

**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. Joyce Schachter (CPSO #68284)
(the Respondent)**

INTRODUCTION

In September 2024, the Respondent performed surgery on the Patient. The Patient contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care.

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of March 21, 2025. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to medical record documentation and ensuring that the procedure carried out reflects what has been explicitly worded in the surgical consent form and the Patient's understanding of surgery, in accordance with surgical protocol.

COMMITTEE'S ANALYSIS

The Patient identified the following concerns regarding the Respondent's care and conduct:

- Failed to remove her ovaries and fallopian tubes during her total hysterectomy at The Ottawa Hospital on September 27, 2024, despite her consenting to a "Vaginal total hysterectomy with bilateral salpingo-oophorectomy (BSO), with anterior and posterior vaginal repair followed by a Kelly stitch to her bladder", resulting in the Patient having to undergo additional surgery;
- Failed to identify if the Kelly stitch to the Patient's bladder was completed or not; and
- Inappropriately blamed her computer and a "breakdown in team communication" for the reason why the Patient did not receive a total hysterectomy.

The Committee had concerns about the Respondent's clinical care as well as her medical record-keeping.

Specifically, in reviewing the medical record, the Committee noted that the Respondent failed to perform the correct and intended procedure. This occurred despite the fact that documentation to confirm the intended procedure (including a signed consent form) was available in the Patient's chart at the time.

Additionally, the Committee was concerned that the Respondent did not adequately document her pre-operative discussions with the Patient regarding the BSO and did not record details regarding the use of a Kelly stitch in the operative report, despite having discussed this procedure with the Patient prior to the surgery. The Committee remarked that the Respondent's history with the College includes complaints about the Respondent's medical record-keeping.

Given the seriousness of the deficiencies in the Respondent's care, the Committee determined that it was appropriate to caution the Respondent, as set out above.

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