NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

Level 24, AON Building,
1 Willis Street, Wellington 6011
PO Box 10509, The Terrace,
Wellington 6143, New Zealand
Telephone: +64 4 381 6816
Website: www.hpdt.org.nz

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

HPDT NO:	**1317/Med22/549D**
UNDER	the Health Practitioners Competence Assurance Act 2003 ("the Act")
IN THE MATTER	of a disciplinary charge laid against a health practitioner under Part 4 of the Act
BETWEEN	**DIRECTOR OF PROCEEDINGS** designated under the Health and Disability Commissioner Act 1994
AND	**DR ROBERT MORTON**, of Mosgiel, General Practitioner
	Practitioner

HEARING	held in Dunedin on 5 – 9 December 2022 and 20 June 2023 (AVL)
TRIBUNAL	Ms A J Douglass (Chair) Mr C Nichol, Dr G Sharpe, Dr S Ure and Dr K Good (Members)
IN ATTENDANCE	Miss D Gainey, Executive Officer
APPEARANCES	Ms L Preston KC and Ms C McCulloch for the Director of Proceedings Mr A Holloway and Ms G Wiesman, Ms Beattie (20 June 2023) for the Practitioner

---

DECISION OF THE TRIBUNAL
Dated 3 August 2023

CONTENTS

Introduction

[1] Dr Robert Morton is a vocationally registered General Practitioner (GP). For many years he has been Ms Nikki Cockburn's primary GP at the Mosgiel Health Centre (MHC) and one of the owners of that practice.

[2] This disciplinary Charge of professional misconduct (the Charge) concerns Dr Morton's treatment and prescribing of two highly potent medications to his patient Ms Cockburn for her psoriasis, a debilitating skin condition.

[3] The Charge is set out in the Schedule attached to this decision.[1]

[4] The Director of Proceedings (the Director) says that between 2013 and 2018 Dr Morton failed in his care of Ms Cockburn in two aspects of his prescribing practice. First, on 9 October 2013 he prescribed Ms Cockburn, who was 30 years old at the time, a highly teratogenic medication, Neotigason,[2] without fully informing her of the risks and ensuring the possibility of pregnancy was excluded.[3] Secondly, over a five year period Dr Morton gave Ms Cockburn repeat and excessive prescriptions of Dermol, a steroid-based medication, despite warnings from others involved in Ms Cockburn's care and without adequately informing her of the risks associated with heavy and long term use.[4]

[5] While it is not part of the Director's case that Dr Morton intended harm to his patient, the Director says that this is a case of clinical negligence by the practitioner: Dr Morton's failure to follow appropriate prescribing practices was contrary to accepted standards of care such that his conduct was negligence and / or malpractice in his scope of practice and that it was conduct that brings discredit to the medical profession pursuant to s 100(1)(a) and s 100(1)(b) of the Health Practitioners Competence Assurance Act 2003 (the Act).

---

1 Amended Charge dated 28 September 2022 as set out in the Schedule to this decision (the Charge).

2 Neotigason ("acitretin" is the generic name) is a teratogenic medicine that can cause birth defects or abnormalities in a developing embryo. It is used in the treatment of severe psoriasis, keratinisation and other skin conditions.

3 The Charge, Particulars 1 and 2.

4 The Charge, Particulars 3, 4 and 5.

[6] Although Dr Morton defended the Charge, there is significant agreement over the facts underpinning the particulars of the Charge. The hearing of the Charge proceeded over four days in Dunedin. Both Dr Morton, the practitioner, and Ms Cockburn, the complainant, gave evidence. The Tribunal was assisted by expert evidence from Dr Garry Brown.

[7] At the conclusion of the hearing the Tribunal found the Charge established and indicated the decision and orders on penalty and costs.

[8] On 20 June 2023 the Tribunal reconvened by way of an Audio-Visual Link (AVL) hearing to determine Dr Morton's application for permanent name suppression.

[9] We set out the reasons for our decision and the orders made below.

Background

[10] Ms Cockburn became Dr Morton's patient in 1986 when he joined MHC. She was four years old at the time and she is now 40 years of age.

[11] On 10 September 2008 Dr Morton diagnosed Ms Cockburn with moderately severe guttate psoriasis. Psoriasis is a chronic inflammatory skin condition that is managed, not cured.[5]

[12] On the same day, Dr Morton referred Ms Cockburn to Dr Strack, a dermatologist at Dunedin Hospital.[6]

[13] On 13 October 2008, Dr Strack advised Dr Morton that he had seen Ms Cockburn, agreed that she had guttate psoriasis and recommended treatment with Daivonex and Dermol ointments, using each on alternate days.[7]

---

5 Brief of Evidence Dr Garry Brown at [1.9]. Psoriasis is a long-term condition which can be itchy, painful and makes it difficult for the person to concentrate or sleep. Guttate psoriasis is characterised by multiple small patches of affected skin over widespread areas of the body.

6 ABOD, p 287.

7 ABOD, p 288.

[14] On 24 November 2008 and on 21 March 2009, Ms Cockburn was again reviewed by Dr Strack and then by [Dr E], a visiting dermatologist.[8]

[15] On 27 August 2012, Ms Cockburn was seen by [Dr A], a trainee GP Registrar at MHC.[9]

[16] On 29 August 2012, following the consultation, [Dr A] wrote to Ms Cockburn advising that Dermol is a very strong steroid that may be harming her skin and body and that she should stop using it until there was a review by one of the doctors at MHC.[10] Ms Cockburn does not recall receiving the letter from [Dr A].

[17] Around the same time, [Dr A] placed an alert on Ms Cockburn's electronic medical file stating: "BE CAUTIOUS WITH SCRIPTING DERMOL OVERUSING".[11]

[18] In February and May 2014 Dr Morton received letters from [Dr E], Dermatologist, advising that Ms Cockburn should no longer be prescribed Dermol.

[19] On 12 November 2015, a locum doctor, [Dr T], issued an increased prescription of 6 x 30g tubes of Dermol, with two repeats of 6 x 30g tubes. This prescription was authorised by telephone and was a marked increase in the dosage prescribed[12]

[20] Over the next two years, Ms Cockburn was prescribed this increased amount of Dermol on a further 11 occasions. Dr Morton was the prescriber on nine of those occasions. While many were telephone requests, he saw Ms Cockburn on three occasions for in-person consultations.

[21] In November 2018, while in Auckland Ms Cockburn had a discussion with a friend about her health. She made a self-diagnosis via a Google search that she had Cushing's Syndrome,[13] a condition caused by the long-term use of corticosteroids, such as Dermol.

---

8 ABOD, pp 289 and 290.
9 ABOD, Clinical Notes, p 91.
10 ABOD, p 291.
11 ABOD, p 148.
12 See Schedules A and B to Charge of this decision.
13 Cushing's Syndrome is a group of symptoms caused by exposure to high cortisol levels and the long-term

[22] Ms Cockburn then attended another GP at MHC where the diagnosis of Cushing's Syndrome was confirmed.

[23] In addition to Dermol, Dr Morton prescribed Neotigason for Ms Cockburn's psoriasis.

[24] On 9 October 2013, Ms Cockburn attended an appointment with Dr Morton because her psoriasis was not getting any better. During the appointment, Dr Morton provided Ms Cockburn with a prescription for Neotigason and advised her to fill it when she received the results of blood tests which he ordered, provided that these were satisfactory.

[25] On the same day, Dr Morton submitted a Ministry of Health application for Subsidy by Special Authority (Special Authority).[14] In doing so, he confirmed that he had ruled out pregnancy in Ms Cockburn and had provided her with all the necessary information regarding the risks of treatment with this medication.

[26] On 14 October 2013, Ms Cockburn received favourable blood test results, a filled prescription, and began using the Neotigason.

[27] Around 8 November 2013, Ms Cockburn discovered she was pregnant. Due to the risk of severe foetal malformation, Ms Cockburn terminated the pregnancy.

[28] On 24 November 2013 Dr Morton provided a written apology to Ms Cockburn in relation to his prescribing of Neotigason on 9 October 2013.

[29] Initially in 2014, Ms Cockburn raised a complaint with MHC regarding Dr Morton's prescribing of Neotigason and she saw another doctor at MHC. In May 2014 she returned to Dr Morton as her GP in the practice.

---

use of corticosteroid medications. The hallmark signs of Cushing Syndrome are a fatty hump between the person's shoulders, a rounded face, and pink or purple stretch marks on their skin.

[14] ABOD, Document 3, p 152; Screenshot of Special Authority form.

[30] On 24 March 2015, eighteen months following the prescription of Neotigason, Ms Cockburn discovered she was pregnant again. Due to her ongoing risk of severe foetal malformation, Ms Cockburn subsequently terminated the second pregnancy.

[31] On 23 August 2019, following the diagnosis of Cushing's Syndrome, Ms Cockburn laid a complaint with the Office of the Health and Disability Commissioner (HDC) regarding Dr Morton's treatment and prescribing of both medications.

[32] On 15 January 2021 the HDC issued an opinion finding that Dr Morton was in breach of Rights 4 and 6 of the Code of Health and Disability Consumers' Code of Rights (HDC Code).

[33] The HDC opinion was then referred to the Director who then laid the Charge now before the Tribunal.[15]

Relevant law

Professional misconduct

[34] The primary purpose of the Tribunal's disciplinary powers is the protection of the public by the maintenance of professional standards.

[35] Section 100 of the Act defines the grounds on which a health practitioner may be disciplined. Dr Morton has been charged with professional misconduct under both s100(1)(a) and/or (b) of the Act as follows:

> **100 Grounds on which health practitioner may be disciplined**
>
> (1) The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that—
>
> (a) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of

[15] The referral by the Health and Disability Commissioner to the Director of Proceedings was made pursuant to s 45 of the Health and Disability Commissioner Act 1994. The Charge Is laid by the Director of Proceedings under s 91 of the Health Practitioners Competence Assurance Act 2003.

> which the practitioner was registered at the time that the conduct occurred; or
>
> (b) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred;

[36] The Tribunal and the Courts have considered the term "professional misconduct" under s 100(1)(a) on many occasions. In *Collie v Nursing Council of New Zealand,*[16] Gendall J described negligence and malpractice as follows:

> Negligence or malpractice may or may not be sufficient to constitute professional misconduct and the guide must be standards applicable by competent, ethical and responsible practitioners and there must be behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error, oversight or for that matter carelessness.

[37] "Malpractice" is defined in the *Collins English Dictionary* as:[17]

> The immoral, illegal or unethical conduct or neglect of professional duties. Any instance of improper professional conduct.

And in the New Shorter Oxford English Dictionary:[18]

> 1. Law. Improper treatment or culpable neglect of a patient by a physician or of a client by a lawyer … 2. Gen. A criminal or illegal action: wrongdoing, misconduct.

[38] Section 100(1)(b) of the Act creates another route by which a finding of professional misconduct may be made. This is where the practitioner's conduct has or is likely to bring discredit on the particular health profession. In *Collie v Nursing Council of New Zealand*, Gendall J described the meaning of "conduct likely to bring discredit" on the nursing profession as follows:[19]

> To discredit is to bring harm to the repute or reputation of the profession. The standard must be an objective standard with the question to be asked by the Council being whether reasonable members of the public, informed and with

---

16 [2001] NZAR 74.
17 Collins English Dictionary (2nd Edition).
18 Shorter Oxford English Dictionary (1993 ed), as cited in *Dr E* 136/Med07/76D at [12]–[14].
19 *Collie v Nursing Council of New Zealand* [2001] NZAR at [28].

> knowledge of all the factual circumstances, could reasonably conclude that the reputation and good-standing of the nursing profession was lowered by the behaviour of the nurse concerned.

Burden and standard of proof

[39] The burden of proof is on the Director to establish the Charge against the practitioner.

[40] The Director must produce evidence that establishes the facts on which the Charge is based to the civil standard of proof; that is, proof which satisfies the Tribunal that the conduct alleged in the particulars of the Charge are more likely than not.

[41] The Tribunal must apply a degree of flexibility to the standard of proof, taking into account the seriousness of the allegation and the gravity of the consequences flowing from a particular finding.[20]

Threshold test for disciplinary sanction

[42] There is a well-established two-stage test for determining professional misconduct in this jurisdiction.[21] The two steps are:

(a) First, did the proven conduct fall short of the conduct expected of a reasonably competent health practitioner operating in that vocational area? This requires an objective analysis of whether the health practitioner's acts or omissions can reasonably be regarded as being negligence and/or malpractice or, having brought or are likely to bring discredit to the practitioner's profession; and

(b) Secondly, if so, whether the departure from acceptable standards has been significant enough to warrant a disciplinary sanction for the purposes of protecting the public and / or maintaining professional standards?

[43] In *Martin v Director of Proceedings*[22] Courtenay J in the High Court said that the threshold for disciplinary sanction should not be regarded as "unduly high" but that "a notable

---

[20] *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR 1 (SC) at [112].

[21] *PCC v Nuttalll* Med 08/04/03P; *F v Medical Practitioners Disciplinary* Tribunal [2005] 3 NZLR 774 (CA), as applied in *Johns v Director of Proceedings* [2017] NZHC 2843 at [78].

