MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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NB: PUBLICATION OF THE NAME OR ANY DETAILS LEADING TO THE IDENTIFICATION OF THE COMPLAINANT IS PROHIBITED

DECISION NO: 185/01/79C

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 **GRAHAM KEITH PARRY** medical practitioner of Whangarei

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Miss S M Moran (Chair)

Dr I D S Civil, Dr J C Cullen, Professor W Gillett,

Mr G Searancke (Members)

Mr B A Corkill (Legal Assessor)

Ms K Davies (Hearing Officer)

Mrs G Rogers (Stenographer)

Hearing held at Whangarei on Monday 19 and Tuesday 20 November 2001

APPEARANCES: Mr M F McClelland and Ms C Gelston for a Complaints Assessment Committee ("the CAC")

Mr A H Waalkens for Dr G K Parry.

The Charge

1. The Complaints Assessment Committee (CAC) pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 charges that Dr Parry at Whangarei between May 1995 and March 1996 acted in a way that amounted to professional misconduct in that there were serious deficiencies in his management of patient S namely:

   (a) He failed to appropriately treat the presenting problem of Lichen Sclerosis with potent corticosteroid ointment; and/or

   (b) He failed to discuss the chronically recurrent nature of the disease or to recommend a plan for ongoing management of the disease, including follow-up appointments with the patient;

   (c) The conduct alleged amounts to professional misconduct in paragraphs 1(a) and 1(b) either separately or cumulatively are particulars of that professional misconduct.

The Plea

2. Dr Parry denied the charge.

Onus of Proof

3. The onus of proof is borne by the CAC.

Standard of Proof

4. With regard to the standard of proof, the Tribunal must be satisfied that the relevant facts are proved on the balance of probabilities. The standard of proof varies according to the gravity of the allegations and the level of the charge. The facts must be proved to a standard commensurate with the gravity of what is alleged.

Ongley v Medical Council of New Zealand [1984] 4 NZAR 369 at 375 to 376.

Brake v Preliminary Proceedings Committee (Full Court, High Court, Auckland, 169/95, 8 August 1996 at page 8).

Evidence for the CAC

5. The CAC called three witnesses:

5.1 The complainant patient S.

5.2 Dr Ronald William Jones, Obstetrician and Gynaecologist of Auckland, whom patient S consulted in 1999.

5.3 Dr David John Peddie, Consultant Obstetrician and Gynaecologist at Christchurch Women's Hospital, as to his opinion on the appropriate treatment and management and follow-up of patient S.

Evidence for Dr Parry

6. Dr Parry gave evidence himself.

7. Dr Parry called Dr Paul James Dempsey, a Consultant Obstetrician and Gynaecologist at Taranaki Base Hospital in New Plymouth since 1975, who gave evidence as to his opinion on the appropriate treatment and management and follow-up of patient S. Dr Dempsey's evidence was given via video link.

Factual and Evidential Background

8. On or about 25 May 1995, patient S visited her GP, Dr Geoff Dunn, about severe vaginal itching and a small red blotch on the right labia minor, and a small tear at the bottom of the vaginal opening.

9. By letter dated 25 May 1995 Dr Dunn referred patient S to Dr Parry in the following terms:

> *"… [patient S] has a suspicious looking lesion on the right vulva. This has developed over the last 6 months and appears to have grown quite quickly. She also has a marked atrophic vaginitis and a small fissure posteriorly*
>
> *She did have an anal fissure … which has recurred after sphincterotomy.*
>
> *She also had an abnormal smear 3 years ago which has settled since."*

10. On 31 May 1995 patient S saw Dr Parry at his rooms in Whangarei.

11. Dr Parry carried out an examination of the vulva and made a provisional diagnosis of *lichen sclerosis.*

12. There is some uncertainty, in the Tribunal's view, as to precisely what was discussed at this consultation.

13. Patient S said she asked Dr Parry what *lichen sclerosis* was and the only answer she received was that *"It is quite common in women of your age, in fact a lot who think they have thrush actually have lichen sclerosis"*. She says that Dr Parry gave her no other information about the condition, its treatment, any follow-up that was required, any ongoing management, or any potential for it to develop into cancer.

14. While there is some uncertainty as to precisely what was discussed and agreed at this consultation, Dr Parry recommended and patient S agreed to a biopsy of the area of the abnormal vulval appearance. It was also agreed that Dr Parry would repair the vaginal tear at the same time.

