-person medical examination and personalized consent discussion reflected a lack of judgement.

The Committee concurred with the Assessor's opinion. While the Respondent advised the Committee that pre-operative assessments occurred, there was no documentation to support this. As such, the Committee determined that it was appropriate to caution the Respondent in person, with respect to his pre-operative care and documentation.

Inappropriately closed his practice after agreeing to provide the Patient with revision surgery

The Assessor also concluded that the standard of practice of the profession was not met when the Patient was left without any assistance when the Respondent suddenly closed his practice without taking adequate steps to ensure the Patient's concerns were addressed. This behaviour also displayed a lack of understanding of professional obligations during a practice closure.

While the Committee acknowledged the Respondent's explanation and reflection, the Committee concurred with the Assessor's view and decided to caution the Respondent regarding this aspect of his care and conduct.

In coming to the above dispositions, the Committee considered that the Respondent's significant history of complaints with the College which also raised concerns about his documentation, pre-operative care, and improper practice closure. The Committee was satisfied that in the circumstances, a caution in person for this matter would serve to protect the public interest.

This is a summary of the Committee's decision as it relates to the Caution disposition.