[22] [2010] NZAR 33, Courtenay J at [32].

departure from acceptable standards" is required; and that the threshold is to be reached with care, having regard to both the purpose of the Act and the implications for the practitioner.[23]

[44] The practitioner's personal circumstances, including the subjective reasons for their conduct, are not relevant at the threshold stage, but instead go to the question of penalty.[24]

Professional standards and guidelines

[45] There are several relevant professional standards that apply in this case and these standards were available to Dr Morton throughout the time he prescribed the medications.

[46] The relevant New Zealand Medical Council (Medical Council) Standards include:

(a) *Good Medical Practice* (2008-2016);[25]

(b) *Good Prescribing Practice* (2010-2016)[26], a specific standard in relation to safe prescribing practices. In summary, this standard requires practitioners to:

> Only prescribe medicines when they have adequately assessed the patients' condition and/or have adequate knowledge of the patients' needs and are satisfied that the medicine or treatment is in the patients' best interests;
>
> Be familiar with the indications, side effects, contra indications, appropriate dosages, effectiveness and cost-effectiveness of medicines they prescribe;
>
> Ensure that the patient is fully informed and consents to the proposed treatment and has received appropriate information, including an assessment of expected risk, side effects, benefits and costs;

---

[23] *Martin v Director of Proceedings* [2010] NZAR 33, Courtney J at [32].
[24] *McKenzie v MPDT* [2004] NZAR 47 at [71]; *Cole v PCC* [2017] NZHC 1178, [128]–[130]; *Paltridge* 382/Med11/172P at [118].
[25] *Good Medical Practice,* June 2008, April 2013, June 2016 and December 2016.
[26] *Good Prescribing Practice,* April 2010, November 2015 and November 2016.

Periodically review the treatment;

Consider the input that other health professionals including pharmacists might be able to offer regarding medicines, such as information on dosage, possible interactions with other medications or adverse effects; and

Periodically review the effect of the treatment and any new information about the patients' treatment, condition and health if the treatment is being prescribed over an extended period of time.[27]

(c) The Medical Council's statement on *Information, Choice of Treatment and Informed Consent,* (March 2011)[28] advises practitioners of the need to inform their patients about the potential risks and benefits of treatment options available and support them to make an informed choice. This statement sets out the basis of informed consent, and the obligation on practitioners to abide by the Code of Health and Disability Services Consumers' Rights (HDC Code) which gives every patient the right to be fully informed.

[47] Rights 4(1) and 6(1) of HDC Code include:

Right 4

(1) Every consumer has the right to have services provided with reasonable care and skill.

Right 6

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …

[48] Medsafe[29] publishes data sheets, consumer information sheets and prescriber updates in relation to the prescribing of Neotigason and Dermol. These include:

---

[27] ABOD / Bundle, see p 581.
[28] New Zealand Medical Council, Information, Choice of Treatment and Informed Consent, March 2011.
[29] Medsafe is the New Zealand Medicines and Medical Devices Safety Authority. It is a business unit of the

(a) *Medsafe Data Sheet - Dermol*[30]*.* This information sheet warns that long-term continuous topical therapy should be avoided where possible, as adrenal suppression could occur even without occlusive dressings being placed over the cream on the skin, to enhance effectiveness. As early as July 2010, the data sheet warned that as with other topical corticosteroids, prolonged use of large amounts of treatment for extensive areas could result in sufficient systemic absorption to produce the features of Cushing's Syndrome.

(b) *Medsafe Data Sheet – Neotigason*[31]*.* This information sheet advises practitioners that Neotigason is a highly teratogenic medication and should only be prescribed by medical practitioners who were experienced in the use of systemic retinoids and who understand the risk of teratogenicity associated with acitretin therapy.

Evidence and witnesses

[49] The parties provided an Agreed Bundle of Documents (ABOD / Bundle). The Bundle included details of the complaint made by Ms Cockburn to the HDC and the responses from Dr Morton; Ms Cockburn's clinical records and related correspondence held on Ms Cockburn's clinical file; the Ministry of Health's dispensing data for Ms Cockburn; Medsafe publications and Medical Council Standards; and a preliminary competence report by the Medical Council regarding Dr Morton that was undertaken during 2020.

[50] The Director called two witnesses, Ms Cockburn, the complainant, and Dr Garry Brown, expert witness.

[51] Ms Cockburn gave evidence about the events that are the subject of the Charge and the care provided to her from Dr Morton.[32] In relation to particulars 1 and 2, she described her appointment with Dr Morton on 9 October 2013 at which Dr Morton prescribed Neotigason,

---

Ministry of Health and is the authority responsible for the regulation of therapeutic products in New Zealand.

30 Medsafe Data Sheet – *Dermol*, 2010, 2015, 2017 and 2018.

31 Medsafe Data Sheet – Neotigason, July 2013.

32 Document 6, Brief of Evidence of Nikki Cockburn dated 19 October 2022.

including what she understood from the prescription. She then described what happened when she subsequently discovered she was pregnant.

[52] In relation to Particulars 3 to 5, Ms Cockburn gave evidence about the prescribing of Dermol by Dr Morton and other health practitioners at MHC, the result of the long-term effects of Dermol use, and how she came to discover for herself that she had Cushing's Syndrome.

[53] Dr Garry Brown gave expert evidence regarding Dr Morton's treatment of Ms Cockburn. He has been a vocationally registered GP for over 30 years. While working in general practice he has held other current roles including as an ACC Medical Advisor for treatment injury, Fellowship Censor for the Royal New Zealand College of General Practitioners (RNZCGP) and as an independent advisor to the HDC.

[54] Dr Brown's role is to assist the Tribunal.[33] He provided information and comment on the prescribed medicines in this case and the relevant Medsafe data sheets including the Medsafe information for prescribers and the process for applying for a Special Authority to prescribe Neotigason. Dr Brown gave his opinion as to the extent to which he considered Dr Morton had departed from the standards of care and accepted practice when providing treatment to Ms Cockburn.

[55] Dr Morton provided a written brief of evidence and gave oral evidence in his defence of the Charge.[34] He gave a frank and open account of his care and treatment of Ms Cockburn as her primary GP from December 1986 until the end of November 2018. This included the prescribing of Neotigason on 9 October 2013 and also his over-prescribing of Dermol. Dr Morton explained that he apologised to Ms Cockburn, the steps he took once he realised his error in relation to his prescribing of Neotigason to Ms Cockburn and the subsequent self-audit of his practice and his prescribing of Dermol.

---

[33] Health Practitioner's Disciplinary Tribunal "Amended Practice Note No. 3" (17 November 2021) applies the High Court Rules Code of Conduct for Expert Witnesses.

[34] Document 13 Brief of Evidence of Dr Robert Morton dated 9 November 2022.

[56] Dr Morton provided three character references from his medical colleagues.[35]

Liability

Tribunal's consideration of the Charge

[57] The central issue for the Tribunal to determine is whether Dr Morton's prescribing practice fell below the standard of care reasonably to be expected of a medical practitioner and whether any departures from professional standards separately, or cumulatively, are sufficiently serious to warrant a disciplinary sanction.

[58] The Tribunal is required to make an evaluative judgement of all the evidence and make findings on the evidence in relation to each particular of the Charge to the requisite standard of proof, on the balance of probabilities.

[59] Neither Dr Morton's nor Ms Cockburn's credibility as a witness is in issue. Each of them gave respectful accounts about the doctor / patient consultations and their interactions with each other. Appropriate concessions were made when either of them could not understandably recall some aspects of the GP consultations given the passage of time since 2012 and 2013 – events that occurred a decade ago.

[60] In addition to their oral evidence, the Tribunal has considered the most contemporaneous written evidence that is available including the clinical notes and statements made by both Dr Morton and Ms Cockburn at the time that these events occurred.

[61] Dr Morton has defended the Charge of professional misconduct. Mr Holloway, counsel for the practitioner, submitted that Dr Morton wanted to face his peers and speak directly to the Tribunal to explain his perspective of what happened and why.

[62] The nub of Mr Holloway's submission is that Dr Morton accepts his clinical errors in prescribing Neotigason and Dermol to his patient (and has apologised for these errors). He does not admit that his conduct amounts to clinical negligence warranting a disciplinary

[35] Documents 10,11 and 12.

sanction. Counsel further submitted that this is not a case of malpractice or conduct that has brought discredit to the profession.

[63] While there is agreement over many of the facts underpinning the particulars of the Charge, and some of the particulars are admitted, Mr Holloway submitted that it remained for the Tribunal to decide whether each of the five particulars is established separately, and cumulatively, as negligence so as to amount to professional misconduct.

[64] We now turn to make findings on each particular of the Charge.

Neotigason

[65] Particulars 1 and 2 concern Dr Morton's prescribing of Neotigason to Ms Cockburn at a consultation on 9 October 2013.

[66] Neotigason (generic name, acitretin) is an oral retinoid used in the treatment of severe psoriasis when the psoriasis is resistant to other forms of therapy. Neotigason is a powerful human teratogen that has a very high risk of causing severe and life-threatening birth defects to fetuses. This risk can persist until the product has been completely eliminated from the patient's system, which can take at least two to three years following the end of treatment.

[67] Conditions to be met before prescribing Neotigason include ensuring that the patient understands the teratogenic risk of the medication, the need to undergo regular pregnancy testing before treatment, during treatment, and periodically for a period of two years after stopping treatment, as well as the need for effective contraception for one month before, and throughout the entire duration of treatment and for two years after treatment. After 2013 when these events took place, the Medsafe advice on pregnancy testing and contraception has been updated to a period of three years after treatment.

[68] In New Zealand, before Neotigason can be prescribed, the prescriber must apply for a Special Authority from Health New Zealand. (In 2013, this was the Ministry of Health.) The Special Authority form requires a practitioner to confirm that they have informed the patient of the risk of teratogenicity if Neotigason is used during pregnancy, and the need to avoid becoming pregnant during treatment and for a period of two years afterwards.

[69] Dr Brown told the Tribunal that Neotigason is not a medication commonly prescribed by GPs. While it is within a GPs scope of practice to prescribe Neotigason, it is much more likely to be prescribed by a specialist, such as dermatologist.

[70] There is no dispute that Ms Cockburn met the criteria for treatment with Neotigason. However, due to the fact that she is female, and was 30 years old at the time of the prescribing, significant care needed to be taken to ensure that she was adequately informed of the risk of taking Neotigason and that those risks were appropriately managed as required by Medsafe.

Particular 1 – Prescription of Neotigason (acitretin) on 9 October 2013

[71] There is some overlap between Particulars 1(a) and 1(b).

[72] Particular 1(a) is primarily concerned with the alleged failure by Dr Morton to provide *detailed written information* about the effective use of contraception and the risk of severe fetal malformation during treatment with Neotigason whereas particular 1(b) alleges there were failures by Dr Morton to provide *both detailed verbal and / or written information* about effective contraception use and the risks associated with Neotigason use.

[73] On 9 October 2013 Ms Cockburn attended a consultation with Dr Morton at MHC. She made the appointment because her psoriasis was not getting any better. She had attempted other therapies such as UVB, [36] and topical steroids. The UVB treatment had not had the desired effect.

[74] The consultation was 16 minutes long (allocated for 10 minutes) during a typically busy day for Dr Morton at MHC.

[75] Dr Morton says that he was frustrated as by this time Ms Cockburn had not yet had another appointment with the dermatologists. She had been referred three times to the Dermatology Department over the previous 12 months.

---

[36] Ultra Violet Light B (UVB) therapy involves exposing the skin to an artificial UVB source. UVB penetrates the skin and slows the growth of affected skin cells.

[76] He told her about Neotigason and that it might be worth trying as it did not involve the use of strong doses of on-the-skin corticosteroids. He told her that a "Special Authority" was required and he applied for this authority during the consultation.

[77] Dr Morton says that he told Ms Cockburn that Neotigason was very dangerous to developing babies. If she were to take it, she needed to be on reliable contraception – "double contraception" - i.e. both oral contraception and use of condoms. He inquired about her menstrual cycle and she informed him she was on a day or two post period. He prescribed oral contraception and told her she should start the active oral contraceptive tablets immediately and to wait until the blood tests were back before starting the Neotigason.

[78] Dr Morton wrote in the notes, "Contraception re-started", which he says was because he initiated the discussion about contraception in order to prescribe this medication and that Ms Cockburn told him that she was not presently on the pill. [37]

[79] Dr Morton's notes are brief. He recorded a valid concern over the safety of long-term use of Dermol, the topical steroid cream that Ms Cockburn was using at the time. The clinical notes for this consultation read as follows:[38]

> here re skin. lots of very small lesion. has some control with dermol but the problem of long term safety.
>
> discussed options. will try neotigason as long as bloods satisfactory.
>
> bloods ordered.
>
> contraception re-started.
>
> wt 66 \ bp 110/70.
>
> see one month mometasone for upper face shrt prn courses
>
> Off work certificate

[37] Dr Morton Brief of Evidence at [85].
[38] ABOD, p 87. Clinical notes.

[80] Dr Morton prescribed a 30-day supply of Neotigason that same day, along with a three-month supply of the oral contraceptive pill. Dr Morton accepts that he should have performed a pregnancy test at this consultation, and regrets omitting to do so.