15. That same day, 31 May 1995, Dr Parry wrote to Dr Dunn:

"I think she has some degree of lichen sclerosis but certainly think this is an abnormal appearance particularly on the right vulva. I think this should be excised and go to the laboratory. I would also take the opportunity to excise the split at the posterior fourchette and try and put that back together for her so that at least it might heal well and allow intercourse to occur again."

16. On 2 June 1995 patient S was admitted to Mercy Hospital, Northland, where Dr Parry carried out a vulval biopsy and a Fenton's procedure of the posterior fourchette.

17. On 2 June 1995 Dr Dunn's records indicate that Dr Parry wrote to him that day advising that patient S had had a vulval biopsy and small Fenton's repair.

18. On 9 June 1995 Dr E Johnson, Pathologist, made an histology report excluding malignancy and recording:

"The appearances are of marked lichen sclerosis and atrophism with no evidence of malignancy. Diagnosis: lichen scclerosis and atrophism".

19. On 20 June 1995 patient S said she telephoned Dr Parry's rooms as she was under considerable stress not knowing whether she had a cancerous condition which might need immediate treatment. She was told by the receptionist that the result was that there was no cancer but it was *lichen sclerosis*. Patient S said she asked if there was any treatment for the problem to which the receptionist said *"Haven't we sent you a script for 1% hydrocortisone cream?"* to which patient S said she replied *"No"*.

20. On 21 June 1995 patient S said she received a letter from Dr Parry dated 16 June 1995:

"This is to let you know that your biopsy came back showing lichen sclerosis. This is a chronic condition but showed no evidence of any malignancy. I would be happy to see you again any time you were concerned."

21. Enclosed with the letter was a prescription for 1% hydrocortisone cream and its application. No further information was provided at that time.

22. Patient S said that having received Dr Parry's letter of 16 June, she looked in the dictionary to see what the word *"chronic"* meant which she recalled as being lingering, lasting, and severe.

23. Patient S said that during the next month she used the cream. At times she thought it was helping but the itching had always been spasmodic, being worse during warm weather; and believed that as it was a chronic condition it might take time to improve.

24. On 19 February 1996 patient S again visited Dr Dunn regarding the continuation of the vulval itching which she described as severe. Patient S told the Tribunal that she did not feel very happy about Dr Parry's treatment and what she described as the total lack of information provided to her, but did not mention this to Dr Dunn at the February consultation.

25. On 21 February 1996 Dr Dunn wrote a further referral letter to Dr Parry:

"… You performed a vulval biopsy in June 1995 which showed benign changes of lichen sclerosis. She continues to have some itching and whiteness in this area.

I would be very grateful if you could advise what degree of follow-up should occur with this, whether a further biopsy is necessary at any stage or whether visual or smear type specimens would be appropriate.

The hydrocortisone 1% which she was given does seem to control the symptoms reasonably well.

Thank you very much for your advice. Please send her an appointment if you feel this would be appropriate."

26. On 8 March 1996 patient S had a further consultation with Dr Parry.

27. There is some disagreement between Patient S and Dr Parry as to what was said at this consultation and its purpose. Patient S said she asked Dr Parry a number of questions; that he told her her condition was incurable and may become cancerous in time; that he believed it was associated with asthma and eczema; that he did not discuss the use of potent cortico steroid ointments, the need to follow up, nor did he discuss the need for

ongoing management of the disease; that he supplied some oestrogen cream, but otherwise gave no other information.

28. Dr Parry said he regarded that consultation particularly as a consultation to answer a number of questions about which patient S was still unclear, and reassured her that by utilising some topical oestrogen cream (Dienoestrol) it might be possible for her to resume intercourse. Dr Parry said that patient S did not express to him that she was unhappy about his treatment or lack of information. In this regard, it is noted that in answer to a question from Dr Parry's counsel, patient S said that Dr Parry answered all the questions she asked at that consultation.

29. That same day, Dr Parry wrote to Dr Dunn:

"I saw [patient S] today. She has a number of questions that she had not quite got clear in her own mind after her biopsy and I think I was able to answer these. She had been avoiding intercourse because of the fourchette and I think that if she now re-instates intercourse that things will be more of a problem. I have given her some oestrogen cream to try to mature the vaginal mucosa in case she does wish to restart and certainly there [are] a number of people that believe that the oestrogen cream is quite useful for treating lichen sclerosis anyway."

