Medical Practitioners Disciplinary Tribunal

PO Box 5249 Wellington   Telephone (04) 499-2044   Facsimile (04) 499-2045
All Correspondence should be addressed to The Secretary

DECISION NO: 38/98/20C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **PAUL FRANCIS SILVESTER** medical practitioner of Thames

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Dr F E Bennett, Dr B D Evans, Dr A M C McCoy,

Mr G Searancke (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Date of Hearing:	19 May 1998 at Hamilton
Date of Receipt of Closing Submissions:	12 June 1998
Date of Decision:	13 July 1998

APPEARANCES: Mr K W Harborne for the Complaints Assessment Committee ("the CAC").

Mr H Waalkens for Mr Silvester.

1.1 FACTORS beyond the control of the Chair have delayed issue of this Decision, which is regretted.

1.2 THE CHARGE (as amended on 12 May 1998):

MR Silvester is charged by the CAC, pursuant to Section 93(1) (b) of the Medical Practitioners Act 1995 ("the Act"), that on or about 19 October 1994 at Thames in the course of his management of A for a de-gloving laceration over the anterolateral aspect of the distal left thigh:

(i) Carried out a surgical procedure in Accident and Emergency under local anaesthetic, rather than in theatre under general anaesthetic;

(ii) Carried out an immediate closure of the wound rather than a delayed closure;

thus exposing the patient to greater risk of infection and complications, such conduct constituting conduct unbecoming a medical practitioner, and being conduct which reflects adversely on the practitioner's fitness to practise medicine."

2. BACKGROUND:

2.1 ON 19 October 1994 Ms A was a pillion passenger involved in an accident with a truck. She was admitted to Thames Hospital where Mr Silvester was on duty.

2.2 MS A suffered injuries to her left arm and left leg. Her left leg was split/cut from her mid shin to the top of her thigh. The arm was scraped and bruised. The leg was by far the worst of the two injuries. Ms A' friend, the driver of the motorcycle, broke his femur. It is common ground that Mr Silvester appropriately attended initially to the driver of the motorcycle.

2.3 THE Thames Hospital discharge summary states:

"She bounced off the truck and it appears that she sheared off the subcutaneous tissues with an extensive laceration of the lateral aspect of the left knee."

2.4 THE laceration was described as *"a forty centimetre irregular laceration",* that is, it was about 16 inches in length.

2.5 THE flap was described as showing minor contusion with some clot on the wound, but no grass or gravel was identified.

2.6 ON admission to Thames Hospital Ms A complained of a painful left forearm and an anaesthetist applied a local anaesthetic arm block which also enabled a more comfortable x-ray assessment of her arm. An x-ray indicated that Ms A’s left arm was not fractured.

2.7 **MR** Silvester then proceeded to deal with the soft tissue injury to the left leg of Ms A. The wound was irrigated with what was described as *"a moderate volume of dilute local anaesthetic"*. The wound was then closed and a dressing applied. The record indicates that Mr Silvester spent an hour irrigating the wound, instilling dilute local anaesthetic and assessing the viability of the flap of skin and fat. The diagnosis was given of a de-gloving injury of the left knee. Mr Silvester's comment is noted that he recognised it was *".... an explosive injury to lift such an extensive flap, probably the result of impact on the truck that drove across the path of the cyclists."*

2.8 **IN** his letter to the Complaints Assessment Committee Mr Silvester explained *"The wound margins were bleeding and viable. There was little contusion of the fatty tissue and skin, and no skin loss. The patient was anxious to recognise that there was no skin loss, and I found that I could close without tension, so opted to do this over a long soft rubber drain."*

2.9 **MS** A was transferred by helicopter to xx Hospital on the following morning where she was seen that day by Mr French, an orthopaedic surgeon.

2.10 **THE** hand written notes made by the house surgeon state *"SB (seen by) Mr French, wound seen, ragged laceration, patient advised there is the danger of losing some of the skin"*.

2.11 **TYPED** notes of 21 October 1994 dictated by Mr French state *"The wound is not obviously infected, but there is a large 15 x 10 cm area of skin on the lateral aspect of the incision, which has dubious viability"*.