[81] Ms Cockburn says that in the consultation Dr Morton suggested that she try a drug called Neotigason. She couldn't remember if Dr Morton asked her if she was taking oral contraception or not. She does not remember saying that she was. Nor does she remember being told to use two types of contraception while using Neotigason.

[82] Ms Cockburn says that Dr Morton did not tell her that the medication could harm her baby if she was to fall pregnant and he did not tell her that it would affect any other pregnancies for two years after she stopped taking Neotigason. She says:

> I do remember Robert asking me if I thought I might be pregnant and I told him no because I didn't know I was. He didn't give me a pregnancy test to make sure.

[83] On 7 November 2013 Ms Cockburn subsequently found out that she was pregnant. She did a Google search on Neotigason and found the list of warnings and protocols that should have been followed before she started taking the drug. That was how she found out that she should not have become pregnant for two years after stopping the medication.

[84] On 12 November 2013, she had an ultrasound scan which showed that she was around six and a half weeks pregnant. She says that if Dr Morton had told her the effects of Neotigason would last two years, she would never have started using it. She was only 30 years old at the time and still wanted children.

[85] Dr Morton accepts that he did not provide any written information about Neotigason.[39] In his letter of apology to Ms Cockburn he said that as part of the consultation he should have given Ms Cockburn a printout about the medication he was prescribing, and that this information was available in the drug datasheet.[40]

---

[39] Dr Morton Brief of Evidence at [90].

[40] ABOD, p 303. Letter from Dr Morton to Ms Cockburn dated 24 November 2013,

[86] Medsafe Data Sheets and Consumer Medicine Information Sheets are readily available for medications prescribed in New Zealand. They are intended to inform the doctor and the patient of the benefits and risks of taking a certain medication, the correct way to take the medicine and to provide any warning the doctor and the patient should be aware of (such as contraindications and possible side effects).

[87] Under the heading "Contraindications", the Neotigason Data Sheet states:[41]

> Neotigason is highly teratogenic and must not be used by women who are pregnant. The same applies to women of childbearing potential unless strict contraception is practised four weeks before, during and for two years after treatment …

[88] The form also contains information about the risk to pregnancy associated with the use of Neotigason:

> Neotigason is highly teratogenic. Its use is contraindicated not only in pregnant women and women who might become pregnant during or within two years of the cessation of treatment, but in all women of childbearing potential. The risk of giving birth to a deformed child is exceptionally high where Neotigason is taken before or during pregnancy, no matter for how long or at what dosage. Foetal exposure to Neotigason always involves the risk of congenital inflammation. …
>
> In relation to contraindications of Neotigason:
>
> …
>
> 4. It is absolutely essential that every woman of childbirth potential who is to undergo treatment with Neotigason uses an effective contraceptive (preferably 2 complementary methods) without interruption for four weeks before, during and for 2 years after the discontinuation of treatment with Neotigason. …
>
> …
>
> 6. A negative pregnancy test must be obtained as a minimum, one week before commencement of treatment (it is advisable to perform additional pregnancy tests at monthly intervals during therapy and at 1-3 monthly intervals after stopping therapy).[42]

---

[41] ABOD, p399. Medsafe Data Sheet – Neotigason (1 July 2013 – Version 2).

[42] The current Medsafe advice is that contraception is used and pregnancy avoided for three years after discontinuing treatment with acitretin. At the time Ms Cockburn was prescribed Neotigason in 2013, the

[89] Dr Morton referred to his own audit of isotretinoin, a similar drug to acitretin (Neotigason) which is also subject to similar restrictions. When he initiated this prescribing, his audit confirmed that he obtained a signed written consent form each time and provided written information.[43] In Dr Morton's mind he wrongly assumed he had excluded pregnancy and that Neotigason had the same stand-down period as isotretinoin.

[90] In *Good Prescribing Practice*, the Medical Council states that the provider should: [44]

> Satisfy yourself that patient understands how to take or use any medicine prescribed and is able to take or use it.

[91] Prescribing Neotigason to female patients requires careful management of the ongoing teratogenic risk. Dr Morton did not fulfil the requirements in the Medsafe Data Sheet, or his obligations discussed below as set out in the Special Authority form, despite certifying that he had done so when he submitted this to the Ministry of Health.

[92] As Dr Morton acknowledged, DermNet, Medsafe, NZ Formulary, and Google were likely available to him from his consultation room computer.[45]

[93] Dr Morton pointed out that the packet in which Neotigason is dispensed has a warning about the dangers associated with pregnancy in red bold letters on the outside and has a patient package information leaflet inside with the tablets.[46] However, we do not consider that this information discharges a practitioner from providing the readily available information about the risks of this very potent medication.

[94] While it clearly would have been preferable and best practice for Dr Morton to provide written information such as the Medsafe Data Sheet, as part of a process of informed consent by Ms Cockburn to this treatment, we do not consider that on its own Dr Morton's failure to provide detailed written information about effective contraception or the risks of fetal malformation if pregnancy occurred was contrary to acceptable prescribing practices. Such

---

Medsafe advice was that contraception be used and pregnancy avoided for two years.

43 Dr Morton Brief of Evidence at [100].

44 ABOD, pp 605 and 606.

45 Transcript, pp 254 and 255.

46 Document 13, Dr Morton's Brief of Evidence, Appendix 3.

failures should be considered in the overall context of the process of informed consent and what he told Ms Cockburn about the risks and benefits of this medication.

[95] Particular 1(a) in relation to the failure to provide detailed written information about this prescription is not established.

[96] In view of our finding in relation to particular 1(a) that no detailed *written* information was provided to Ms Cockburn, the focus of particular 1(b), sub-particulars (i),(ii) and (iii) is about what Dr Morton told Ms Cockburn at the consultation – "*verbal and/or written*" information.

[97] Dr Morton accepted that there was a failure on his part not to know, and therefore not to advise Ms Cockburn about the long-lasting effects of Neotigason, as set out in particular 1(b)(ii).[47]

[98] We accept that Dr Morton did give some oral advice to Ms Cockburn about the risk of Neotigason and the requirement for double contraception. However, even if he did, he did not explain to her the need to use the effective contraception without interruption for a period of four weeks *before* commencing Neotigason and for two years *after* discontinuing treatment because he was not aware of this information himself.

[99] Dr Morton felt that based on his discussion with Ms Cockburn there was "no way" she could be pregnant. He informed her she would need to continue contraception for 3-4 months after completing the treatment (as he mistakenly thought it was the same as for isotretinoin, another orally administered retinoid for acne). Dr Morton admitted that this was the wrong advice about how long contraception is necessary after discontinuation due to ongoing teratogenic risk.[48] He did not convey there is a very high risk of a severe fetal malformation if pregnancy had occurred within two years of discontinuing treatment with Neotigason.[49]

---

[47] Document 18, Synopsis of submissions for Dr Morton at [3.1].
[48] Dr Morton Brief of Evidence at [91].
[49] See Monthly Index of Medical Specialties (MIMS) now replaced with the NZ Formulary.

[100] There is a very clear process required to be followed to ensure that the possibility of pregnancy has been excluded prior to the commencement of treatment with Neotigason. Dr Morton failed to inform his patient that she must not become pregnant for a period of two years after discontinuing the treatment with Neotigason.

[101] Dr Morton failed to follow Medsafe's recommendation to perform pregnancy tests at monthly intervals while treating with this medication.

[102] Even if Dr Morton did tell Ms Cockburn to have pregnancy tests at three-monthly (not monthly) intervals after discontinuing treatment with Neotigason he did not give her advice about the requirement to have pregnancy tests four weeks *prior* to commencing the medication and throughout the course of the medication. His advice about pregnancy tests was not documented and his notes are inadequate.

[103] Particulars 1(b) and sub-particulars (i),(ii) and (iii) are established.

[104] In relation to particular 1(c), Dr Morton acknowledged it was a mistake not to have advised Ms Cockburn to begin the medication in a month's time.[50]

[105] The Ministry of Health dispensing data shows that Ms Cockburn was not on oral contraception medication at the time she began taking Neotigason.

[106] Dr Morton's notes state, "contraception restarted". This note was based on his consultation with Ms Cockburn and his incorrect assumption that there was "no way" she could be pregnant at that time.[51]

[107] Ms Cockburn says that she does not accept that there was no way she could be pregnant. For her, there was no way that she could have known. In the event, she became pregnant on or around 12 October 2013 (the day before the consultation). This was based on

---

[50] Transcript, p 65/12.
[51] Dr Morton, Brief of Evidence at [91].

the ultrasound scan and the last day of her menstrual period. Ms Cockburn confirmed that Dr Morton did not ask her to do a pregnancy test.[52]

[108] As Dr Brown has explained,[53] there was no need to treat the patient immediately; it would have been reasonable for Dr Morton to wait and ensure that there was a period of at least four weeks on contraception. He failed to confirm that Ms Cockburn had been using effective contraception without interruption for four weeks prior to commencing treatment with Neotigason.

[109] We are satisfied that particular 1(c) is established, (noting there is some overlap and 1(b)(i)).

[110] In relation to particular 1(d), we are satisfied that Dr Morton failed to obtain a negative pregnancy test.

[111] Dr Morton felt confident that Ms Cockburn would not be pregnant and for that reason when he ordered the appropriate blood tests prior to starting this medication he did not request a pregnancy test. Dr Morton admitted that he could have simply "ticked the box" [54] (i.e. hCG or "pregnancy hormone") to obtain a pregnancy test when he sought the blood tests. By not doing so, he did not obtain a negative pregnancy test before commencing Ms Cockburn on Neotigason.

[112] Relying on a patient's opinion on whether or not they may be pregnant does not satisfy the requirement for the doctor to ensure the possibility of pregnancy is excluded. The onus lay on Dr Morton, not his patient, to exclude pregnancy prior to prescribing Neotigason. As acknowledged by Dr Morton, this was not done by either a urine test or a blood test.

[113] Particular 1(d) is established.

---

[52] Ms Cockburn, Brief of Evidence at [9].
[53] Director of Proceeding's submissions at [45].
[54] Dr Morton, Brief of Evidence at [94] and [95].

[114] We are satisfied that Dr Morton failed to ensure his patient was aware that treatment should not begin until the second or third day of her next normal menstrual period.

[115] Particular 1(e) is established.

[116] While we have found that the requirement for Dr Morton to provide detailed written information was not mandatory and therefore not strictly a departure from the applicable standards, *Good Prescribing Practice* (particular 1(a)), we are satisfied that the remaining sub-particulars 1(b), (c), (d) and (e) are separately established.

[117] As acknowledged by Dr Morton, it would have been prudent and a sensible step to provide Ms Cockburn with the written information available in the Medsafe datasheets and given her time to be informed of the risks of this treatment, whilst obtaining a pregnancy test and excluding the possibility of pregnancy.

[118] There was nothing so urgent about this prescription that it could not have waited until Dr Morton was satisfied the safety precautions had been complied with. There was no documented plan with respect to ongoing pregnancy testing, and that Ms Cockburn understood the need for and had reliable contraception for at least two years following cessation of the treatment.

[119] A patient in Ms Cockburn's position has the right to the information that in her circumstances she would expect to receive. Right 6 of the HDC Code provides:

> **Right 6**
>
> Right to be fully informed
>
> (1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including—
>
> (a) an explanation of his or her condition; and
>
> (b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and

(c) advice of the estimated time within which the services will be provided; and

(d) notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and

(e) any other information required by legal, professional, ethical, and other relevant standards; and

(f) the results of tests; and

(g) the results of procedures.

(2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

(3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about—

(a) the identity and qualifications of the provider; and

(b) the recommendation of the provider; and

(c) how to obtain an opinion from another provider; and

(d) the results of research.

(4) Every consumer has the right to receive, on request, a written summary of information provided.

[120] We agree with Dr Brown's opinion that as Neotigason is potentially a very hazardous medication, a proportionate response is required: the more dangerous the effects of taking the medication, the more caution should be taken before prescribing it.[55]

[121] There was a clear failure by Dr Morton to provide the necessary and appropriate information to his patient – whether in writing or orally (and recorded in the clinical notes) or both, and to exclude the possibility that Ms Cockburn was pregnant.

[55] Dr Brown Brief of Evidence at [2.35].

[122] We are satisfied that separately and cumulatively, particulars 1(b) to (e) of the Charge are established (not particular 1(a) as conduct that fell below accepted prescribing practice and is negligence in Dr Morton's scope of practice.

Particular 2 – Failed to meet the requirements of the Special Authority Form

[123] On the same day, Dr Morton submitted a Special Authority for Neotigason.[56]

[124] In doing so, he completed a declaration that confirmed that he had ruled out pregnancy in Ms Cockburn prior to prescribing, and that Ms Cockburn had been informed not to become pregnant for at least two years following cessation of the medication.