30. Dr Parry said he dictated this letter to Dr Dunn immediately following the consultation with Patient S.

31. Patient S did not seek a further consultation regarding the *lichen sclerosis* until 22 January 1999 when she saw another GP, Dr Nigel Cane (who was then in the same practice as Dr Dunn).

32. Dr Cane referred patient S to Dr Ronald William Jones at Auckland who is a sub-specialist with an international reputation in vulval disease. There are only two or three other practitioners in New Zealand who have Special Clinics devoted to vulval disease.

33. On 26 January 1999 Dr Cane wrote to Dr Jones in terms which stated he was seeking "a second opinion" as well as advice with regard to ongoing treatment.

34. On 5 February 1999 patient S consulted Dr Jones. In his evidence, Dr Jones said he had a lengthy discussion with patient S. He said he would have discussed the nature of the condition, the unknown cause, the treatment, the importance of follow-up and the very small risk of cancer developing. He also gave patient S and her partner a one page hand-out which describes the disease of *lichen sclerosis*.

35. He prescribed a potent topical cortico steroid ointment (Dermovate) and asked patient S to return in two months time for assessment.

36. Dr Jones said that Dermovate was regarded as the standard form of treatment in 1995, but that in mild cases 1% hydrocortisone was effective.

37. That same day, 5 February 1999, Dr Jones wrote to Dr Cane advising that:

> *"… The clinical features are typical of relatively long-standing lichen sclerosus. Vulval contracture is already evident.*
>
> *I have told her that she needs to use a more potent steroid such as Dermovate on a regular basis for two months. I will then review the situation."*

In that letter, Dr Jones also commented (as a result of the consultation with patient S) that the 1% hydrocortisone cream which Dr Parry had prescribed in 1995 *did not provide any benefits.*

38. By 6 April 1999 Dr Jones was able to report to Dr Cane that the *lichen sclerosis* affecting patient S had *"improved dramatically since regularly applying Dermovate ointment"*.

39. Dr Jones accepted that some clinicians prefer to introduce patients to a low potency steroid to see what effect that has before moving to a more potent cream. He also accepted that there has been a theoretical consideration that a high potency cream can have an effect of thinning the structures around the vulva but in practice that does not appear to have been so proved if used in an appropriate fashion. If a potent steroid is applied for a very lengthy period of time then thinning of the skin may occur.

40. When asked if he would be critical of an obstetrician and gynaecologist who held the view that this might be a reason why one would not start with a more potent steroid cream, Dr Jones answered that 1% hydrocortisone cream has been used for many years in this setting and there has been the belief that any steroid might cause thinning.

41. When referred to the passage in Dr Dunn's letter of 21 February 1996 to Dr Parry that *"The hydrocortisone 1% which she was given does seem to control the symptoms reasonably well"* Dr Jones accepted that with such information some practitioners would take the view that you would not embark on a more potent steroid at that stage.

42. When asked whether it was the case that in 1995 1% hydrocortisone was more commonly used in this type of situation than the more potent Dermovate cream, Dr Jones answered that nobody knew the answer to that question but he thought it would be fair to say that 1% hydrocortisone was used widely for the treatment of *lichen sclerosis* at that period in time.

43. The CAC called Dr Peddie, Consultant Obstetrician and Gynaecologist at Christchurch Women's Hospital as to his opinion on the appropriate treatment and management and follow-up of patient S. Dr Peddie has specialist knowledge in vulva dermatology, and has operated a Vulval Dermatology Clinic (of one session per month) since 1995 down to the present time,.

44. Dr Peddie referred to the older textbooks which describe a variety of managements including excision, topical preparations such as hydrocortisone, anti puritics, oestrogen cream, and recommendations for follow-up between "close" and no recommendation. He stated that vulval dermatology has expanded out into almost a sub-specialty, and that the management of these sometimes difficult conditions is in general better taught to the new generation of O & G specialists. He stated that once the results of a biopsy had been received he considered it a minimum that Dr Parry should have explained to patient S that the biopsy had excluded malignancy and that there should have been a brief description about what was known about *lichen sclerosis* and how it is normally treated and followed up (as per Dr Jones' handout). He stated there should have been a treatment and follow-

up plan for patient S, or another appointment to discuss the same but noted that Dr Parry had asked patient S to contact him if she had further concerns.

