SUMMARY

Dr. Howard Jeffrey Silverman (CPSO# 63891)

1. Disposition

On January 22, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required Dr. Silverman, a plastic surgeon, to appear before a panel of the Committee to be cautioned with respect to removing and reinserting an implant at an OHPIP (Out-of-Hospital Premises Inspection Program) Level 2 facility, contrary to the OHPIP Program Standards, performing the procedure without there being any type of available assistance, failing to obtain and document informed consent to undergo a procedure under local anaesthetic, and showing a lack of judgment and ability in evacuating an acute post-operative hematoma in the sub-muscular plane under local anaesthesia without any sedation or general anaesthesia.

2. Introduction

A patient complained to the College regarding the post-operative care that Dr. Silverman provided after performing a breast augmentation on her. Specifically, the patient was concerned that when she reported internal bleeding, Dr. Silverman asked her to meet him at his office, and then removed the implant, excavated, sutured, and stuffed gauze into her and reinserted the implant without her consent or adequate anesthetic and with no one to assist him. The patient also alleged that Dr. Silverman performed the procedure while both parties were wearing street clothes, that Dr. Silverman did not allow her to use the phone prior to the procedure, that she nearly fell off the operating table on multiple occasions because of her pain, and that Dr. Silverman left her blood on the overhead light, floor, and examination room wall.

Dr. Silverman informed the College he received a call from the patient in the evening after the breast augmentation procedure informing him that she had noticed an abrupt increase in the size of her right breast, and that she was experiencing pain in her breast and arm. They agreed to meet at his office, which is a Level 2 OHPIP-certified facility later that night. Upon examination, he found that the patient had a moderately large hematoma in her right breast, and informed her that he would need to explore the breast under local anesthesia. Dr. Silverman stated he did not

sedate the patient as he prefers to give sedation only under more intensely monitored surroundings (in hospital). He proceeded without a surgical assistant, as is his general practice.

Dr. Silverman also informed the College that prior to the procedure he informed the patient that it looked like there was blood in the breast pocket around the implant, and that it needed to be removed in order for the breast to heal properly. Dr. Silverman stated that he informed the patient of his proposed approach (open the breast pocket and explore it, remove the blood collection, control the bleeding and re-suture the breast) and explained that it was done with local anesthetic in his office. Dr. Silverman indicated to the College that he wore a mask and full-length sterile surgical gown over his own clothes and sterile gloves during the procedure.

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, as well as College policies and relevant legislation.

4. Committee's Analysis

The Committee noted that Dr. Silverman performed the procedure at his office, which is an OHPIP Level 2 facility, and that such facilities are not intended for emergency surgery or appropriate for inserting a large prosthesis such as a breast implant. Such procedures should be conducted in Level 3 facilities. Dr. Silverman did not adhere to the OHPIP Program Standards.

While the Committee appreciated that one can drain a hematoma in a Level 2 facility, which is what Dr. Silverman intended to do, Dr. Silverman showed a lack of judgment in failing to recognize in advance that, with a sub-muscular implant, a patient would bleed from the muscle, and that he may have to remove the implant, which is what occurred in this case.

The Committee also noted that, although Dr. Silverman stated that he felt "comfortable" performing the procedure alone, he disregarded the fact that intercostal blocks have a risk of pneumothorax and that there was no one in the office to call for help if the patient developed an adverse reaction to the local anesthetic that he administered prior to performing the procedure.

With respect to the issue of consent, Dr. Silverman indicated that he discussed his approach with the patient prior to performing the procedure and that the patient verbally consented to it. However, there is no documentation in the medical record of any consent discussions, and the Committee looks to this record as a contemporaneous reflection of what actually transpired.

Finally, the Committee noted that, while Dr. Silverman was correct not to give sedation to an unmonitored patient, given the patient's previous medical history and her anxiety about surgery in general, he again demonstrated a lack of judgment in assuming that the patient would tolerate the procedure under regional anesthetic, and without sedation or general anesthesia.

The Committee took no further action on the other aspects of the patient's complaint.

With respect to the patient's concerns that both parties wore street clothes during the procedure and that she fell off the operating table multiple times because of her pain, Dr. Silverman denied these allegations and there was no independent information to either confirm or refute them.

With respect to the patient's concern that Dr. Silverman did not allow her to use the telephone prior to the procedure, it was unclear to the Committee whether the patient in fact made this request before or after receiving the local anesthetic; however, in the Committee's view it would have been reasonable for Dr. Silverman to have informed the patient that she could not use the telephone after he administered the anesthetic or while he was performing the procedure.

With respect to the patient's concern that Dr. Silverman left her blood on the overhead light, floor, and examination room wall, in the Committee's view some blood during the procedure would have been expected and Dr. Silverman submitted documentation to the Committee that reasonably supported that he has his office space appropriately cleaned on a regular basis.