[125] When completing the Special Authority, the doctor is required to tick boxes as a "prerequisites" to prescribing as follows:

> Application details:
>
> ☐ Applicant is a vocationally registered dermatologist, vocationally registered general practitioner or nurse practitioner working in a relevant scope of practice;
>
> and
>
> ☐ Applicant has up-to-date knowledge of the safety issues around acitretin and is competent to prescribe acitretin;
>
> and
>
> ☐ Patient is female and has been counselled and understands the risk of teratogenicity if acitretin is used during pregnancy and **the applicant has ensured that the possibility of pregnancy has been excluded prior to the commencement of the treatment and that the patient is informed that she must not become pregnant during treatment for a period of two years.**[57] **(**Emphasis added)

[56] ABOD, p152; Document 3, Screenshot of Special Authority form.
[57] ABOD p 154, Document 3, Screenshot of Special Authority Application form.

[126] Dr Morton said the way in which the electronic version of the form appears on the computer screen meant that some of the wording is cut off, including the requirement to advise the patient not to become pregnant for a period of 2 years.[58]

[127] Mr Holloway submitted that Dr Morton did not knowingly make a false declaration as he believed that he had excluded the possibility of pregnancy. He did not see the reference to Neotigason's long-lasting effects and assumed that the words he could not see were the same as those on the form for isotretinoin.

[128] If Dr Morton could not see all the information contained on the Special Authority, then he should not have submitted it confirming that he had seen it and complied with it. It is the applicant prescriber – Dr Morton – not the patient, who has the onus of establishing these requirements to ensure patient safety.

[129] The second box requires the applicant, who is the prescriber, to confirm, among other things, that they have up-to-date knowledge of the treatment options for psoriasis and that they are aware of the safety issues around acitretin (Neotigason) and are competent to prescribe it.

[130] Dr Brown confirmed that there are many readily available resources about Special Authority medications such as Neotigason for GPs to access. Had Dr Morton provided Ms Cockburn with a printout of the Medsafe datasheet, this would have given her all the necessary information she needed to understand the risks and long-term consequences of taking Neotigason.

[131] We are satisfied that while Dr Morton did not intend to file a false declaration he ought to have ensured that the pregnancy risks as expressly stated on the Special Authority form were excluded when he submitted the form.

[132] We agree with Dr Brown's opinion that given the significant risks associated with this medication, there was at least a moderate departure by Dr Morton from acceptable standards

[58] Dr Morton Brief of Evidence at [86].

of care. The adverse effects to Ms Cockburn which were a direct result of this departure from acceptable standards (and which the requirements around the prescribing of this medication are designed to prevent) indicate a more severe than moderate departure.[59]

[133] Reasonable members of the public could reasonably conclude that care is taken by doctors when completing a Special Authority form. The Special Authority process is designed to protect patient safety when prescribing medicines such as Neotigason, precisely to avoid the harm that ensued to Ms Cockburn.

[134] Particular 2 is established as negligence and conduct that has brought discredit to the profession.

Particular 3, 4 and 5 Prescribing of topical steroid (Dermol 0.05%) from 2013-2018

[135] Particulars 3, 4 and 5 are concerned with Dr Morton's alleged repeat and over-subscribing of Dermol from 2013 to 2018.

[136] Dermol is a topical steroid that is highly potent. As an example, Dermol is 600 times as potent as a commonly used topical steroid ointment, hydrocortisone.[60]

[137] On rare occasions, topical steroid use can result in Cushing's Syndrome. This only occurs after long-term use of large quantities of topical steroids. Cases of Cushing's Syndrome caused by topical steroid use most often occurred because of inappropriate prescribing or over-the counter sales (without the need of a prescription) of corticosteroids in countries where that is permitted.[61]

[138] In 2008, after Ms Cockburn was diagnosed with guttate psoriasis by Dr Morton, she was referred to a dermatologist, Dr Strack. Dr Strack initially recommended Dermol and Daivonex treatment (on alternate days).

---

[59] Dr Brown Brief of Evidence at [2.60].

[60] Dr Brown Brief of Evidence at [3.3], Information on DermNet website.

[61] In New Zealand, hydrocortisone is available over the pharmacy counter, but Dermol is a prescription only medication.

[139] Dr Morton first prescribed Dermol to Ms Cockburn on 25 July 2011.

[140] Between 2013 and 2018 she was prescribed Dermol and a range of other topical steroids. While a number of different doctors at MHC prescribed this medication, Dr Morton acknowledged he was by far the most prolific prescriber.

[141] As submitted by Mr Holloway, the prescribing of Dermol to Ms Cockburn can be divided into three phases. The first phase was leading up to a letter from [Dr A] on 29 August 2012 where an alert was placed on the MedTech system which stated: "BE CAUTIOUS WITH SCRIPTING DERMOL OVERUSING".

[142] The second phase of prescribing commenced with the first time Dr Morton prescribed Dermol following [Dr A]'s letter. This was on 14 March 2013.[62] At this time Dr Morton reduced the usual prescription by three-quarters from 360g to 90g. During this second phase of prescribing the quantities prescribed to Ms Cockburn ranged from 30g to 180g.

[143] The third phase of prescribing commenced when [Dr T] (another GP at MHC) prescribed 540g on 12 November 2015. Dr Brown agreed that it was this phase that was the "concerning period".[63]

Particular 3 (a) – failing to act on alert

[144] Particular 3(a) alleges that Dr Morton failed to take notice or act on an alert placed on Ms Cockburn's electronic records during the first phase of prescribing Dermol to Ms Cockburn.

[145] Mr Holloway submitted that this sub-particular adds little to the Charge and ought to be subsumed into particular 5 as part of the context of the over-prescribing of Dermol.

---

[62] Dr Morton, Brief of Evidence, Schedule - Prescribing of Dermol Treatment at p 28.
[63] Transcript, p 168 / 6-10.

[146] The alert was placed on the Practice Management System on 28 August 2012 by [Dr A], a GP Registrar who was working at the time at MHC. The alert stated: "BE CAUTIOUS WITH SCRIPTING DERMOL OVERUSING".

[147] On 29 August 2012 [Dr A] wrote to Ms Cockburn stating that following his consultation with her he had noticed she had received a large amount of Dermol over the past 15 months. He was concerned that she may have been over-using Dermol and stated "I think it would be safest if you stopped … ".[64] Ms Cockburn did not recall receiving this letter.

[148] On 30 January 2013 Dr Morton was called in by [Dr W] to discuss patient management as Ms Cockburn was asking for more Dermol. There had been a repeat prescription three weeks prior to this consultation. [Dr W] declined the request for a prescription as she had concerns about Dermol overuse.[65]

[149] In March 2013 the clinical notes record that Dr Morton reduced the quantity of Dermol being prescribed.

[150] Dr Morton cannot remember whether he saw [Dr A]'s alert in March 2013 when he next prescribed Dermol for Ms Cockburn or on subsequent occasions. He said that the alert itself was "buried" in the practice management system.[66] It would not have been visible to any doctor opening up Ms Cockburn's file without scrolling down to the bottom of the alert tree.

[151] Dr Morton says that he was trying to keep the quantities of Dermol prescribed to Ms Cockburn down, up until November 2015, and there are incidences where he did reduce the amount to 90 grams. However, he acknowledges that after [Dr T]'s prescribing in November 2015 his caution failed and he continued to repeat prescribe the new amount as a long term medication without addressing the significant increase which had occurred.[67]

[152] [Dr A] took prudent steps to place an alert on the electronic medical file to warn prescribers of the overusing of Dermol for this patient. While Dr Morton did not notice and

---

[64] ABOD, p 291. Letter from [Dr A] to Ms Cockburn dated 29 August 2012.
[65] ABOD, Clinical notes, pp 89-90.
[66] Dr Morton, Brief of Evidence at [43].
[67] Dr Morton, Brief of Evidence at [44].

therefore did not act on the alert, we are not satisfied that the Dermol prescribing after 28 August 2012 by Dr Morton and other prescribers was inappropriate until [Dr T]'s unexplained significant increase in the prescription in November 2015.

[153] Particular 3(a) is not established.

Particulars 3(b)-(e) – The dermatologist's letters

[154] Particular 3(b) to (e) alleges that Dr Morton failed to take notice of two letters from a dermatologist and to place an alert on his patient's electronic medical records following receipt of these letters.

[155] In a letter dated 1 February 2014, [Dr E] raised a concern about Ms Cockburn's use of Dermol cream, stating: "It is essential that she never uses Dermol again".[68]

[156] Secondly, Dr Morton received a letter dated 3 May 2014 from [Dr E] advising that:[69]

> … psoriasis can be quite unstable after coming off Dermol but she should certainly not restart this.

[157] After Ms Cockburn discovered she was pregnant she asked to change doctors and on 25 November 2013 she transferred to the care of [Dr O]. {Dr O] was Ms Cockburn's doctor when the February and May 2014 letters arrived. Ms Cockburn did not in fact consult with [Dr O] in the following months.

[158] Dr Morton initially stated that he did not read the letters because Ms Cockburn had transferred to another doctor.[70] Mr Holloway submitted that while the letters were addressed to Dr Morton, he wanted to respect Ms Cockburn's privacy and decision to change doctors.

---

[68] ABOD, p 36. Letter from [Dr E] to Dr Morton dated 1 February 2014.
[69] ABOD, p 308. Letter from [Dr E] to Dr Morton dated 3 May 2014.
[70] Dr Morton Brief of Evidence at [45].

[159] In his evidence before us, Dr Morton's recollection of receiving these letters changed from his earlier account. He explained how he would receive the letters by signing them with his initial, as shown on each of the letters, so they could be forwarded for [Dr O's] attention.[71]

[160] We are satisfied on the balance of probabilities that Dr Morton failed to take notice and act on these clear warnings from the dermatologist that Ms Cockburn should stop using the Dermol ointment.

[161] We also do not accept that Dr Morton had discharged his responsibility to Ms Cockburn when she changed practitioners following Dr Morton's prescribing of Neotigason on 9 October 2013. Dr Morton initiated the referral to the dermatologist. He took no steps to ensure that these letters were directly conveyed to [Dr O].

[162] In any event on 30 May 2014, after receipt of the second letter Dr Morton resumed his role as primary GP for Ms Cockburn.

[163] We are satisfied that Dr Morton failed to take notice and act on the two letters from the dermatologist which was critical to Ms Cockburn's care. Dr Morton could not absolve his responsibility to Ms Cockburn to ensure quality and continuity of care when she changed GPs in the practice.

[164] Particulars 3(b), (c), (d) and (e) are established.

Particular 4 – Informing of the risks associated with long-term and heavy use of steroid-based medication

[165] Particular 4 alleges that Dr Morton failed to adequately inform Ms Cockburn of the risks associated with long-term and heavy use of steroid-based medication. Schedule A of the Charge sets out the 29 occasions when Dermol was prescribed to Ms Cockburn from 14 March 2013 until 28 September 2018.

[166] According to Dr Morton's own audit, of these 29 occasions, only six were in-person consultations (9 October 2013, 4 September 2014, 31 August 2015, 17 January 2018, 13 April

[71] Transcript, pp 279/18 - 281/6.

2018, and 16 July 2018). In the other 23 instances Dr Morton authorised and signed a prescription generated after a telephone request for repeat prescriptions.

[167] Dr Morton says that he was not the initiator of Dermol as this was initially prescribed by another doctor in 2011. He states he had not counselled Ms Cockburn specifically about the potential risks in the way he would have if he had started the medication. He does say, however, that he did inform her that long-term heavy use could lead to problems of thinning of her skin.

[168] By 30 January 2013, [Dr W] attended Ms Cockburn in relation to rashes on her hands caused by household cleaning. Dr Morton was present during this consultation. [Dr W] noted that Ms Cockburn had received a large prescription of Dermol three weeks ago and was requesting more. [Dr W] recorded "Declined as have concerns about Dermol overuse". [Dr W] discussed the treatment plan with Dr Morton.

[169] We are satisfied that by this date, if not before, Dr Morton was aware of the amount of Dermol that Ms Cockburn had received, and that there were concerns raised over the amount used. Dr Morton, in consultation with another doctor, had considered it inappropriate to prescribe more Dermol at this time and had instead prescribed an alternative treatment.

[170] We accept Dr Brown's evidence that from 1 February 2014 it became inappropriate to prescribe Dermol to Ms Cockburn.

[171] Mr Holloway submitted that it was inconceivable that [Dr E], the dermatologist, would not have explained the risks of Dermol to Ms Cockburn on 1 February 2014. There had been three face-to-face consultations with dermatologists and eight face-to-face consultations with GPs by this time at which Dermol was discussed or prescribed. For the first in-person consult on 9 October 2013 Dr Morton prescribed Neotigason to which particulars 1 and 2 of the Charge relate.

[172] Dr Morton admits that while he informed Ms Cockburn long-term heavy use could lead to problems of thinning of her skin, he did not warn her of the potential for systematic side effects such as Cushing's Syndrome because he was not aware that this could happen.[72]

[173] As it transpired after talking with a friend and making a Google search, subsequently Ms Cockburn made a self-diagnosis of Cushing's Syndrome.

[174] In *Good Prescribing Practice*[73] the standard for appropriate prescribing practices requires doctors to only prescribe medicines or treatment where the doctor has adequately assessed the patient's condition and is satisfied that the medicines or treatment are in the patient's best interests. To ensure that the doctor's prescribing is appropriate and responsible, the doctor should:

> Be familiar with the indications, adverse effects, contraindications, major drug interactions, appropriate dosages, monitoring requirements, effectiveness and cost-effectiveness of the medicines that you prescribe …
>
> …
>
> Prescribe in accordance with accepted practice and any relevant best-practice guidelines. Prescribing outside of accepted norms should only occur in special circumstances for the patient's informed consent. It might be useful to discuss the proposed treatment with a senior colleague before completing the prescription.

