

**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. Raymond Gregory Hendel (CPSO #64241)
(the Respondent)**

INTRODUCTION

In 2011, the Complainant saw the Respondent for assessment of a ganglion cyst on her left finger. In 2012 and 2013, the Respondent administered injections to treat her finger. In August 2014, the Respondent recommended the removal of the ganglion cyst. In November 2014, the Respondent performed surgery for a trigger finger on the Complainant's hand. 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 that the Respondent failed to remove a left ganglion cyst from her finger and instead performed surgery for a trigger finger in November 2014. She is also concerned that the Respondent was rude and abrupt in his approach to her during her post-operative visit, by stating, "Well, now you won't ever have a trigger finger, will you?" when questioned about the surgery.

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of July 19, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to the performance of an incorrect procedure, the failure to address a surgical error, and professional communications.

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's care to the Complainant fell below the standard of practice of the profession in performing an incorrect procedure. The Assessor was of the view that the Respondent may not have comprehensive knowledge of the hospital's operating room procedures and policies. In the Assessor's view, the Respondent did not display a lack of skill or judgement, and he was not likely to expose future patients to harm or injury, as this might represent a single incident and not a recurring problem.

Concern that the Respondent failed to remove a left ganglion cyst from her finger and instead performed surgery for a trigger finger

As noted by the Assessor, all documentation prior to surgery pertained to a ganglion cyst in the Complainant's left small finger. From the hospital record, the operating room booking sheet listed a diagnosis of left small trigger finger and the procedure as a left small trigger finger release, as did the consent form the Complainant signed. The Respondent performed this procedure, despite no previous diagnosis of a trigger finger. There is no documentation to corroborate the Respondent's assertion that his assessment on the date of surgery indicated the ganglion cyst had resolved, or that he diagnosed a trigger finger and discussed this finding with the Complainant prior to her signing the consent form to proceed with a trigger finger release.

It is clear to the Committee that the Respondent failed to follow best practices in this case, and that, as the Assessor noted, he demonstrated a lack of comprehensive knowledge of and a failure to observe common procedures that would minimize patient risk.

Ultimately, the Committee was of the opinion that the Respondent's care fell below the standard of practice in performing a different procedure on the Complainant than had been previously discussed and agreed to (particularly in the absence of any documentation indicating that the Complainant understood and agreed to the change in surgery).

Concern that the Respondent was rude and abrupt in his approach to her during her post-operative visit

The Respondent did not dispute the comments that the Complainant attributed to him. In the Committee's view, the Respondent's comments as described by the Complainant were inappropriate. Additionally, the Committee was concerned by the Respondent's failure to acknowledge that he performed the wrong procedure on the Complainant, as required by the College's policy, *Disclosure of Harm*.