2.12 **THE** following day it was apparent that Ms A was unwell, and x-rays showed the presence of gas in the soft tissue, suggestive of infection from a gas forming organism.

2.13 **AT** operation the necrotic tissue was removed and multiple further procedures were required including skin grafting.

2.14 **MS** A remained in hospital until 10 November 1994 and further admissions were later required.

3. PARTICULAR (i) OF THE CHARGE:

"Carried out a surgical procedure in Accident and Emergency under local anaesthetic, rather than in theatre under general anaesthetic."

3.1 EVIDENCE FOR THE CAC:

A:

3.1.1 **WHEN** she was seen by Mr French at xx on 21 October he took away the bandage. Her knee had some blue/black areas on it and Mr French said that he would need to keep eye on those.

3.1.2 **ON** the night of 21 October she was very uncomfortable and feeling nauseous. She explained *"I felt that no one was too sure what was happening"*.

3.1.3 **AS** a result of further x-rays she remembers the situation being treated as urgent, the possibility of gangrene being indicated, and Mr French told her that she might lose her leg from the hip joint and she was asked to sign a consent form.

3.1.4 **THE** whole experience was very unpleasant. She spent about three weeks in hospital. She has been left with severe cosmetic damage and some continued physical disability. The wound has impacted on the way she lives and the things she can do. She realises that she is never going to have a normal leg and that it may now be as good as it is likely to get.

3.1.5 **HER** concern is that if Mr Silvester had dealt with the wound under general anaesthetic rather than local anaesthetic there was a greater chance that she may not have suffered the infection which resulted.

John Gary French:

3.1.6 **MR** French is a specialist orthopaedic surgeon, his qualifications being MB. Ch.B. F.R.A.C.S. (Orthopaedics).

3.1.7 **WHEN** he saw Ms A on 21 October the wound was not obviously infected but he was concerned about the viability of a large 15 x 10 cm area of skin on the lateral aspect of the incision. She had spiked a temperature on the night of the 20th of October but there was no obvious cause and his plan was to continue antibiotics and observation.

3.1.8 **THE** situation changed on the 22nd of October. On a ward round that morning he found Ms A was unwell with a high fever and was mildly dehydrated. She had developed marked tenderness over the whole of the anterior and lateral aspects of the

left thigh and the wound had become obviously more necrotic on its lateral aspect with a purple appearance.

3.1.9 **X-RAYS** were taken which demonstrated gas in the tissues, particularly the subcutaneous layer but no convincing evidence of gas in the muscles.

3.1.10 **UNDER** the presumed diagnosis of gas gangrene Ms A was transferred to theatre urgently. The wound was re-opened. There was a large collection of watery pus with a foul smell found in the subcutaneous fat layer extending well up the lateral and antero lateral aspects of the thigh. The wound was extended proximally. There was extensive subcutaneous fat necrosis over the lateral aspect of the distal thigh and the antero lateral aspect of the mid thigh. The deep fascia however was intact and the underlying muscles were entirely healthy. All necrotic fat was excised from the wound as was necrotic skin on the antero lateral aspect of the knee. The wound was heavily debrided down to bleeding healthy tissue. At the end of the procedure the wound was left open for a delayed closure for a further debridement if necessary.

3.1.11 **ON** 23 and 24 October 1994 Ms A was returned to theatre for wound inspection and repeat debridement. Closure of the wound followed a few days later with skin grafting. He continues to see Ms A who will need further operations in the future.

3.1.12 **IN** Mr French's opinion:

(a) It would have been preferable for the wound to have been debrided under a general anaesthetic rather than a local anaesthetic.

(b) If one uses a general anaesthetic it has the advantage of giving complete pain relief enabling the surgeon to undertake a thorough inspection and cleaning of the wound and debridement of any damaged tissue.

(c) By instilling dilute local anaesthetic one is not as likely to be able to explore the wound and be certain of removing all foreign matter and damaged tissue as the surgeon could if the patient was under a general anaesthetic. Moreover it would seem that one would have to use a lot of anaesthetic to deal with a wound in this way. He would not himself employ this technique. It would be his expectation that the local, in itself, would affect the appearance of the tissue and would make it harder to tell what was good tissue and what was not.

