SUMMARY

DR. MATHAVEN MOODLEY (CPSO# 77184)

1. Disposition

On September 16, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") ordered general surgeon Dr. Moodley to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Moodley to participate in self-directed learning and provide a written review to the College with respect to:

- review of the following College policies:
    - The Practice Guide
    - Policy #3-15, Consent to Treatment
    - Policy #4-12, Medical Records
- a literature review on investigation, diagnosis and management of periumbilical hernia, including approach to surgical repair
- review of the World Health Organization (WHO) publication on surgical safety initiatives, and of changes he has implemented in his own practice and any actions/initiatives he has taken to enhance site-specific programs in place to improve patient safety in his hospital as a result of this case

2. Introduction

A patient complained to the College that Dr. Moodley had discussed and obtained consent to a surgical procedure, but had performed a different procedure. The patient had undergone prior surgery in 2014. In 2015, he discovered a concerning lump in his abdomen at the incision site of the previous surgery (i.e., an incisional hernia). The patient also had an umbilical hernia which had been present for most of his life. The patient attended Dr. Moodley for discussion of surgery regarding the incisional hernia. At the pre-operative assessment/discussion, the patient gained the impression that he had consented to a procedure whereby Dr. Moodley would make an

incision through the umbilical hernia in order to gain access to the incisional hernia (located above the umbilicus), would place mesh over the incisional hernia, then would repair the umbilical hernia. At the time of surgery, Dr. Moodley simply repaired the umbilical hernia. The patient subsequently discovered that the incisional hernia was still there. The patient complained about the adequacy of Dr. Moodley's pre-operative assessment, Dr. Moodley's failure to perform hernia surgery as discussed (to repair both the umbilical and incisional hernias), and Dr. Moodley's failure to speak to the patient before surgery or to his family after surgery.

Dr. Moodley responded that he was unable, at the pre-operative assessment, to detect an incisional hernia, but that he explained to the patient that at surgery, he would be able to fix the umbilical hernia, and at the same time would use a mesh to cover the incisional site. At surgery, he repaired the umbilical hernia. He stated that, after every operation, he makes an attempt to speak to family members. He cannot recall why he did not talk to this patient's family after surgery.

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 Committee found that the consent and operative documentation in this case failed to relate to the treatment discussed, due to a communication issue between Dr. Moodley and the patient/family, with different plans of what they were expecting. Dr. Moodley should have reviewed his notes before surgery, and whether or not he did, he went on to undertake a procedure different from the one he had discussed with the patient and obtained consent for. A physician is expected to be involved as an advocate for a safe health-care system, where the chance of such errors would be minimized. As Most Responsible Physician (MRP), Dr.

Moodley was expected to communicate with the family after the procedure and he failed to do so. His approach at a post-operative follow-up with the patient was also less than satisfactory.

In reviewing the documentation in this case, the Committee noted that Dr. Moodley's use of "shorthand" in his handwritten notes would render parts of his record illegible to others. The Committee included self-directed learning with respect to adequate medical record-keeping in the SCERP, as set out above.