45. Dr Peddie stated it would appear that Dr Parry was not aware that stronger steroids could have been beneficial and that regular follow-up by either himself or another practitioner with an understanding of the condition should have continued. He added that it is not easy to keep up to date with every aspect of O & G and it can be helpful to share knowledge and information with colleagues.

46. He stated that the management outlined in Dr Jones' handout would have been the generally accepted method of treating *lichen sclerosis* in 1995 and 1996.

47. In answer to Dr Parry's counsel, Dr Peddie accepted that as he had a particular interest in vulval disease he had more knowledge than most generalist O & Gs would have, and that as a consequence he had a higher appreciation of the use of the more potent treatment (Dermovate) such as used by Dr Jones in the case of patient S.

48. When asked whether he agreed with Dr Dempsey's evidence (referred to below) about whether the movement towards using Dermovate or a similar cream was more prevalent now than it was in 1995, Dr Peddie replied that there had been a gradual move to increasingly use the stronger steroids adding *"If you read the literature, you read about it in the late 80s early 90s, but its takes a while to filter out to the trenches"*. He accepted that the message of filtering *"out to the trenches"* may have become more well known after 1995.

49. Dr Peddie agreed that if a gynaecologist were given the message that the cream appeared to be controlling the symptoms reasonably well then that would be a reassuring sign but that he himself would also ask the patient. He accepted that in judging Dr Parry much would depend on the impression Dr Parry got from the clinical picture in its entirety.

50. Both Dr Jones and Dr Peddie stated that it was difficult to make any conclusions as to how severe the condition of patient S was in 1995 without having seen her at that time.

51. Dr Peddie also accepted that whether it were in 1995/1996 or today, if you were a generalist and only seeing two or three patients a year with a particular condition (such as *lichen sclerosis*) then you would not have a written handout (as did Dr Jones). It would depend on your practice.

52. Dr Paul James Dempsey gave evidence via a video link on behalf of Dr Parry. Since 1975 he has been practising both as a Consultant Obstetrician and Gynaecologist at Taranaki Base Hospital in New Plymouth as well as in private specialist practice.

53. Dr Dempsey described himself as being of a similar age and training background to Dr Parry and also working as a generalist gynaecologist in a provincial city as did Dr Parry. He stated that in 1995 it was his recollection that 1% hydrocortisone was still widely used for the treatment of *lichen sclerosis* and that it was not until some time after this that high potency steroids became widely used.

54. In answer to questions on behalf of counsel for the CAC, Dr Dempsey stated that particularly in 1995 it was his understanding that for the treatment and management of *lichen sclerosis* a number of gynaecologists would start a patient on a low dose and see what control that dose managed to have on the symptoms and then if necessary would increase the dose.

55. Dr Dempsey stated that now it is more likely he would commence a patient at a higher dose but he did not do so in 1995. He said there had been a change in treatment over the years. He could not be sure when the use of Dermovate became standard treatment, whether it be in 1995, 1996 or 1997, but that at some time around then it became available, probably later in the provinces, in the bigger clinics.

56. Prior to the use of Dermovate becoming generally accepted, if the 1% hydrocortisone did not control the symptoms then he would probably have sought advice from, or referred the patient to, someone like Dr Jones.

57. Dr Parry gave evidence that if there had not been an improvement he would have referred patient S to the vulva clinic for further management options before increasing the dosage of

steroid cream. Referring to that, Dr Dempsey said that such a referral was something he would not normally discuss with a patient. He thought, at that time, the follow-up of most patients he saw (who came from a similar sized place as Dr Parry's with no vulval clinic) would be left to their general practitioner particularly if the patient was symptom free.

58. With regard to the issue of pre-malignancy, he was not aware in 1995 that there was any risk of this.

59. Dr Dunn was not called to give evidence. In answer to an enquiry, he wrote to counsel for the CAC on 31 October 2001. His letter was presented to the Tribunal as part of the evidence. In his letter, he expressed his availability to give evidence if required.

60. His letter stated that he did not have any concerns regarding the management of patient S in 1995. He felt that the important concern regarding malignancy had been answered which was his main concern. He stated that it could certainly have been helpful if he had contacted patient S at that stage to check on her symptoms but, being more concerned with the initial appearance of the lesion, he did not notice that irritation was a major problem.

61. In his letter he stated that patient S presented again in February 1996 and, because of the persistence of symptoms and the appearance of the vulva, he wrote to Dr Parry asking if any further follow-up should be done. Again, he stated he was more concerned with the possibility of malignancy which he understood could occasionally occur with white areas on the vulva.