Oliver Ross Nicholson:

3.1.13 **MR** Nicholson is a specialist orthopaedic surgeon, his qualifications being M.B., Ch.B. (New Zealand) 1947, F.R.C.S. (England) 1950, F.R.A.C.S. 1954.

3.1.14 **IT** was Mr Nicholson's evidence that the preferred technique would be to cleanse the wound and debride it under a general anaesthetic. He explained, while conceding there was no obvious foreign material in the wound, that wounds of this type occurring on the roadside should be regarded as having the potential to develop an infection.

3.2 EVIDENCE FOR MR SILVESTER:

Paul Francis Silvester:

3.2.1 **PAUL** Francis Silvester, qualifications MB. Ch.B (1971), F.R.A.C.S. (1981), has practised as a general surgeon at Thames Hospital since 1984.

3.2.2 **HE** is very familiar with the use of local anaesthesia and as well, general anaesthesia, for acute or elective surgery in a wide variety of medical settings.

3.2.3 **FROM** his initial assessment of the two patients it was apparent to him that they would require transfer to a hospital with an orthopaedic specialist facility, as Thames Hospital would be unable to offer the treatment which they required.

3.2.4 **ALTHOUGH** he contacted xx Hospital and requested immediate transfer of both patients once they had stabilised, an unexpectedly lengthy delay in response from xx Hospital resulted in the transfer of both patients being held over until the following morning.

3.2.5 **HE** formed the opinion that introduction of local anaesthetic to enable preliminary assessment of the injury to Ms A' left leg, and continued local anaesthetic for provision of definitive treatment, was appropriate for the following reasons:

(a) The injury to the leg was able to be adequately treated and managed under a local anaesthetic - rather than a general.

(b) Planned transfer to xx Hospital was imminent and administering a general anaesthetic might delay the transfer.

(c) Bearing in mind the possibility that revision or other surgery for the wound might be required, administration of one general anaesthetic at Thames Hospital may have compromised the preparedness or ability of a second general anaesthetic to be administered.

3.2.6 **HAD** he considered that Ms A' wound were better treated under a general anaesthetic, he would not have hesitated to have proceeded in that regard rather than by way of local anaesthetic. He treated her at the time in accordance with what he thought would be in her best interests.

3.2.7 **THE** objective of treatment of the left leg under local anaesthetic was assessment and planning while the other patient was recovering and whilst he awaited transfer details from xx.

Michael Frederick Klaassen:

3.2.8 **HE** is a plastic surgeon at Hamilton with qualifications of MB Ch.B and F.R.A.C.S.

3.2.9 **HAVING** been instructed by counsel for Mr Silvester to provide an independent opinion, it was based on the relevant medical notes of Mr Silvester/Thames Hospital, some (but not all) of the xx Hospital records, a draft of the statement of Mr Silvester's evidence and as well, some of the incidental records concerning the CAC process and notice of charge.

3.2.10 **MR** Silvester's early management of his patient's limb injury, given the circumstances, was in his opinion correct. He also considers that in carrying out local anaesthesia in the Accident and Emergency Department, Mr Silvester did not expose the patient to greater risk of infection and complications.

3.2.11 **USING** dilute local anaesthetic solution, within safe doses and without adrenaline, as he did, Mr Silvester was able to irrigate the wound thoroughly and explore the wound to determine its depth, extent and status.

3.3. DISCUSSION AND FINDING:

3.3.1 **THIS** first particular of the charge must, of course, be considered in context of the claim that the patient was exposed to greater risk of infection and complications. Put another way, the Tribunal is required to determine whether Mr Silvester's care of Ms A compromised the chances of a satisfactory outcome.

3.3.2 **IT** is noted that an anaesthetist was available to Mr Silvester and it was possible for him to call in appropriate nurses. The facility to carry out the procedure under general anaesthetic was available at Thames at the time in question.

3.3.3 **IT** was accepted by all four doctors who gave evidence that a general anaesthetic had the advantage of giving complete pain relief, thus enabling the surgeon to undertake a thorough inspection and cleaning of the wound and debridement of any damaged tissue without the same concern about the discomfort occasioned to the patient.

