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 bilateral breast augmentation and breast lift surgery on the Complainant. The Complainant developed a post-operative infection that required antibiotics and wound care.

The Complainant was scheduled for a follow-up appointment to discuss her post-operative concerns with the Respondent, but the Respondent took a leave of absence from his practice in July 2021. He subsequently closed his plastic surgery clinics.

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 about the Respondent's care and conduct after he carried out breast lift and implant surgery on her. Specifically, the Respondent:

- **Failed to properly perform the surgery in that the Complainant developed a staph infection, there was a four-inch necrotic hole that required ongoing treatment, there remains terrible scarring, her implants are still sitting too high/adjacent to her armpits, she is still in pain and she has developed capsular contracture**
- **Failed to provide follow-up or post-operative wound care instructions**
- **Failed to follow up with the Complainant regarding her wound swab results**
- **Failed to appropriately document the Complainant's surgery**
- **Inappropriately cancelled the Complainant's consultation for revision surgery after scheduling it for September 20, 2021, without notification or reason and without further contact from his office.**

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of August 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 the obligations and responsibilities regarding temporary absences or closing of a medical practice to ensure continuity of patient care, including communicating with patients and his failure to follow College policy, *Closing a Medical Practice*

2. His failure to document discussions with patients regarding consent to treatment, being sure to document the discussions of planned operative management, the risks and benefits of the planned procedure, as well as the goals and expectations.

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 opined that the Respondent did not display a lack of knowledge, skill or judgement in regard to the surgical procedure he carried out on the Complainant. The Committee decided to take no action on that aspect of the complaint.

The Committee took no action on the Complainant's concerns regarding post-operative wound care and follow-up of wound swab results.

The Assessor noted that the medical record lacked adequate documentation to indicate that the Respondent discussed breast augmentation surgery in detail with the Complainant. The Committee decided to caution the Respondent in regard to his failure to document the consent discussion.

The Assessor expressed the view that, in failing to provide follow-up care to the Complainant and failing to assist her in getting care elsewhere once he closed his practice, the Respondent's overall treatment of the Complainant 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.