

**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. Laurence Harold Klotz (CPSO # 30375)
(the Respondent)**

INTRODUCTION

The Patient began seeing the Respondent in 2014, when she underwent a partial nephrectomy for cancer. In September 2016, the Respondent performed further surgery to remove the remainder of the Patient's kidney due to metastases. The Patient had complications during the surgery and post-operatively, and her care was transferred to another urologist, who arranged for further urgent surgery. The Complainant, a family member of the patient, 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 failed to provide appropriate pre-operative, intra-operative or post-operative care while acting as the Patient's urologist in September/October 2016.

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of April 9, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to his clinical care and communications, and also accepted an undertaking from the Respondent that included some restrictions on his surgical practice, courses and one-on-one instruction in communications.

COMMITTEE'S ANALYSIS

Pre-operative Care

- The hospital performed a divisional review and an external review, which identified issues concerning the Respondent's pre-operative care, including a lack of pre-operative documentation, pre-operative planning (including no adequate pre-operative staging and/or consultation with a gynecologist, no biopsy of the pelvic mass or tumour markers etc.) and questionable judgment in terms of the surgical approach (i.e. choosing a laparoscopic approach rather than an open approach). The Committee shared these concerns.

- While the Respondent disagreed with the opinions and conclusions expressed during the hospital's review, and provided a report from another physician that overall was supportive of his care, he decided to enter into an undertaking with the hospital (and subsequently with the College) to restrict his practice in certain aspects.

Intra-operative Care

- In both the hospital's reviews, there were concerns about the Respondent's decision to perform the Patient's surgery laparoscopically and/or to continue laparoscopically once complications arose. The reviews also raised concerns about potentially inadequate supervision of residents, in that the Respondent was not present for the closure of the diaphragm, and a failure to biopsy the other masses in the abdomen and the pelvis. The Committee expressed concern with the Respondent's judgment in stepping out of the operating room at the time of closing the diaphragm (a critical juncture given the difficulty in repairing a diaphragm in such circumstances) and not assessing if the residents had closed the diaphragm properly. There were also concerns with respect to the accuracy of the Respondent's operative note, which he dictated months after the surgery, and which is at odds with information obtained from the residents involved in the surgery.

Post-operative Care

- While the Respondent stated he did have a discussion with the Patient's family post-operatively about the surgery and any complications encountered (which the family refutes), he did not document any such discussion. Information in the chart confirmed the Respondent did not make regular visits to assess the Patient post-operatively despite a problematic course. The hospital reviews identified concerns regarding the Respondent's post-operative documentation, including the content of his email to the surgeon he asked to consider taking over the Patient's care. The Committee noted that it appeared the Respondent attempted to minimize the Patient's issues in reporting her clinical progress and status to the other surgeon at the time of transfer.
- Overall, the Committee had concerns about the Respondent's communication with the Patient and her family, given the lack of proper documentation of discussions he said he had with the family (including the consent discussion with the Patient and the immediate post-operative discussion with the family), as well as with his intra-professional communication, given his lack of appropriate communication with the surgeon he asked to take over the Patient's care.