3.3.4 **MR** Klaassen proffered the view that using dilute local anaesthetic solution to irrigate the wound thoroughly and explore it was correct. Mr Harborne questioned this evidence, on the basis that Mr Klaassen was not present to observe the procedure undertaken and was relying on what Mr Silvester had told him.

3.3.5 **MR** Waalkens submitted it is clear on the evidence that no-one can say that Mr Silvester's conduct or omissions caused infection and complications any greater than the patient may have sustained in any event.

3.3.6 **MR** Nicholson was, seemingly, not overly critical of the local versus general anaesthetic decision. He merely said it was *"preferable"*.

3.3.7 **UNDER** questions from Professor Evans, Mr Nicholson restated that it was *"probably preferable"* to clean the wound under general anaesthetic. Thus, at its highest, Mr Nicholson's evidence was simply that it was *"preferable"* to proceed under general anaesthetic rather than local, certainly not mandatory. As was observed by Mr Waalkens, when singled out, it is only possible to say that a general anaesthetic in the main theatre was preferable.

3.3.8 **MR** Harborne submitted the inference from the evidence of both Mr Klaassen and Mr Silvester was that the cause of the subsequent skin necrosis and infection was at least partially due to the care that Ms A received after leaving Thames Hospital. Mr Silvester explained under cross examination that *"he felt let down by the management at xx Hospital"*. However in closing submissions Mr Waalkens stated

this was not the view of his client but that the original injury was the cause of the subsequent problems. Therefore Mr Waalkens' emphasis that Mr Silvester does not wish to criticise the management at xx Hospital, is appropriate.

3.3.9 **THE** evidence plainly established that the wound was a clean one. Ms A gave evidence that the jeans/trousers that she wore were not torn. Mr Silvester said that the wound was clean (he wrote it in the notes at the time). The Tribunal considers that Mr Silvester assessed the wound correctly, as a shearing-type injury and he did not consider it was contaminated.

3.3.10 **FOR** the Complaints Assessment Committee it was submitted that an anaesthetist was available. The cleansing of the wound could therefore have been performed under general anaesthetic. The Tribunal considers that the availability of an anaesthetist was never in question. Mr Silvester's evidence is accepted that resources did not influence his decision. He carried out what he considered was optimal management in the circumstances. The Tribunal finds that availability of an anaesthetist is not relevant to the charge.

3.3.11 **ON** the evidence the Tribunal is bound to conclude that Mr Silvester's examination under local anaesthetic did not cause infection and complications any greater than the patient may have sustained in any event. Mr Klaassen was quite specific that the infection suffered by Ms A was as a result of necrosis, rather than on account of a failure to adequately clean the wound. Ischaemia (not infection) is the primary cause of flap necrosis, an environment in which infection thrives, but not a cause in itself.

3.3.12 **MR** Silvester's clinical judgement at the time was that he had adequately explored, irrigated and cleaned the wound under local anaesthetic. In the Tribunal's view there is inadequate evidence to establish that this was not the case. He was of the opinion that the wound had been adequately cleaned as he noted in the records. The Tribunal is simply not prepared to substitute its judgement for the judgement exercised by Mr Silvester to perform the procedure in question under local rather than general anaesthetic, because his judgement depended upon his own assessment of the wound and the time, place and circumstances. That said, however, the Tribunal would have to conclude, on the evidence of the expert witnesses, that such wounds are generally best explored under general anaesthetic, for the reasons given by Mr French and Mr Nicholson.

3.3.13 **THE** Tribunal finds that the surgical procedure carried out by Mr Silvester in Accident and Emergency under local anaesthetic, rather than in theatre under general anaesthetic, on the facts of this case, did not expose the patient to greater risk of infection and complications.

4. PARTICULAR (ii) OF THE CHARGE:

"Carried out an immediate closure of the wound rather than a delayed closure."

4.1 EVIDENCE FOR THE CAC:

4.1.1 **MR** French explained there are a number of reasons for leaving the wound open and delaying closure. One is that it keeps all tension off the tissue. If one closes the wound then the stitches are a source of tension on the skin flap and the tension affects the

blood supply to the tissue, e.g. to the skin flap, which compromises its ability to survive. Another is that if you leave it open it is getting air and there is then less chance of anaerobic organisms growing in the wound.

