SUMMARY

Dr. Young-Soo Peter Kong (CPSO# 51910)

1. Disposition

On May 11, 2018, the Inquiries, Complaints and Reports Committee (the Committee) ordered Dr. Kong (Urology) to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Kong to:

- Successfully complete the next available session of the following courses:
    - the CMPA (Canadian Medical Protective Association) e-learning module on communication (from the CMPA Good Practices Guide)
    - the CMPA module on Informed Consent
- Review and submit written summaries of the following policies/guidelines:
    - The College's policy, *Medical Records*
    - The College's policy, *Consent to Treatment*
    - The CMPA Perspective Article "Better Communication can Help", published March 1, 2018, Volume 10
- Engage in focused educational sessions with a Clinical Supervisor acceptable to the College for a period of six months to address the following deficiencies in his practice:
    - Comprehensive documentation of consent discussions indicating discussions of surgical procedures, material risks, and benefits
    - The general principles of effective communication
- Undergo a reassessment with an Assessor selected by the College approximately six months after the completion of the educational program, which assessment may include:
    - a review of a minimum of 15 charts (or, if that is not possible, a lesser number agreed to by the College)
    - in-person interview with Dr. Kong

- interviews with other stakeholders such as colleagues and co-workers.

2. Introduction

A patient expressed concern that Dr. Kong failed to provide him with adequate care. Specifically, the patient was concerned that Dr. Kong failed to obtain his informed consent and answer questions about a proposed surgical procedure (a left nephroscopy), pressured and rushed him into agreeing to the procedure, damaged his left ureter during the procedure, which resulted in him needing his left kidney stone removed urgently, was not forthcoming with him or his family about the surgical complication, and contacted his family's home several times against their wishes.

Dr. Kong responded that he did obtain the patient's informed consent to undergo the surgery. He further indicated that regrettably ureter injury is a known complication of a nephroscopy and said he did speak to the patient's family after the surgery and explained the complication. He acknowledged that after the surgery he contacted the patient's family to find out how the patient was doing and that after the family indicated that they did not want to speak to him he did not call them back.

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 always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The College retained an independent opinion (IO) provider to comment on Dr. Kong's care. The IO provider opined that the informed consent process in this particular care was adequate as Dr. Kong saw the patient many times prior to surgery to answer the patient's questions and consent forms were contained in the chart indicating that the patient's consent was informed.

The Committee disagreed with the IO provider's view that the patient's consent was informed. It noted that simply because the record included a consent form that the patient had signed (which indicated that the risks, benefits, and the option of doing nothing were all discussed) and there may have been multiple opportunities for the patient to ask any questions he had, there was no indication in the record that a detailed discussion of risks and benefits occurred. The Committee noted that The College's policy statement, *Consent to Treatment* provides that during consent discussions physicians must engage in an effective dialogue with patients and must indicate the parties who were involved in the discussion and exactly what was discussed. Simply making a notation in the record that the risks and benefits were discussed is insufficient. In this case there was just a notation in the record that the risks and benefits were discussed and there was no documentation describing what exactly Dr. Kong discussed with the patient.

The IO provider opined, however, that Dr. Kong's care in this particular case was adequate, i.e. that his surgical approach was appropriate and that Dr. Kong had the skill to do the procedure. The IO provider noted that ureteral injury is a recognized complication of this type of surgery and that in this case Dr. Kong identified the ureter injury and that he managed it appropriately.

The Committee agreed that ureteral injury is a rare but known complication of a nephroscopy and agreed with the IO provider's view that Dr. Kong managed this complication appropriately

The Committee noted that the record confirmed that Dr. Kong spoke to the patient's family after surgery and appropriately arranged to transfer the patient's care for further management.

The Committee did not view Dr. Kong's follow-up with the patient's family as unreasonable as the medical record only documented three telephone calls and there was no indication Dr. Kong contacted the patient's family after the family asked that he not call them anymore.

The Committee therefore concluded the appropriate disposition in this particular case was to require Dr. Kong to complete the SCERP, as described above.