[175] Although Dr Morton was not the initiator of the prescribing of Dermol he was by far the most frequent and ongoing prescriber from March 2013 to September 2018. Dr Morton undertook his own audit.[74] During this period he saw Ms Cockburn on six occasions with in-person consultations and prescribed her large amounts of Dermol (up to 540g).

[176] As noted in the Medsafe Data Sheet[75], as with other topical corticosteroids prolonged use of large amounts or treatment of sensitive areas can result in sufficient systemic absorption to produce the features of Cushing's Syndrome.

---

[72] Dr Morton Brief of Evidence at [52].
[73] ABOD, p 605, Medical Council, *Good Prescribing Practice* (November 2016).
[74] Dr Morton Brief of Evidence, attached Schedule.
[75] ABOD, p 390, Medsafe Data Sheet (July 2010).

[177] In the 2015 Data Sheet, Medsafe warned that treatment with Dermol should not continue for more than 4 weeks, and if continuous treatment was necessary, a less potent preparation should be used. It warned that the maximum weekly dosage should not exceed 50gm / week.

[178] We are satisfied that by continuing to over-prescribe Dermol to his patient, Dr Morton acted contrary to accepted standards of care. He failed to inform Ms Cockburn of the risks associated with long-term and heavy use of steroid based medication, particularly after the clear warnings that had been provided by the dermatologist. We are not required to find that there was a failure by Dr Morton to diagnose Cushing's Syndrome.

[179] In the 2012 and 2013 clinical notes there is some recognition that the dangers of using Dermol were discussed. However, the risks of ongoing and continued use of Dermol are not reflected in the notes. Ms Cockburn should have received further information. She herself diagnosed Cushing's Syndrome and therefore it was reasonable to assume that she was unaware of this risk. Dr Morton should have ensured that she understood these risks and that the clinical notes, at the very least, should have reflected an informed discussion with her.

[180] We accept Ms Cockburn's explanation that she did not understand the long-term dangers of continued use. While she did not necessarily need to know that Cushing's Syndrome was one possible risk it was not until November 2018 when she went to Auckland and discussed her condition with a friend and undertook a Google search that she found out.[76]

[181] Particular 4 is established.

Particular 5 – Repeat prescriptions between 3 October 2016 and 28 September 2018

[182] Particular 5 alleges that from October 2016 to September 2018 Dr Morton prescribed Dermol 0.05% at an increased amount on nine occasions as set out in Schedule B in the Charge.

[76] Ms Cockburn Brief of Evidence at [34].

[183] On 12 November 2015 [Dr T], a locum GP at MHC, increased the amount of Dermol being prescribed to Ms Cockburn's in a single prescription of Dermol to 6 x 30g tubes, with two repeats.

[184] There is no explanation in the clinical records to explain why this increase occurred, or why the medication was set as long-term in the MedTech system.

[185] On 3 October 2016 when Dr Morton next prescribed Dermol to Ms Cockburn, he also prescribed it at this higher rate. He continued to prescribe at this higher rate on a further eight occasions (making a total of nine occasions) between October 2016 and September 2018.

[186] None of the nine instances of prescribing Dermol at this high level were accompanied by any clinical notes indicating why Dermol was prescribed at this level, and many are accompanied by no clinical notes at all.

[187] Dr Morton accepts that the amounts prescribed were too high and were more than he intended to prescribe Ms Cockburn and much more than he had ever prescribed in the past.[77]

[188] Dr Morton gave evidence to explain how the practice dealt with repeat prescribing and MHC's policy at this time. Dr Morton disputed that MHC's policy that was provided to the Tribunal was the actual policy that was relevant at the time. He stated that his own practice and "commonly" other practices provide for repeat prescribing of most medicines subject to having a face-to-face consult every three to six months, a criterion which on its face Ms Cockburn met.[78]

[189] Regardless of MHC's policy, on multiple occasions there were repeat prescriptions of excessive amounts of Dermol prescribed by Dr Morton and others at the practice. There were 11 occasions of such large quantities and there was a cumulative effect resulting in a failure to prescribe responsibly and safely.

---

[77] Dr Morton Brief of Evidence at [25].
[78] Synopsis of closing submissions for Dr Morton at [110].

[190] Based on the dispensing information provided by the Ministry of Health, Dr Brown calculated that between 2013 and 2018, Ms Cockburn was prescribed a total of 9,870g of Dermol by Dr Morton and other prescribers, of which Dr Morton prescribed 7,140g of the total amount.[79] Dr Brown described the amount of Dermol prescribed to Ms Cockburn as "industrial quantities".[80] Added to this, she was prescribed various other potent steroids, including significant amounts of prednisone.

[191] Rights 6 and 7 of the HDC Code are relevant in this context. A patient must have the opportunity to consider and discuss the relevant information with the treating doctor to make an informed decision about the treatment.[81] Right 6 of the Code states that "Every consumer has the right to the information that a reasonable consumer, in the consumer's circumstances would expect to receive". Ms Cockburn was entitled to know the cumulative risk and long-term effects of potent topical steroid use. In the event, Ms Cockburn self-diagnosed the steroid induced Cushing's syndrome.

[192] We also accept Dr Brown's opinion that the generally accepted rule in prescribing is that "if you sign your name to a prescription, you are responsible for what is on the page".[82] Put another way, it is not an excuse that the prescriber did not realise what they were prescribing. It remained Dr Morton's responsibility each time he prescribed for Ms Cockburn to ensure the medication prescribed was suitable and appropriate.[83]

[193] Particular 5 is established.

Is the disciplinary threshold met?

[194] The Tribunal is satisfied that the conduct in relation to the prescribing of Neotigason on 9 October 2013, particulars 1(b)-(e) and particular 2 is established as negligence in Dr

---

79 Dr Brown Brief of Evidence at [3.17].
80 Dr Brown Brief of Evidence at [3.64].
81 This is so a patient can make an informed choice and give informed consent. Written consent is required where a procedure involves "a significant risk of adverse effects".
82 Dr Brown Brief of Evidence at [3.55].
83 Dr Morton Brief of Evidence at [3.55].

Morton's scope of practice. Particular 1(a) is not established. In relation to the prescribing for Dermol, particulars 3, 4 and 5 are established as negligence. Particular 3(a) is not established.

[195] We accept Mr Holloway's submission that Dr Morton's conduct did not involve a type of illegal or immoral conduct that would amount to malpractice in Dr Morton's scope of practice as a general practitioner under s 100(1)(a) of the Act.

[196] The relevant standards (including the Medical Council's *Good Prescribing Guide* and *Good Medical Practice*) state the following:

- Ensuring your knowledge of what you are prescribing is accurate and up-to-date.

- Providing relevant information to your patient in a format accessible and relevant to them. [Note: HDC Code]

- Ensuring the medication is suitable for your patient (type, amount, and contraindications).

- Checking in with your patient on a regular basis to ensure the medication is still suitable for your patient.

- Completing any legal requirements prior to providing medication (such as Special Authority Forms).

- Checking prescriptions before you sign or approve them.

- Acting on warnings or concerns.

[197] The Tribunal is satisfied that the proved particulars each fall short of the conduct expected of a reasonably competent medical practitioner working in general practice when prescribing these potent medications for this patient.

[198] The Tribunal cannot make a finding of professional misconduct by reason only that it considers Dr Morton has breached the professional standards of reasonable conduct, by clinical negligence. The second step of our assessment requires the Tribunal to be satisfied that the health practitioner's acts or omissions are significant enough to require a disciplinary sanction. The disciplinary threshold is not an unduly high one.[84]

[199] At the heart of this case lies the responsibility of Dr Morton as Ms Cockburn's GP to inform her and himself of the risks, to prescribe safely and to follow accepted prescribing practice. It also required Dr Morton to pause and continually re-assess whether his prescribing for his patient continued to be appropriate.

[200] What is required of a practitioner in these circumstances is a proportionate response to the risks involved. In the case of these medications the Medsafe Data Sheets make it very clear that prescribers need to be very vigilant with commencing the use of each of these medications and informing patients of the ongoing risk.

[201] The Tribunal acknowledges the degree of harm suffered by Ms Cockburn arising from the prescribing and overuse of both Neotigason and Dermol. However, unlike the term "negligence" in the common law, there is no requirement under a disciplinary charge for the Director to prove that damage or harm has been suffered by the patient and that such harm was caused by the practitioner's breach of their duty of care owed to the patient. Instead, a disciplinary charge of clinical negligence under s 100(1)(a) of the Act focuses on the practitioner's breach of their duty in a professional setting.[85]

[202] While Dr Morton could not have excluded all possibilities of harm, Ms Cockburn was not fully informed of the risk involved with these highly potent medications. In relation to Neotigason, Dr Morton did not follow good prescribing practice and the guidelines required him to exclude the possibility of pregnancy for Ms Cockburn to proceed with this medication. In relation the excessive prescribing of Dermol there were a number of failures by Dr Morton that led to excessive and repeated prescribing over a long period of time.

---

[84] *Martin v Director of Proceedings* [2010] NZAR 33 at [30]-[32].
[85] *Dr N* 58/Med05/15D at [24]-[25].

[203] We are also mindful that there were other GPs involved with Ms Cockburn's care. However, the Charges relate to Dr Morton's care only. Even if a number of other doctors were involved with the continued and overprescribing of Dermol, the primary responsibility lay with him to review the prescribing practice on an ongoing basis. Viewed objectively, members of the public expect a GP to take that primary responsibility to ensure continuity of care.

[204] We are satisfied that Dr Morton's conduct in relation to these aspects of the Charge does bring discredit to the medical profession. It is one thing to make a clinical error and indeed, largely own up to it; it is another to ensure that the medication the doctor prescribed did not cause harm to his patient, and that his patient has information to make decisions for herself. Patients place trust in doctors to make decisions that are in their best interests.

[205] In our objective analysis, reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good-standing of the medical profession was lowered by Dr Morton's failures in respect of two aspects of care to his patient: firstly, Dr Morton signed a Special Authority form for Neotigason confirming that he had ensured that the possibility of pregnancy was excluded when it had not been (particular 2); and secondly, despite warnings from colleagues, he continued to prescribe Dermol over a considerable period of time which led to an adverse and significant outcome for Ms Cockburn (particular 5).

[206] The Charge of professional misconduct for clinical negligence in respect of all particulars 1-5 (except for 1(a) and 3(a)) and bringing discredit to the profession (particulars 2 and 5) is established as professional misconduct pursuant to s 100(1)(a) and (b) of the Act.

[207] We agree with Dr Brown's opinion that Dr Morton's conduct in relation to the Charge was a series of moderate to severe departures from accepted prescribing practice.

[208] In respect of the second step of our assessment, Dr Morton's conduct taken as a whole is a significant departure from professional standards in respect of his prescribing practice on these occasions and is sufficiently serious to warrant a disciplinary sanction for the purposes of protecting the public and maintaining professional standards.

Penalty

Penalty principles

[209] The Tribunal must now go on to consider the appropriate penalty under s 101 of the Act. The penalties may include:

(a) Cancellation of the practitioner's registration;

(b) Suspension of the registration for a period not exceeding three years;

(c) Censure;

(d) An order that the practitioner may only practise with conditions imposed on employment, supervision or otherwise;

(e) A fine of up to $30,000; and

(f) An order that the costs of the Tribunal and / or the PCC to be met in part or in whole by the practitioner.

[210] The Tribunal adopts the principles contained in *Roberts v Professional Conduct Committee,*[86] where Collins J identified the following eight factors as relevant whenever the Tribunal is determining an appropriate penalty. In particular, the Tribunal should always consider the penalty that:

(a) most appropriately protects the public and deters others;

(b) facilitates the Tribunal's important role in setting professional standards;

(c) may punish the practitioner, though this is not the objective of any penalty;

(d) allows for the rehabilitation of the health practitioner;

[86] [2012] NZHC 3354 per Collins J at [44]-[51].

(e) promotes consistency with penalties in similar cases;

(f) reflects the seriousness of the misconduct;

(g) is the least restrictive penalty appropriate in the circumstances; and

(h) looked at overall, is the penalty "fair, reasonable and proportionate in the circumstances".

Director's submissions

[211] Ms McCullough, counsel for the Director of Proceedings appropriately acknowledged that this is not a case which would give rise to a penalty of cancellation or suspension. That is in part due to the length of time that has passed since the events during which Dr Morton has practised safely, and the fact that Dr Morton's regulatory body, the Medical Council completed a preliminary competency report which identified no concerns in Dr Morton's practice. [87]

[212] Furthermore, the Director acknowledged that Dr Morton has removed himself from the situation which he himself identified as an underlying reason for some of the failures in his practice and established in this disciplinary Charge, namely the heavy workload Dr Morton was managing at MHC.

[213] While it is often the case that proceedings taken by the Director result in penalties such as suspension or cancellation, all cases which result in findings of professional misconduct are serious cases, even where they do not call for these most grave penalty outcomes.