4.1.2 **MR** French explained that the wound while left open is covered with a sterile dressing. This means that nature is given a chance to deal with the infection but it also means that while it is open you do not have the problem of the infection developing under the skin where it cannot be seen. Even if infection does develop, it leaks out into the dressing rather than building up inside the closed wound. It means that one can physically see whether there is any further deterioration of tissue and carry out further debridement of the wound if required.

4.1.3 **BECAUSE** the wound had not been debrided under general anaesthetic, there was, if anything, more reason for undertaking a delayed closure. This was because road side injuries are well known as having potential for infection. The road side by its nature is a dirty area carrying with it an increased risk of infection. Even if one had carried out the procedure under general anaesthetic, the wound should still have been left open, but there is even more reason for doing so where it had been cleaned under a local anaesthetic as in this instance.

4.1.4 **MR** Nicholson explained the problem with closing the wound by suturing, is that the skin edges may appear viable, because they are bleeding, but once the wound has been closed by suturing, some degree of swelling is inevitable, and this may be sufficient to compromise an already precarious blood supply.

4.1.5 **MR** Nicholson opined it was well established in World War II, and in subsequent conflicts, that in wounds of this type, a delayed primary closure, i.e. closure in a few days time, had no disadvantages and did not risk the development of an infection underneath a necrotic skin flap, which inevitably gives rise to widespread tissue necrosis.

4.1.6 **WITH** this type of wound, even if it had been cleansed in the operating theatre with voluminous irrigation, many surgeons would have opted not to close the wound on the day of injury. It is something of a tenet of surgical practice to delay the closure of a wound such as this.

4.1.7 **IN** support of his evidence Mr Nicholson attached to his brief an extract from "Clinical Science for Surgeons - Basic Surgical Practice" 2nd Edition edited by Marshall and Ludbrook at pages 363-364 which states, inter alia:

"17.4.2 Delayed Closure

If it is uncertain that an untidy wound can be effectively converted to a tidy one it is unsafe and unwise to close the wound. .... Open wounds treated by delayed closure under dressings heal by granulation tissue forming mesenchymal scar. Excessive scar is an acceptable price for low morbidity and mortality."

4.1.8 **THE** article goes on to state:

"Delayed primary closure

The first few days of wound healing are phagocytic and preparative rather than fibroblastic and reparative - the continuing biological debridement complements the surgical procedure. Because of this, closure can be delayed for a few days without prejudice to the end result or to the speed of healing."

4.1.9 **MR** Nicholson concluded his evidence by stating:

"Certainly the preferred technique would be to cleanse the wound and debride it under a general anaesthetic. I personally however am more critical of the decision to close a wound such as this rather than any inadequacy of the cleansing of it.

It is apparent that Mr Silvester recognised that "the primary injury was to the blood supply of fat and skin ..." and yet failed to adopt the safer course of not closing the wound. If anything, the knowledge that one had not cleansed and debrided the wound under a general anaesthetic would be added reason for leaving the wound open."

4.2 EVIDENCE FOR MR SILVESTER:

4.2.1 **HE** explained that his closure of the wound conferred no disadvantage. Leaving the wound closed still allowed for immediate observation and appropriate action. Mr Silvester suggested that indications or signs of problems were available at xx Hospital at a much earlier stage than appropriate action was taken to alleviate such problems.

4.2.2 **MR** Silvester explained to Dr McCoy his feelings of having been let down by a lack of appropriate management of Ms A at xx Hospital. Mr Silvester conceded he may have misjudged the viability of the flap, but nothing more, and he considered his treatment of Ms A was adequate by reference to an immediate closure of the wound rather than a delayed closure.

4.2.3 **MR** Silvester explained to Mr Searancke that one of his reasons for closing the wound related to Ms A's concern of losing the skin, so he pulled it together. The edges looked pink. He considered the entirety of the wound was clean. There was no active bleeding. And most importantly he was able to draw the edges together without problems.