62. Dr Dunn stated in his letter to the CAC that his notes indicated the hydrocortisone cream helped the symptoms of patient S. While his letter of February 1996 to Dr Parry indicated that the symptoms were controlled reasonably well, he appreciates that any symptoms in that area can be unpleasant and distressing but, on reading his notes in October 2001 he stated that he obviously did not pick up on the symptoms being severe, but now accepts that they may well have been.

63. With regard to malignancy, the evidence before the Tribunal tended to establish that in 1995 it was not thought that there was a significant risk of malignancy developing from the condition of *lichen sclerosis*.

64. Patient S also complained about other aspects of Dr Parry's management but as they do not form part of the charge we do not find it necessary to refer to them.

The Law

65. Dr Parry has been charged with professional misconduct, the test for which is well-established. A repeatedly cited test is to be found in *Ongley* (above) at pages 374 to 5 where Jeffries J stated:

> *"To return then to the words "professional misconduct" in this Act. In a practical application of the words it is customary to establish a general test by which to measure a fact pattern under scrutiny rather than to go about and about attempting to define in a dictionary manner the words themselves. The test the Court suggests on those words in the scheme of this Act in dealing with the medical practitioner could be formulated as a question: Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would reasonably be regarded by his colleagues as constituting professional misconduct? With proper diffidence it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the composition of the tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application to it of reputable, experienced medical minds supported by a layperson at the committee stage."*

66. In *B v The Medical Council* (High Court, Auckland, 11/96, 8/7/96), (in the context of a charge of conduct unbecoming), Elias J stated:

> *"In the case of diagnosis or treatment, conduct which falls short of the mark will be assessed substantially by reference to usual practice of comparable practitioners. … Those standards to be met are, as already indicated, a question of degree; … I accept that the burden of proof is on the balance of probabilities. Assessment of the probabilities rightly takes into account the significance of imposition of disciplinary sanction. I accept that the court must be satisfied on the balance of probabilities that the conduct of the practitioner is deserving of discipline."*

67. The applicable principles to be taken from these statements are:

67.1 A finding of professional misconduct or conduct unbecoming is not required in every case where a mistake is made or an error proven.

67.2 The question is not whether an error was made, but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations (in all the circumstances of the particular case).

67.3 The departure from acceptable standards and/or the failure to fulfil professional obligations must be significant enough to attract sanction for the purposes of protecting the public.

68. Following the decisions of *Ongley* (above) and *B* (above) - which were given in the professional disciplinary context and on appeal from specialist tribunals - the question is whether Dr Parry's conduct was conduct which is culpable, i.e. conduct deserving of discipline.

The Decision

69. The foregoing is not a comprehensive summary of all the evidence which the Tribunal heard. In reaching its decision, however, the Tribunal has given careful consideration to all of the evidence presented to it and to the helpful submissions made by both counsel. It has also assessed the credibility of each of the witnesses, all of whom it found to be truthful. While there are some aspects in respect of which there are differing accounts as between patient S on the one hand and Dr Parry on the other, the Tribunal has found that this can be attributed to their different understanding and to the passage of time and not to any lack of credibility on the part of either.

70. The charge is dealt with in respect of each part.

71. The first part states that there were serious deficiencies in Dr Parry's management of patient S namely:

(a) He failed to appropriately treat the presenting problem of Lichen Sclerosis with potent cortico steroid ointment.

72. The Tribunal is not satisfied that there were serious deficiencies regarding this part of the charge.

73. When Dr Dunn referred patient S to Dr Parry in May 1995 his principal concern was to exclude malignancy. The Tribunal also accepts that it was a principal concern for Dr Parry (as well as for patient S).

74. When the histology report was received in June 1995 excluding malignancy and making a diagnosis of *lichen sclerosis*, the application of 1% hydrocortisone cream was an appropriate treatment, at that time.

75. With regard to the second consultation in March 1996, the Tribunal cannot be certain on the evidence presently before it, precisely what was discussed between patient S and Dr Parry. At the time of that consultation, Dr Parry had before him Dr Dunn's letter of 21 February 1996 in which Dr Dunn stated that the hydrocortisone 1% seemed to control the symptoms reasonably well. Dr Parry relied on that written communication; and, patient S in answer to a question from Dr Parry's counsel accepted that Dr Dunn would have reached that conclusion as a consequence of what patient S had told him.