[214] For the Director, it was submitted that the appropriate penalty in this case is censure of the practitioner, a condition on his practice and a fine in the range of $7,000 - $10,000.

[215] The condition sought was that Dr Morton for a period of three years is to notify any prospective employers and / or medical practitioners he is in partnership with, of the

[87] ABOD, p 63, Medical Council of New Zealand Preliminary Competency Report.

Tribunal's decision, including for example, the RNZCGP, who employ Dr Morton to train and examine GP Registrars.

[216] Counsel emphasised the purpose of this condition is to ensure accountability, but also to provide ongoing support to Dr Morton from his professional peers.

[217] The Director acknowledged that given Dr Morton's current workplace, supervision would not be suitable**.**

Practitioner's submissions

[218] Mr Holloway submitted that Dr Morton has from the outset accepted he made errors and apologised unreservedly and repeatedly for doing so, both in person and in writing.

[219] Counsel submitted that his first mistake – in relation to the prescribing of Neotigason occurred during a relatively short consultation in 2013 during which he was trying to find a solution for Ms Cockburn's crippling psoriasis. Ms Cockburn became pregnant shortly afterwards. He also did not know, and therefore did not tell Ms Coburn, about Neotigason's persistent effect.

[220] There is no evidence of any similar areas with retinoid prescribing. Dr Morton gave evidence of the changes he has made in audits conducted in response to the harm experienced by Ms Cockburn, including an audit of oral retinoids (acitretin (Neotigason) and isotretionoin) and of the Dermol prescribing from the practice.

[221] Counsel submitted that Dr Morton's second mistake – the over-prescribing of Dermol, the steroid based medication, arose from a series of small unfortunate errors that compounded over time. Dr Morton and various other GPs considered it appropriate to prescribe Dermol for Ms Cockburn's psoriasis. This was a serious affliction and Dermol was one of the few things that helped. It was hard to access specialist care.

[222] In relation to the over-prescribing of Dermol, it was submitted that what Ms Cockburn suffered was a mistake made by [Dr T], the locum GP, near the end of 2015 that Dr Morton

subsequently failed to detect and correct. The resulting quantities of Dermol prescribed – all of which it seems Ms Cockburn had dispensed to her – was sufficient to put her at risk of Cushing's syndrome.

[223] Mr Holloway submitted that Dr Morton's response to his mistakes cannot be faulted: he is a thoughtful, caring and humble GP, whose life is his work.

[224] For these reasons, counsel submitted that the circumstances of this case warrant censure and nothing more. Counsel referred to *Re H*,[88] as an example where censure alone was ordered by the Tribunal. If this penalty was thought insufficient, then a nominal fine could be considered. There are insufficient grounds to consider conditions, suspension or cancellation.

Comparable cases

[225] Both counsel referred to cases involving clinical negligence. These cases are to guide the Tribunal as to a consistent approach to applying a penalty, acknowledging that every case is considered on its own facts.

[226] We consider the two cases below are the most relevant and we have heard extensive submissions given by counsel as to their applicability.

[227] In *Williams*[89] Dr Williams, a medical practitioner, over-prescribed a combination of a potent topical steroid and an antifungal cream in circumstances that amounted to professional misconduct concerning 12 different patients. There was also a second category of the charge concerning dietary advice in circumstances that departed from accepted medical practice and resulted in actual harm to the patient.

[228] Dr Williams was censured and fined $10,000 and ordered to pay 40% contribution to costs of $145,000. There were three conditions placed on Dr Williams' practise including a focus on Dr Williams' treatment of skin conditions, his prescribing practices and his clinical

---

88 Dr H, 946/Med17/378D.

89 909/Med16/371P.

record keeping with a supervisor involved. He was ordered to complete a course focussing on treatment of patients with skin conditions, and the Tribunal's decision was made available to his employer through his primary health organisation. A further condition was for Dr Williams to have due regard to the Medsafe Data Sheets and the Medical Council of New Zealand's *Good Prescribing Guidelines* for every prescription he wrote for any topical steroid.

[229] In *Director of Proceedings v Liston,*[90] Dr Liston, an oral and maxillofacial surgeon was charged in relation to failing to inform his patient that a lesion on his tongue was cancer, despite having received results confirming this diagnosis following an excisional biopsy. The Tribunal found that his conduct was unquestionably negligent in his reading of the biopsy reports and his failure to refer the patient to a multidisciplinary team for review.

[230] In *Liston*, the Tribunal did not consider that cancellation or suspension from practice was justified. Dr Liston was censured and fined $5,000. He was ordered to pay 30% contribution towards the costs totalling $21,000.

[231] In discussing the appropriate penalty, the Tribunal made allowances for the pressures and stresses Dr Liston was under and the limited resources he had available to him for the correct interpretation of biopsies and proper performance of his professional duties. On appeal to the High Court, the Court upheld the Tribunal's decision and dismissed the appeal.[91]

Aggravating and mitigating factors

[232] We have considered the following aggravating factors:

[233] First, this was not a one-off situation where there was poor prescribing practice: in relation to the over-prescribing of Dermol (particulars 3-5) occurred over a number of years.

[234] Secondly, there were two different medications for the debilitating condition of psoriasis. Having made the clinical error with prescribing Neotigason in October 2013,

---

[90] 940/Den17/387D.

[91] *Liston v Director of Proceedings* [2018] NZHC 2981.

Dr Morton did not review his prescribing for Dermol and the overall management of his patient's condition. These missed opportunities included:

(a) [Dr N]'s alert placed on the clinical file;

(b) [Dr W]'s query on 30 January 2015. At this time she called in Dr Morton to seek his advice and reduced the dose of Dermol to 1 x 30 g tube;

(c) Dr Morton did not consider or act on the specialist advice from the dermatologist that he had requested.

(d) He continued to prescribe Dermol without review of his patient management of Ms Cockburn and her medications when he resumed as her primary GP on 30 May 2014. At this point in time in the doctor/patient relationship, Dr Morton showed a lack of insight into resuming as Ms Cockburn's primary GP and the impact of the prescribing of Neotigason within their therapeutic relationship.

(e) He signed repeat prescriptions and did not follow the Medical Council's prescribing guidelines for repeating and checking prescriptions.

[235] In relation to mitigating factors, we consider first that Dr Morton has provided several apologies to Ms Cockburn, including immediately, on 24 November 2013 when he realised he made the prescribing error in respect of Neotigason. Dr Morton unreservedly accepted that he made an error and repeatedly apologised for doing so. We accept that Ms Cockburn did not consider it appropriate for him to visit her home for the purpose of apologising to her. However, we accept that his intent was to unreservedly apologise for his error.

[236] Secondly, Dr Morton has made changes to his practice. He has undertaken self-audits of his practice and conducted those in response to the harm experienced by Ms Cockburn. These changes and audits have included: an audit of oral retinoid prescribing and an audit of Dermol prescribing; cleaning up alerts on the practice management system, changing the system for prescribing, organising educational sessions, self-reporting to the Medical Council and requesting a competence review, undertaking a preliminary competence inquiry,

changing consult times from 10 to 15 minutes to ensure less pressure and stress on his practice. He has also paid for Ms Cockburn to access private healthcare.

[237] Thirdly, after being referred to the Medical Council by the Health and Disability Commissioner a preliminary competence inquiry was undertaken. Dr Morton has cooperated fully with this process and subsequent HDC investigation and opinion, as well as the disciplinary proceedings.[92]

[238] Fourthly, Dr Morton is well regarded by his peers and has contributed considerably to the community. The Tribunal received several references.[93]

[239] Fifthly, and significantly in comparison with the case of *Williams,*[94] Dr Morton has gained a thorough understanding of how these clinical errors occurred. He has recognised that the workload at this time was a contributory factor to the errors that occurred. In March 2022 he sold his practice and he is now working part time as an employee and independent contractor. He attends a monthly peer review group and is involved in the review of patient case discussion and records. He has found his ongoing peer review very supportive.[95]

Penalty finding

[240] The Tribunal has considered the relevant penalty principles, the comparative cases and the aggravating and mitigating factors in reaching a decision on the appropriate penalty that is tailored to our finding of professional misconduct by Dr Morton.

[241] Ms Cockburn has a chronic, debilitating condition, and she very much wanted an effective treatment. She (and her mother) provided the Tribunal with a sobering account of the impact these events have had on her in relation to the effects of the prescribing of Neotigason and the excessive amounts of Dermol prescribed to her.[96]

---

92 ABOD, p 623, Letter dated 30 September 2020.
93 Documents 10,11 and 12.
94 909/Med16/371P.
95 ABOD, p 624.
96 Documents 21 and 22, Impact statements.

[242] In assessing the appropriate penalty, the Tribunal is mindful of the overarching objectives of the Act for the protection of the public and to maintain high professional standards. Punishment of the practitioner is a secondary purpose of the Tribunal's assessment of an appropriate penalty.

[243] We agree with counsel that this is not a case where cancellation of registration or suspension of the practitioner from practice is warranted. Dr Morton does not pose a risk to the public. He has spent several years making amends to his practice to avoid repetition of these failures with his prescribing practice.

[244] Censure alone would be insufficient to recognise the seriousness of our finding of professional misconduct. We consider censure – to signal to the profession and the wider public the serious nature of the professional misconduct – together with a fine of $3,000 and a condition on Dr Morton's practice is just and proportionate to the seriousness of the professional misconduct in this case.

[245] Rehabilitation of the practitioner is not an issue in this case. The condition to be imposed is that Dr Morton must notify his current employer and the RNZCGP, the professional body with whom he continues to be involved for professional training of GPs, of this decision.

[246] In our assessment, Dr Morton's conduct has a number of mitigating features that deserve weight and therefore any fine should be pitched at the lower end in comparison to *Williams* where there were two distinct aspects of the charges and a number of patients involved.

[247] The Tribunal considers this penalty fairly reflects the seriousness of the misconduct, but equally takes into account the fact that Dr Morton's conduct was borne out of negligence, and unintended conduct on his part.

[248] This penalty is the least restrictive appropriate circumstances and reflects the need to maintain professional standards. The Tribunal recognises that Dr Morton has faced up to these very serious clinical errors early and has continued to do so. This should send a message

to the medical profession, and the wider public, that admitting clinical errors and acting on them is the ethically responsible approach by a doctor.

Costs

[249] The Tribunal may order the practitioner to pay part or all of the costs and expenses of and incidental to the HDC investigation and prosecution in respect of the Charge, and the cost of the hearing by the Tribunal.[97]

[250] An order for costs in any professional disciplinary proceeding involves the judgement as to the proportion of the costs that should be properly borne by the profession (being responsible for maintaining standards and disciplining its own profession) and the proportion which should be borne by the practitioner who has caused the costs to be incurred.

[251] When ordering the appropriate amount of costs, the Tribunal must consider the need for the practitioner to make a proper contribution towards the costs. In doing so, the Tribunal takes 50% of the total reasonable costs as a starting point.[98]

[252] The HDC investigation and Director's total costs are estimated at $108,057.40.[99] The Tribunal's costs are estimated at $75,570.71.[100] This is a total of $183,628.11.

[253] The Director submitted that as the Charge has been proven it is appropriate and in the public interest that Dr Morton make a reasonable contribution to the costs involved in the disciplinary process.

[254] The Director acknowledged Dr Morton's cooperation throughout the process and submitted that an order of 40% contribution would be appropriate in this instance.

---

97 Health Practitioners Competence Assurance Act 2003, s 101(1)(f).
98 *Cooray v Preliminary Proceedings Committee,* HC Wellington, AP23/4, Doogue J, 14 September 1995.
99 Document 20, HDC and Director of Proceedings Costs.
100 Document 23, HPDT Estimate of Costs.

[255] Mr Holloway agreed that Dr Morton had engaged with the process responsibly and with a high degree of cooperation. Some credit for this is appropriate. Counsel submitted there could be a further reduction from 40% of reasonable costs.

[256] The HDC's total estimated costs of $108,057.40 were not insignificant. These costs included the expert fees of Dr Brown of $13,400. Mr Holloway submitted that the HDC's costs should be reduced to approximately $95,000 as it was not necessary for Dr Brown to attend the entire hearing.

[257] In our view, it was appropriate for Dr Brown, the only expert witness, to attend the entire hearing. Dr Brown assisted the Tribunal when considering this Charge, involving clinical and pharmacological evidence and an assessment of the standard of care to be expected from a general practitioner. Dr Brown's evidence was tested in cross-examination by the defence, and he answered questions from the Tribunal.

[258] We consider Dr Brown's costs are reasonable and there should be no reduction of the HDC and Director's costs to prosecute this disciplinary Charge.

[259] Dr Morton was entitled to defend the Charge. Although he largely admitted the Charge there were aspects which have been fully explored during this hearing. Two sub-particulars of the Charge were not proved. He has been cooperative.

[260] Dr Morton did not submit that he was unable to meet these costs.

[261] Balancing all of these factors, we consider it is just and proportionate for the practitioner to pay a contribution of 40% of the estimated total costs of $183,628.11, to be fixed at $74,000. Costs are to be shared between the Director and the Tribunal with costs to the Director of $49,334 and $24,666 to the Tribunal.