4.2.4 **TO** Professor Evans Mr Silvester conceded it might have been more prudent to leave the wound open. Asked whether, he might in hindsight, be inclined to consider a different style of management of Ms A, Mr Silvester said he considered he had made an appropriate response, and that in his opinion the outcome was dictated by the speed of impact, and to a lesser extent, by xx Hospital management of the patient.

4.2.5 **MR** Klaassen explained it was reasonable for Mr Silvester to tack the wound together, given his reported assessment of it.

4.2.6 **IN** expressing agreement with the statement in the article produced by Mr Nicholson, that primary closure is preferred for clean surgical wounds and contaminated wounds made tidy by debridement, Mr Klaassen explained, in the event the wound should not

have been closed, that it would have been a simple enough matter to re-open and re-evaluate the wound site. Mr Klaassen said he agreed with the explanation given by Mr Silvester to the CAC in his letter of explanation.

4.2.7 **ALTHOUGH** conceding to Mr Harborne under cross-examination that it may have been easier to examine the wound under general anaesthetic, however Mr Klaassen explained it is safer to avoid a general anaesthetic if at all possible, and that a local anaesthetic or regional anaesthetic, used skilfully, is generally much better.

4.2.8 **MR** Klaassen said he agreed that the type of wound suffered by Ms A is well recognised as having the potential for infection to develop, that road sides are by their nature dirty places, and that closure of a wound by suturing may be sufficient to compromise an already precarious blood supply.

4.2.9 **GENERALLY** Mr Klaassen was critical of xx Hospital's initial management and treatment, or lack of it, of Ms A. Mr Klaassen concluded his evidence on the note that he would be very critical of Mr Silvester if he had attempted to manage Ms A' injury at Thames Hospital on an on-going basis.

4.3 DISCUSSION AND FINDING:

4.3.1 **THE** second particular of the charge must, again, be considered against the assertion that immediate closure of the wound rather than a delayed closure exposed Ms A to greater risk of infection and complications.

4.3.2 **MR** Waalkens raised an issue of jurisdiction. As originally framed the charge did not contain this second particular. On the application of Mr Harborne the charge was amended by the Tribunal to include the second particular prior to the hearing.

4.3.3 **FROM** a letter tendered in evidence by Mr Waalkens during the hearing (Exhibit 6) he explained that it was quite clear that the Complaints Assessment Committee, when considering what charge to bring, dismissed the criticism of Mr Silvester for closing, rather than leaving the wound open.

4.3.4 **AS** authority for Mr Waalkens' submission that the Complaints Assessment Committee should be estopped from having a *"second bite"* by inclusion of the second particular, whether by way of an amendment to the charge or by a new particular (or charge) or whatever, Mr Waalkens referred the Tribunal to a recent decision of the Medical Council in the case of Ms D against Dr M, a decision of the Council dated 11 May 1998. Mr Waalkens explained the effect of this decision, in the medical context, under the predecessor Act, is that the Medical Council has determined, where the investigative process rejects a particular part of the complaint, and decides not to bring a charge in respect of it, that that puts an end to the matter. Whilst conceding the facts of the case in point are different and indeed related not to a particular, but to the entire charge, Mr Waalkens submitted the principle at law still remains. Mr Waalkens argued *res judicata*, the rule in *Henderson v Henderson* and the legal principle of *"issue estoppel"* to prevent a party (in this case the Complaints Assessment Committee) by now bringing this new particular.

4.3.5 **THE** Tribunal does not accept this submission. The Tribunal has an inherent power to amend, and of course the express power in Paragraph 14 of the First Schedule of the Act. Logically it would not make sense to provide a specific power to amend under Paragraph 14 of the First Schedule if the charge can only proceed as originally framed by the Complaints Assessment Committee. Having rejected Mr Waalkens submission relating to the jurisdictional point, the Tribunal will now proceed to an assessment of the substance of the second particular.