76. Both Dr Jones and Dr Peddie, who have (and had at the material time) specialist knowledge in vulval disease accepted that 1% hydrocortisone was used widely for the treatment of *lichen sclerosis* at that time and that if Dr Parry had understood that the symptoms were being controlled reasonably well then it would not be unreasonable to continue the use of it.

77. The Tribunal finds that there was no intimation to Dr Parry that matters were not under control which would necessitate either a change in management or a referral.

78. Accordingly, the Tribunal is not satisfied that the first part of the charge has been proven.

79. The second part of the charge states that there were serious deficiencies in Dr Parry's management of patient S, namely:

> ***(b) He failed to discuss the chronically recurrent nature of the disease or to recommend a plan for ongoing management of the disease, including follow-up appointments with the patient.***

80. The Tribunal deals with each part of this particular.

81. The first part is that Dr Parry failed to discuss the chronically recurrent nature of the disease with the patient.

82. The Tribunal accepts that this part of the particular has been proved.

83. While it is accepted that Dr Parry wrote to patient S on 16 June 1995 stating that *lichen sclerosis* was a chronic condition, this did not constitute an adequate explanation or discussion of the chronically recurrent nature of the disease. To merely describe it as chronic was not giving an adequate explanation. What was required was to inform the patient of the recurrent nature of the disease and what treatment or management could be provided to deal with that condition on an ongoing basis.

84. The Tribunal also accepts that the second particular of the second part of the charge has been proved.

85. Dr Parry failed to recommend a plan for ongoing management of the disease. As one member of the Tribunal observed, all he needed to do was to write to patient S's general practitioner and say what treatment he had provided and what circumstances would warrant a repeat appointment or re-examination.

86. Equally, it is evident no follow-up appointments had been made with the patient, though the Tribunal notes that Dr Dempsey would not necessarily have made follow-up appointments in similar circumstances.

87. Though the Tribunal has found both particulars of the charge proved, it was unanimous in finding these did not amount to professional misconduct.

88. When patient S first consulted Dr Parry, he made a provisional diagnosis of *lichen sclerosis* but did not discuss its nature in full. It would be unfair to criticise him for not giving a full explanation at that point. It was a provisional diagnosis only and had to await the radiologist's report. Further, the question of malignancy remained a possibility and, no doubt, was a major worry for patient S.

89. When Dr Parry wrote to patient S on 16 June 1995, having received the laboratory results, it seems that his sole or principal focus was to exclude malignancy.

90. Though he failed to give an adequate explanation of his final diagnosis and recommendations for treatment, the fact is patient S saw him again on 8 March 1996. By then Dr Parry had received a letter from Dr Dunn which indicated that the treatment which Dr Parry had prescribed did appear to be controlling the symptoms "reasonably well". Moreover, patient S asked Dr Parry a number of questions all of which he answered. Dr Parry said patient S did not express to him at that consultation any unhappiness about his treatment or the lack of information and the Tribunal has no reason to doubt that.

91. Dr Parry reported to Dr Dunn immediately following the examination.

92. Though there was no further follow-up by Dr Parry, as would normally be expected, the Tribunal is not satisfied that in 1996, having regard to the particular circumstances, Dr Parry could fairly be said to have so failed in his duty as to warrant sanction. In that regard, it accepts that the applicable standard is more aptly reflected in the practice described by Dr Dempsey rather than that described by Drs Jones and Peddie both of whom had sub-specialist knowledge.

93. The Tribunal concluded the evidence did not establish that Dr Parry's omissions compromised patient S's overall management or that his shortcomings were so significant as to amount to professional misconduct.

Orders

94. The charge of professional misconduct laid against Dr Parry is dismissed.

95. An interim order was made at the hearing on Monday 19 November 2001 suppressing the name of the complainant or any details leading to her identification. Having regard to the subject matter of the charge that order is made permanent.

96. An order was made on 26 August 2001 pursuant to section 106(2)(a) that the hearing be held in private; a further order was also made at the beginning of this hearing pursuant to section 106(2)(b) to prohibit publication of any part of the proceedings during the hearing; the latter order was made with the intention that once the decision was made it would be available for publication. Accordingly, the interim order made pursuant to s.106(2)(b) is hereby discharged.

DATED at Wellington this 11th day of January 2002

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S M Moran

Deputy Chair

Medical Practitioners Disciplinary Tribunal