Name suppression

Application by practitioner

[262] On 1 December 2022 ahead of the substantive hearing held on 5-8 December 2022, Dr Morton applied for orders prohibiting the publication of:

(a) His name and any particulars likely to lead to him being identified (including the location and the name of his former medical practice, MHC);

(b) His [family member] name [Ms R]; and any particulars likely to lead to [Ms R] being identified; and

(c) Details of [Ms R's] [suppressed by order of the Tribunal).

[263] A supporting affidavit from Dr Morton was filed at that time.

[264] At the hearing on 8 December 2022, an in-Chambers application was made by Dr Morton's counsel seeking an adjournment of the application for permanent name suppression in order to obtain a follow-up report from a [suppressed by order of the Tribunal] professional regarding [Ms R's] health.[101] The Tribunal granted the adjournment.

[265] On 17 February 2023, counsel for Dr Morton filed an updated affidavit from Dr Morton.[102]

[266] On 6 March 2023 the Director filed a notice of opposition setting out the grounds on which she was opposed to the making of the orders sought by the practitioner.

[101] Transcript of in-Chambers hearing, 8 December 2022, p 4.

[102] Affidavit of Dr Robert McKay Morton in support of application for permanent non-publication order dated 16 February 2023.

[267] Both Dr Morton and [Ms R] filed further affidavits on 17 March 2023.[103] Attached to [Ms R's] affidavit is a letter from [Dr N], a GP at MHC in response to a request by [Ms R] to write a letter detailing why she requests permanent name suppression for, Dr Morton.[104]

[268] Following the filing of the practitioner's affidavits on 17 March 2023 the Director indicated that she intended to abide the application for suppression of Dr Morton and [Ms R's] names. The Director remained opposed to the application as applied to MHC.

[269] Ms Cockburn, the complainant in this matter, filed a submission as she is entitled to do under s 95(3) of the Act.[105]

[270] The Tribunal has also received a letter from the partners of MHC.[106]

[271] Both counsel for the practitioner and the Director filed submissions and the application for non-publication orders was heard via AVL on 20 June 2023.

Legal principles

[272] The Tribunal's power to order non-publication is governed by s 95(2) of the Act. The test under s 95(2) requires the Tribunal to be satisfied that it is desirable to make one or more of the orders listed.

[273] Section 95 of the Act provides:

> **95 Hearings to be public unless Tribunal orders otherwise**
>
> (1) Every hearing of the Tribunal must be held in public unless the Tribunal orders otherwise under this section or unless section 97 applies.
>
> (2) If, after having regard to the interests of any person (including, without limitation, the privacy of any complainant) and to the public interest, the Tribunal is satisfied that it is desirable to do so, it may (on application by any

[103] Two affidavits of Robert McKay Morton in support of application for permanent non-publication order dated 17 March 2023, and Affidavit of [Ms R] in support of practitioner's application for permanent non-publication order dated 17 March 2023.

[104] Above n 103. Exhibit MM1, Letter dated 15 March 2023 from [Dr N] to Tribunal.

[105] Ms Cockburn' s submission by email dated 12 June 2023.

[106] Letter dated 15 June 2023 for MHC.

> of the parties or on its own initiative) make any 1 or more of the following orders:
>
> …
>
> (d) an order prohibiting the publication of the name, or any particulars of the affairs, of any person.

[274] The starting point in any consideration of name suppression is the fundamental principle of open justice, a principle which is reflected in s 95(1) of the Act which requires the proceedings to be held in public unless the Tribunal orders otherwise.[107]

[275] The Tribunal has a duty to hold every hearing in public under s 95(1) of the Act unless the Tribunal is satisfied that it is "desirable" to make an order under s 95(2) of the Act.

[276] The public interest factors to be considered by the Tribunal have been set out in a number of decisions.[108] These public interest factors include:

(a) Openness and transparency in proceedings;

(b) Accountability of the disciplinary process;

(c) The public interest in knowing the identity of the practitioner charged with a disciplinary offence;

(d) The importance of freedom of speech enshrined in s 14 of the New Zealand Bill of Rights Act 1990; and

(e) Unfairly impugning other practitioners.

---

[107] *Erceg v Erceg* [2016] NZSC 135, [2017] 1 NZLR 310.

[108] For example, *Anderson v Professional Conduct Committee of the Medical Council of New Zealand* an Unrep (Wellington High Court), Gendall J, CIV-2008-485-1646, 14 November 2008; *Johns v Director of Proceedings* [2017] NZHC 2843, Moore J at [177].

[277] A useful description of the competing public and private factors has been provided by the Court in *Anderson v PCC:*[109]

> [36] Private interests will include the health interests of a practitioner, matters that may affect a family and their wellbeing and rehabilitation. Correspondingly, interests such as protection of the public, maintenance of professional standards, both openness and transparency and accountability of the disciplinary process, the basic value of freedom to receive and impart information, the public interest in knowing the identity of the practitioner found guilty of professional misconduct, the risk of other doctors' reputations being affected by suspicion, are all factors to be weighed on the scales.
>
> [37] Those factors were also referred to at some length in the Tribunal**.** Of course, publication of a practitioner's name is often seen by the practitioner to be punitive but its purpose is to protect in advance public interest by ensuring that it is informed of the disciplinary process and of practitioners who may be guilty of malpractice and professional misconduct. It refers also to the principles of openness of such proceedings, and the freedom to receive and impart information.

[278] It is well established that where a charge of professional misconduct is proven the practitioner will be named in the preponderance of cases.[110] What may be considered desirable at the time of the interim application for non-publication may be considered differently after a substantive hearing where an adverse finding is made. [111]

[279] [In *Dr X v Director of Proceedings*,[112] the Court stated that there must be something more "sufficiently compelling" than stress or "the inevitable embarrassment" of the disciplinary proceedings to justify suppression of a practitioner's identity and to overcome the imperatives behind publication. The practitioner's or a family member's serious health concerns may be sufficient to warrant suppression of the practitioner's identity.

---

[109] High Court, Wellington, CIV-2008-485-1648, 14 November 2008, per Gendall J at [36]-[37].

[110] *A v Director of Proceedings* HC Christchurch CIV-2005-409-2244, 21 February 2006 at [42] (also known as *T v Director of Proceedings* and *Tonga v Director of* Proceedings), cited in *Johns v Director of Proceedings* [2017] NZHC 2843 per Moore J at [169].

[111] *Beer v A Professional Conduct Committee* [2020] NZHC 2828, per Edwards J at [40].

[112] *Dr X v Director of Proceedings* [2014] 1798 Simon France J at [14]-[15].

Practitioner's submissions

[280] Ms Beattie, counsel for the practitioner, submitted that the public interest in naming Dr Morton is low. The complainant, Ms Cockburn, will know the outcome of this case and there is no additional benefit to her of Dr Morton being named.

[281] Ms Beattie submitted there is no evidence that Dr Morton presents a risk to any other patients and that this case is truly a sad "one-off" type of case. Dr Morton has since established his competency by a Medical Council review and there have been audits conducted of Dr Morton's steroid and retinoid prescribing.

[282] Counsel submitted that there is nothing in the nature of the conduct that weighs more in favour of publication – such as dishonesty or sexual impropriety. On the other hand, there are potential harms that flow from publication.

[283] In summary, counsel submitted that there are two main factors in non-publication. These are first, harm in respect of the impact of publication of Dr Morton's name on his family. The investigation by the HDC and subsequently the proceedings before the Tribunal has caused significant distress for [Ms R].

[284] Most importantly, in the letter from [Dr N] where she states in relation to [Ms R]:

> Her [suppressed by order of the Tribunal] health are precarious after the HDC process, and I am concerned about her. I believe that Dr Morton's name being released publicly would have grave consequences for [Ms R's] [suppressed by order of the Tribunal] health and would strongly recommend that Dr Morton have permanent name suppression to protect [Ms R].

[285] Secondly, counsel submitted that publication of Dr Morton's name is likely to stand in the way of Dr Morton's rehabilitation.

[286] In Dr Morton's affidavit he explained why it may prove impossible for him to continue working with the RNZCGP to train new GPs or provide services to the rural community should he be named. Dr Morton cannot know in advance how damaging publicity will prove to his own health, confidence in professional and therapeutic relationships. As the Court has recognised, there is a public interest in not ending the career of a competent doctor.

Dr Morton has an excellent reputation that is supported by references from four colleagues at MHC.

[287] Ms Beattie submitted that whilst individually the private factors may not make it desirable for a non-publication order, cumulatively, these factors could be considered in support of non-publication.[113]

[288] In respect of the MHC, Dr Morton supported suppression of the MHC. He has a longstanding association with the Clinic and his name is synonymous with the practice.[114] The practice has since cured the system problems that played a part in the over-prescribing moving to an "E-prescribing" system. Naming MHC would attract unfair suspicion of the doctors who work at the practice now.

[289] Ms Beattie referred to a recent decision of the Tribunal, *Dr L*,[115] where the medical practice sought to be named if Dr L was to be named. However, because in that case there was risk of significant harm to the practitioner's health and that of his wife, non-publication orders were made for the practitioner, and extended to his family and medical practice. Ms Beattie submitted that it was "par for the course" that if the practitioner's name was suppressed then the practice name should also be suppressed.

[290] Ms Beattie submitted that there was inaccurate media reporting to date.

Director's submissions

[291] The Director has taken a neutral position in relation to the non-publication of Dr Morton and [Ms R's] names solely in light of the concerns raised in the letter written by [Dr N], relating to [Ms R].

---

[113] See for example, *J v New Zealand Institute of Chartered Accountants Appeals Council* [2020] NZHC 1566 at [95].
[114] Affidavit of Dr Morton dated 16 February 2023 at [20].
[115] 1176/Med20/489P.

[292] The Director did not agree that the other grounds relied on by Dr Morton are sufficient to justify an exception to the fundamental rule of open justice and, but for [Dr N's] letter, would have opposed Dr Morton's application.

[293] Should the Tribunal consider it desirable for Dr Morton's name to be suppressed then the Director opposes the suppression of the name of Dr Morton's former practice, MHC, as an identifying particular.

[294] In reply to the practitioner's submission, that naming MHC would attract unfair suspicion on the doctors who work at the practice, the Director submitted that while Dr Morton has sold his interest in the business, and no longer works there, he is not retired from practice and continues to work at another medical centre.

[295] The Director submitted that the fact that MHC has cured its system problems is not relevant to the issue of whether MHC should be named or not. The naming of MHC is not a punishment, rather it is a decision of whether, starting from a presumption of openness, the Tribunal is satisfied that it is desirable to suppress MHC's name.

[296] The Director had no submissions to make on behalf of Ms Cockburn who independently, as she is entitled to do, provided a separate written submission to the Tribunal.

Analysis

[297] The Tribunal has found the Charge of clinical negligence proved in respect of Dr Morton's prescribing practices for his patient. The starting point in this application for a non-publication order is therefore a presumption that the practitioner's name will be published.

[298] The Tribunal is required to weigh up the competing public and private interests at stake. Every decision will necessarily be case and fact dependent, requiring the public interest to be weighed against particular interests of any person in the context of the facts of the case under review.

[299] We have carefully considered the evidence before us and submissions that have been filed in respect of this application.

[300] Ms Cockburn has provided a thoughtful explanation of her views in support of naming Dr Morton in this case. She has expressed some empathy for Dr Morton and his family.

[301] On balance and viewed objectively, we consider that there are insufficient private factors to outweigh the strong public interest in publication of the name and identifying details of this practitioner. It is therefore desirable for publication of Dr Morton's name in relation to this proceeding.

[302] The primary submission for the practitioner is related to the concerns regarding [Ms R's] health. We acknowledge these health concerns and the distress to [Ms R] regarding this disciplinary proceeding. We took these concerns seriously when they were initially raised at the substantive hearing.

[303] Counsel for the practitioner was given the opportunity to provide the Tribunal with a report on [Ms R's] health from a [suppressed by order of the Tribunal] health professional.[116] That report has not been forthcoming. Six months later, the Tribunal is in no position to assess the risk of harm to [Ms R] should these proceedings be published.

[304] [Dr N], a GP at MHC, has provided a letter of support for the application to be granted. She did not have an ongoing therapeutic relationship with [Ms R] at MHC. As a former colleague, she has also provided a personal reference for Dr Morton. We therefore do not consider that [Dr N] is suitably qualified or the appropriate professional to provide the Tribunal with an independent and objective assessment of the risk of harm to [Ms R] should her name be published.

[305] Counsel for the practitioner submitted that [Ms R's] name should be suppressed. The Director neither consented to nor opposed [Ms R's] name suppression application and advised

[116] Transcript in-Chambers hearing on 8 June 2022, p 4.

that she would abide the decision of the Tribunal. We consider that it is desirable that [Ms R's] name and details of her health are suppressed.

[306] In respect of the remaining ground raised by counsel for the practitioner that publication of his name will undermine his rehabilitation, we are not satisfied that there are compelling factors to displace the presumption of open justice in respect of the disciplinary proceedings.

[307] There is no suggestion that Dr Morton is not fit to practise and or that he poses a risk to the public. To the contrary, we are satisfied from the evidence provided to us that Dr Morton has and could continue to make a valuable contribution as a practising GP to the community that he has served for many years.