4.3.6 **FIRST** it is necessary to resolve any doubt over whether the closure of the wound was primary or delayed in nature. It is the Complaints Assessment Committee's position that Mr Silvester undertook a primary closure. The Thames Hospital notes made by him describe the procedure as *"debride and suture"*. Mr Silvester's evidence at hearing that he had not closed the wound but rather tacked it together (with 57 stitches) does not alter the fact, in the Tribunal's view, that in fact Mr Silvester undertook a primary closure of the wound. Although Mr Silvester probably sutured the wound without tension, there is merit in Mr Waalkens view that it is semantic to differentiate between closing and tacking. As a fact the Tribunal finds that Mr Silvester undertook a primary closure of the wound.

4.3.7 **MR** French and Mr Nicholson were both agreed that a delayed closure was appropriate. It was Mr Nicholson's evidence that the wound was never one where primary closure was appropriate because it could not be made tidy by debridement to make it like a clean surgical wound. Neither Mr Klaassen nor Mr Silvester were

able to point to any disadvantage of delayed primary closure in this instance, other than the patient's level of concern about the wound.

4.3.8 **MR** Klaassen was accepting of Mr Silvester undertaking a primary closure. The basis for his view appears to have been that closing the wound was not going to make any difference because the skin flap was going to fail in any event.

4.3.9 **MR** Klaassen approved the passage on *"soft tissue avulsion"* on the second page of the article produced by Mr Waalkens from Grabb & Smith and says that he himself would have recognised that the avulsed tissue would fail. He would not have re-sutured the avulsed tissue back in place but rather would have removed the entire avulsed soft tissue, removed the skin as a skin graft and reapplied it to the soft tissue defect as the article suggests.

4.3.10 **MR** Klaassen's reasoning is understood to be that Mr Silvester's action in undertaking a primary closure was therefore acceptable because it was going to have to be re-done anyway - that it was really the responsibility of the orthopaedic team at xx to have recognised that fact and intervened earlier.

4.3.11 **THE** issue under focus has resulted in plainly different but nonetheless qualified and expert opinion which differs. Mr Klaassen was quite unshaken in cross-examination on the issue. Mr Nicholson said he was *"more critical"* of the decision to close the wound. However when questioned by Professor Evans Mr Nicholson said it was only *"probably"* preferable to leave the wound open.

4.3.12 **HAVING** carefully considered all of the evidence the Tribunal is satisfied that it was an error on the part of Mr Silvester to have undertaken a primary rather than a delayed closure of the wound. Having so found it is necessary for the Tribunal to determine whether this error did, in fact, result in the patient being exposed to greater risk of infection and complications. It is this aspect of the charge which has caused the greatest difficulty for the Tribunal.

4.3.13 **BY** reference to the comment that the wound *"was not obviously infected"*, it is necessary to be very careful about the difference between infection and ischaemia. The skin flap had its blood supply altered by the de-gloving nature of the injury and became ischaemic, i.e. non-viable, and subsequently died (became necrotic). The Tribunal considers that the infection which developed (second or third day) may well have been present at the outset despite Mr Silvester cleaning the wound. The Tribunal also considers that the infection may have occurred despite more vigorous cleansing of the wound under general anaesthetic and that the tissue viability (or lack of it) was the result of the de-gloving injury the extent of which apparently was mis-assessed by Mr Silvester. The Tribunal is as satisfied as it can be that the non-viability of the avulsed flap of skin and flap was determined at the time of injury.

4.3.14 **THE** conflicts in the evidence of specialists perceived as experts in wound care, have been noted. It is the Tribunal's conclusion that the problems experienced developed because of the difficulty in assessing the extent of the tissue damage from ischaemia, and the complicating effect of a division of care because of the patient's transfer to another hospital. In closing the wound prior to transfer to xx Hospital, the Tribunal

concludes that Mr Silvester may have exposed Ms A to a greater risk of infection. Although the Tribunal considers that this error is not sufficient to warrant a finding being made against Mr Silvester, it strongly recommends to him that he address the issue of wound management in his continuing medical education courses.

4.4 **FOR** the reasons given the charge against Mr Silvester is dismissed.

4.5 **ALTHOUGH** the charge against Mr Silvester was heard in public, interim orders on his application were made prior to the hearing prohibiting publication of any report or account or any part of the hearing by the Tribunal, including publication of his name or any particulars of his affairs, including his occupation, place of residence and practice. The Tribunal considers there is no longer any justification for those orders. Accordingly they are vacated.