[308] In *Johns v Director of Proceedings*[117] Dr Johns had been found guilty of professional misconduct as he ignored recommendations at the time of the birth of a baby born with significant birth defects to undertake an urgent caesarean section, and the baby died. The practitioner was still practising as an O & G specialist.

[309] The non-publication order was overturned on appeal to the High Court.[118] Moore J held that the Tribunal had overstated the risk of publication to the welfare of Dr Johns' mother, the fact that Dr Johns had been assessed as safe to continue practising and that publication would be unduly punitive.[119] His Honour also acknowledged that:[120]

> … In some instances, slavish adherence to the principle of openness does very little to protect or promote the 'public weal' because publication may stand in the way of rehabilitation and therefore optimal performance of the practitioner.

[310] We consider that weighty factors here tend to support the 'public weal' – as Moore J put it in *Johns* – as being better served by Dr Morton standing up to the findings of the Tribunal as he did at the outset by apologising to Ms Cockburn.

---

[117] [2017] NZHC 2843 at [177].
[118] Above n 117.
[119] *Johns v Director of Proceedings* [NZHC] 2843 at [229]-[232].
[120] Above n 119, at [177].

[311] Dr Morton is a very experienced GP and he has reflected deeply on his practice. Rather than suppress the details of this disciplinary Charge, we consider the public interest would be better served by using his experience in his teaching practice. He can be a role model for trainee GPs to show them how to learn from professional mistakes for the betterment of the medical profession as a whole.

[312] There is public interest in knowing the name of the practitioner for the benefit of any of his current patients, future patients or employers. Patients have a right to know about Dr Morton's professional misconduct so they can make a fully informed decision as to whether they consult him or will continue to consult him.

[313] The Tribunal declines Dr Morton's application for permanent name suppression.

[314] There will be an order permanently prohibiting the publication of [Ms R's] name, and any details of her health. All reference to [Ms R] in this decision is to be redacted with reference only to the ground advanced as "the impact on Dr Morton's family".

[315] Although not a party to the proceeding, the partners of MHC advised the Tribunal that naming MHC should Dr Morton's name be suppressed is likely to have an adverse impact on MHC. They expressed the view that there would be greater adverse impact on MHC if Dr Morton's name is suppressed.

[316] As Dr Morton suggests, he is inevitably associated with the MHC. The disciplinary Charge relates to the period during 2013 – 2018 when Dr Morton was working at the MHC while Ms Cockburn was his patient at this practice. He no longer works there.

[317] We consider it is both desirable and realistic that the name of the MHC, Dr Morton's workplace at the time of these events, is also published.

[318] The disciplinary Charge concerns an individual doctor. We do not consider it is in the public interest or desirable that the names of any of the GPs working at MHC, current or past, are identified in this disciplinary proceeding and any reference to them will be suppressed.

[319] At the request of the counsel for the practitioner, Dr Morton's interim non-publication order will continue for a period of 21 days following the date of this decision to enable him to consider his position.

Result and orders of the Tribunal

[320] The Tribunal has found the Charge of professional misconduct is established as negligence in regard to Dr Morton's prescribing of Neotigason (particulars 1 (b),(c) (d) and (e) and 2). Particular 1(a) is not established.

[321] The Charge of professional misconduct is also established as negligence in regard Dr Morton's prescribing of Dermol (particulars 3 (b)(c)(d) and (e), 4 and 5). Particular 3(a) is not established.

[322] Dr Morton's conduct in respect of all particulars 1 to 5, with the exception of particulars 1(a) and 3(a), are separately and cumulatively negligence in the scope of Dr Morton's practice and is conduct that is sufficiently serious to warrant a disciplinary sanction.

[323] Particular 2, in relation to Dr Morton's prescribing of a Special Authority medication Neotigason, and Particular 5 regarding prescribing of excessive amounts of Dermol to his patient, is conduct that has brought and is likely to bring, discredit to the medical profession.

[324] The Tribunal makes the following orders pursuant to s 101 of the Act:

(a) Censure of the practitioner to signal to the medical profession and to the wider public the serious departure from professional standards for the prescribing of these medications pursuant to s 101(1)(d) of the Act;

(b) A condition on Dr Morton's practice that he is to notify his current employer and the Royal New Zealand College of General Practitioners of the Tribunal's findings and this decision pursuant to s 101(1)(c) of the Act;

(c) A fine of $3,000 pursuant to s 101(1)(e) of the Act;

(d) A contribution of 40% of the total costs of the HDC investigation and the Director, $108,057.40 and the costs of the Tribunal estimated as $75,570.71, a total of $183,628.11. The 40% contribution is to be fixed at $74,000 and is payable to both the Director and the Tribunal. Costs are to be shared between the Director and the Tribunal with costs to the Director of $49,334 and $24,666 to the Tribunal.

(e) The application for a permanent non-publication order pursuant to s 95 of the Act:

(i) is declined as it applies to the practitioner, Dr Morton and the Mosgiel Health Centre.

(ii) is allowed in respect of the name and identifying details of [Ms R]. Any reference to her health issues and identifying information before the Tribunal are to be suppressed and redacted in this decision; this decision is to refer only to the ground advanced by the practitioner as "the impact on Dr Morton's family";

(iii) is allowed in respect of all General Practitioners currently working at the Mosgiel Health Centre or who were working there at the time of these events and are referred to in these proceedings.

(f) The interim non-publication order for Dr Morton remains in place for 21 days from the date of this decision should the practitioner wish to exercise his right of appeal.

(g) For the avoidance of doubt, no application was made by the Director for non-publication of the complainant's name and no application is granted.

[327] Under s 157 of the Act, the Tribunal directs the Executive Officer:

(a) To publish this decision and a summary on the Tribunal's website;

(b) To request the Medical Council of New Zealand to publish either a summary of, or a reference to, the Tribunal's decision in its professional publications to members, in either case including a reference to the Tribunal's website so as to enable interested parties to access the decision.

DATED at Dunedin this 3rd day of August 2023

A J Douglass
Chair
Health Practitioners Disciplinary Tribunal

SCHEDULE

PARTICULARS OF CHARGE

TAKE NOTICE that pursuant to sections 91 and 100(1)(a) and 100(1)(b) of the Health Practitioners Competence Assurance Act 2003, the Director of Proceedings has reason to believe that a ground exists entitling the Tribunal to exercise its powers against you and charges that between August 2012 and September 2018, whilst caring for your patient Ms Nikki Cockburn you, being a general practitioner, acted in such a way that amounted to professional misconduct.

IN PARTICULAR:

Prescription of teratogenic medicine (Neotigason) – 9 October 2013

1. On 9 October 2013, when prescribing acitretin (brand name Neotigason) to your patient, you failed to follow appropriate prescribing practices and/or acted contrary to accepted standards of care when you:

   a) failed to provide your patient with detailed written information about:

      (i) the need to use effective contraception without interruption during treatment with acitretin; and/or

      (ii) the risk of very severe foetal malformation if pregnancy occurred during treatment with acitretin;

   and/or

   b) failed to provide your patient with detailed verbal and/or written information about:

      (i) the need to use effective contraception without interruption for four weeks before, and for two years after discontinuing, treatment with acitretin; and/or

      (ii) the risk of very severe foetal malformation if pregnancy occurred within two years of discontinuing treatment with acitretin; and/or

(iii) Medsafe's recommendation to perform pregnancy tests at monthly intervals during treatment with acitretin, and at 1 – 3 monthly intervals after discontinuing treatment with acitretin (for a period of two years);

and/or

c) failed to confirm your patient had been using effective contraception without interruption for four weeks prior to commencing treatment with acitretin;

and/or

d) failed to obtain a negative pregnancy test from your patient prior to commencing treatment with acitretin;

and/or

e) failed to ensure your patient was aware that treatment should not begin until the second or third day of her next normal menstrual period.

AND / OR

2. On or around 9 October 2013, you submitted a Ministry of Health Application for Subsidy by Special Authority confirming (inter alia) that you had ensured that the possibility of pregnancy had been excluded in your patient prior to the commencement of treatment by acitretin and informed your patient that she must not become pregnant for a period of two years after discontinuing treatment with acitretin, when you knew or ought to have known you had not done so.

AND / OR

Prescription of topical steroid (Dermol 0.05%) – 2013 - 2018

3. On multiple occasions between 14 March 2013 and 28 September 2018 (as particularised in Schedule A), when prescribing Dermol 0.05% ointment to your patient you failed to follow appropriate prescribing practices and/or acted contrary to accepted standards of care when you failed to:

a) take notice of and/or act on an alert placed on the patient's electronic medical records on or around 28 August 2012, which stated: "BE CAUTIOUS WITH SCRIPTING DERMOL, OVERUSING";

and / or

b) take notice of and/or act on a letter from a dermatologist dated 1 February 2014, which stated "…It is essential that [the patient] never uses Dermol again…";

and / or

c) place an alert on your patient's electronic medical records, following receipt of the 1 February 2014 letter;

and / or

d) take notice of and/or act on a letter from a dermatologist dated 3 May 2014 discussing the patient's use of Dermol and stating: "…[the patient] should certainly not restart this…";

and / or

e) place an alert on your patient's electronic medical records, following receipt of the 3 May 2014 letter.

AND / OR

4. On multiple occasions between 14 March 2013 and 28 September 2018 (as particularised in Schedule A), when prescribing Dermol 0.05% ointment to your patient you failed to follow appropriate prescribing practices and/or acted contrary to accepted standards of care when you failed to adequately inform your patient of the risks associated with long term and heavy use of steroid-based medication.

AND / OR

5. On multiple occasions between 3 October 2016 and 28 September 2018 (as particularised in Schedule B) you failed to follow appropriate prescribing practices and/or acted contrary to accepted standards of care when you prescribed excessive amounts of Dermol 0.05% to your patient, namely repeat prescriptions in the amount of 6 x 30g tubes per script (with two repeats).

The conduct alleged in the above particulars separately or cumulatively amounts to professional misconduct. The conduct is alleged to amount to malpractice and/or negligence and/or conduct that brings discredit to the medical profession under s100(1)(a) and s100(1)(b).

DATED at Wellington this 28th day of September 2022

SCHEDULE A

Between 14 March 2013 and 28 September 2018, Dr Morton prescribed Dermol 0.05% ointment and/or scalp application to his patient Ms Cockburn on the following occasions:

2013

a) 14 March 2013 (1 x 30g with 2 repeats);

b) 4 June 2013 (1 x 30g with 2 repeats & 1 x Scalp Application 0.05% 1 x 30ml with 2 repeats);

c) 15 July 2013 (1 x 30g with 2 repeats);

d) 29 July 2013 (1 x 30g with 2 repeats);

e) 28 August 2013 (1 x 30g with 2 repeats);

f) 26 September 2013 (1 x 30g with 2 repeats);

g) 9 October 2013 (1 x 30g with 2 repeats);

h) 23 October 2013 (1 x 30g with 2 repeats);

2014

i) 16 April 2014 (1 x 30g with 1 repeat);

j) 12 June 2014 (1 x 30g with 1 repeat);

k) 16 June 2014 (1 x 30g with 1 repeat);

l) 8 July 2014 (1 x 30g with 1 repeat);

m) 13 August 2014 (1 x 30g with 2 repeats & 1 x Scalp Application 0.05% 30 ml with 2 repeats);

n) 4 September 2014 (3 x 30g, no repeats);

o) 8 September 2014 (2 x 30g, no repeats);

p) 22 September 2014 (2 x 30g, no repeats);

q) 24 November 2014 (2 x 30g, no repeats);

2015

r) 15 January 2015	(2 x 30g, no repeats);
s) 24 August 2015	(2 x 30g, no repeats);
t) 31 August 2015	(2 x 30g with 2 repeats & 1 x Scalp Application 0.05% 30 ml with 2 repeats)
u) 2 October 2015	(2 x 30g with 2 repeats);

2016

v) 3 February 2016	(1 x Scalp Application 0.05% 30ml with 2 repeats);
w)3 October 2016	(6 x 30g with 2 repeats);

2017

x) 23 January 2017	(6 x 30g with 2 repeats);
y) 8 May 2017	(6 x 30g with 2 repeats);
z) 26 June 2017	(6 x 30g with 2 repeats);
aa) 27 September 2017	(6 x 30g with 2 repeats);

2018

bb) 17 January 2018	(6 x 30g with 2 repeats);
cc) 13 April 2018	(6 x 30g with 2 repeats);
dd) 16 July 2018	(6 x 30g with 2 repeats & 1 x Scalp Application 0.05% 30ml with 2 repeats); and
ee) 28 September 2018	(6 x 30g with 2 repeats).

SCHEDULE B

Between 3 October 2016 and 28 September 2018, Dr Morton prescribed Dermol 0.05% ointment in the amount of 6 x 30g tubes (with 2 repeats) to his patient Ms Cockburn on the following occasions:

2016

a) 3 October 2016;

2017

b) 23 January 2017;
c) 8 May 2017;
d) 26 June 2017;
e) 27 September 2017;

2018

f) 17 January 2018;
g) 13 April 2018;
h) 16 July 2018; and
i) 28 September 2018.