4.6 **COUNSEL** failed to address a final suppression order in their closing submissions filed some three weeks after the hearing.

4.7 **THE** Tribunal's determination that the interim suppression orders be vacated, was made following careful consideration.

4.8 **IN** granting interim suppression the Tribunal concluded that publication was not necessary to provide some degree of protection, either to the public or to the medical profession.

4.9 **IN** revisiting suppression of name, the Tribunal has endeavoured to apply the relevant legal principles.

4.10 **CONTEMPORARY** legislation regulating the affairs of professional bodies tends to give disciplinary Tribunals a discretion in deciding whether to grant name suppression. However it must be acknowledged that generally there is a statutory presumption in favour of the proceedings of Tribunals being conducted openly and equally.

4.11 **GUIDANCE** as to application of legal principles in this area of the law is given in judgements of the Courts.

4.12 **WHILE** medical profession disciplinary proceedings are strictly civil rather than criminal, *Gurusinghe v Medical Council of New Zealand* [1989] 1 NZLR 139 determined that they are sufficiently analogous in some respects to criminal proceedings for assistance to be derived from the criminal rules of procedure.

4.13 **IN** *R v Liddell* [1995] 1 NZLR 538, the leading case on name suppression in New Zealand, the Court of Appeal is recorded as having said at 546:

"... there is the general question of the principles which should govern the making or refusal of name suppression orders. Understandably Parliament has refrained from attempting any statement of principles in s 140 of the Criminal Justice Act, leaving this difficult area to the Courts.

In considering whether the powers given by s 140 should be exercised, the starting point must always be the importance in a democracy of freedom of speech, open judicial proceedings, and the right of the media to report the latter fairly and accurately as "surrogates of the public". These principles have been stressed by this Court in a line of

cases extending from ***Broadcasting Corporation of New Zealand v Attorney-General*** *[1982] 1 NZLR 120 to* ***Auckland Area Health Board v Television New Zealand Ltd*** *[1992] 3 NZLR 406 where a number of the intermediate decisions are cited. The basic value of freedom to receive and impart information has been re-emphasised by s 14 of the New Zealand Bill of Rights Act 1990. And the principles just mentioned may be seen in vigorous - and, to some, even startling - operation in the Supreme Court of Canada in* ***Edmonton Journal v Alberta (Attorney-General)*** *(1989) 64 DLR (4th) 577 and the High Court of Australia in* ***Nationwide News Pty Ltd v Wills*** *(1993) 177 CLR 1;* ***Australian Capital Television Pty Ltd v Commonwealth of Australia*** *(1993) 177 CLR 106; and* ***Theophanous v Herald & Weekly Times Ltd*** *(1994) 124 ALR 1. There is no need to dwell on this theme."*

4.14 **THE** Court went on to make brief comments as to the possibility of suppression in cases involving acquittal, in this way:

"A case of acquittal, or even conviction, of a truly trivial charge, where the damage caused to the accused by publicity would plainly outweigh any genuine public interest, is an instance when, depending on all the circumstances, the jurisdiction could properly be exercised. .....

The room that the legislature has left for judicial discretion in this field means that it would be inappropriate for this Court to lay down any fettering code. What has to be stressed is that the prima facie presumption as to reporting is always in favour of openness."

4.15 **THE** charge in this case was not trivial. The Tribunal considers it is in Mr Silvester's own interests, as well as the interests of other surgeons at Thames Hospital, for his name and the fact of dismissal of the charge against him to be made public. Perhaps it is even in the public interest that the full facts of this case be known, given the high incidence of road accidents in New Zealand.

4.16 **IN** ordering the interim suppression orders to be vacated, the Tribunal is minded to echo the concluding words of the recent judgement of the Court of Appeal in *The Queen v Dare* 25/6/98 Judgement of the Court delivered by Goddard J CA 195/98:

"We find no reason in Mr Dare's case to grant name suppression on the grounds of personal embarrassment and privacy considerations or simply on the basis of his acquittal given the absence of any other compelling reasons."

DATED at Auckland this 13th day of July 1998

....

P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal