HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Prescription error resulting in potential risks to pregnancy

1. On 15 April 2025, the Health and Disability Commissioner (HDC) received a complaint from Miss A regarding a prescribing error by general practitioner (GP) Dr B and the local medical centre (medical centre1). The error resulted in Miss A being prescribed and dispensed acitretin (a teratogenic[1] retinoid[2] primarily used for psoriasis[3]), instead of isotretinoin,[4] for the treatment of acne. Miss A used the medication as prescribed for eight months before the error was detected. As a result, Miss A's pregnancy options were impacted for a significant period of time.

Information gathered

2. Miss A was a patient of medical centre1. On 6 May 2024, she consulted Dr B for treatment of moderately severe acne. During the consultation, they discussed the use of isotretinoin, including its well-known risks of birth defects if pregnancy occurs during treatment and the need for effective contraception. Miss A agreed to commence isotretinoin on the understanding that she could safely plan a pregnancy six months after the last use of the medication. Baseline blood tests were requested before starting isotretinoin.

3. Dr B mistakenly selected acitretin from the electronic New Zealand Formulary,[5] instead of isotretinoin, and added it to Miss A's medication list. The key difference is that a pregnancy cannot be safely planned for three years after using acitretin, as opposed to six months after using isotretinoin. At the time, neither Dr B nor Miss A noticed the error. Furthermore, Miss A was not aware of the three-year pregnancy stand-down associated with acitretin. Dr B acknowledged the prescribing error. However, he told HDC that, in his view, 'no patient harm has occurred'.

4. HDC has confirmed that the dispensing of the prescription was done in accordance with the special authority required for acitretin.

5. On 27 September 2024, Miss A requested a repeat prescription of her medication. This was authorised by Nurse Practitioner (NP) C at medical centre1, and again, the error went unnoticed at that time.

6. In his response to the provisional opinion, NP C told HDC that he identified the need for a face-to-face review, initiated a recall, and issued the repeat prescription for continuity of

[1] A substance that can cause birth defects or abnormalities in a developing embryo or foetus.
[2] A class of compounds derived from vitamin A that are used to treat various skin conditions such as acne, signs of aging, and sun damage.
[3] A chronic, autoimmune skin condition that causes red, scaly patches on the skin, which can be itchy, painful, and inflamed.
[4] A form of vitamin A that is used to treat severe nodular acne that has not responded to other treatments, including antibiotics.
[5] This is an independent resource providing healthcare professionals with clinically validated medicines information and guidance on best practice, enabling them to select safe and effective medicines for individual patients.

care. He provided evidence that he set a task in the practice management system recording that Miss A had last been reviewed in May 2024 and required a further clinical review and that the prescription was issued pending this. Medical centre1 sent a message to Miss A advising that she was due for a medication review in clinic and requesting that she arrange an appointment prior to seeking a further repeat prescription. NP C noted that this message did not reflect his intended wording, which was that the review occur as soon as practicable, and that the task did not clearly convey this timeframe. He accepted that, although he reviewed the notes and identified the need for review, he did not identify that the medication prescribed was acitretin, which resulted in a delay in detecting the original prescribing error despite the existing repeat-prescribing standard operating procedures (SOPs) at medical centre1 (discussed below). NP C acknowledged that this represented a missed opportunity to identify and correct the error, and he deeply regrets the impact this has had on Miss A.

7. In its initial response, the dispensing pharmacy (the pharmacy) told HDC that the acitretin prescription was dispensed to Miss A on 30 September 2024 and that counselling was provided at the time of dispensing; however, it said that the specific details of that interaction were not documented and could not be confirmed. In its response to the provisional opinion, the pharmacy told HDC that counselling was provided when Miss A collected her prescription on 30 September and that this was recorded in its dispensing system, although no detailed record of the counselling content was made. The pharmacy also said that, based on the information available at the time, the medicine was understood to be a continuation of therapy rather than a new initiation. It said that counselling was provided on that basis, including confirmation of dosing instructions, and that further detailed counselling was not considered necessary in those circumstances.

8. On 10 December 2024, Miss A went to medical centre2 because she was experiencing severe period pain, something she had been dealing with for the previous two years. She also said that she had regular episodes where she fainted or was near fainting. She was seen by NP D who put together a treatment plan. This included arranging an ultrasound, organising a specialist review, prescribing a stronger anti-inflammatory medicine, and giving her advice about how to manage the fainting episodes.

9. At the same appointment, Miss A and NP D also talked about renewing her prescription for isotretinoin, the medication Miss A should have been taking. As part of the usual retinoid monitoring process, routine blood tests were carried out.

10. On 12 December 2024, while actioning this repeat prescription request, a GP at medical centre1 identified that acitretin had been prescribed instead of isotretinoin. The error was escalated to the Chief Medical Officer (CMO), Dr E, and acitretin was removed from Miss A's medication list to prevent further prescribing. Dr B was on extended leave overseas at this time and was not made aware of the error.

11. On 16 December 2024, a senior GP at medical centre1 met with Miss A via an online appointment to explain the prescribing error and apologise on behalf of medical centre1. Miss A was informed that the medication she had been taking was acitretin rather than isotretinoin and that acitretin remains in the body for up to three years after using it. She

was advised that pregnancy during the three-year period carried a significant risk of foetal harm. Medical centre1 then amended Miss A's prescription to isotretinoin.

12. Miss A wrote to medical centre1 on 26 March 2025, requesting an explanation of her options for the future and guidance on what could be done about the error. Having dealt with the matter in December 2024, medical centre1 discovered that Dr B was unaware of the error, and he was informed of it on 28 March 2025. Dr B provided a written apology to Miss A on 10 April 2025. Medical centre1 also met with Miss A on 23 May 2025, providing her with a written summary of the discussion as well as written answers to a number of questions she had for medical centre1. The outcome of the meeting was that medical centre1 would make a referral and pay for Miss A to consult a fertility specialist as well as discuss psychological support required to manage the stress caused by the prescribing error.

13. The CMO at medical centre1 classified the incident as a sentinel event (in this case, an unexpected occurrence resulting in severe temporary harm to Miss A) and initiated internal quality-assurance processes. Dr E discussed the incident at clinical governance meetings and confirmed that medical centre1 conducted an audit of all acitretin prescribing across its network. Dr E also issued education and guidance to all clinical staff to prevent a recurrence of Miss A's situation.

Relevant guidance

Medical Council of New Zealand's (MCNZ) Good Prescribing Practice[6] (February 2024)

14. MCNZ's Good Prescribing Practice guidance requires prescribing to be undertaken in accordance with accepted professional standards and relevant clinical guidelines. It expects medical practitioners to maintain current knowledge of the medicines they prescribe and to base prescribing decisions on a thorough clinical assessment, including consideration of relevant medical and medication history, potential risks, and ongoing monitoring requirements.

Principles for quality and safe prescribing practice[7] (set by the Nursing Council of New Zealand (NCNZ), Pharmacy Council, MCNZ and four other health-related regulatory authorities) (17 September 2024)

15. The principles for quality and safe prescribing practice provide a set of principles to assist prescribers to undertake and maintain quality prescribing practice when prescribing therapeutic products. There are 12 principles, and Principle 4 states 'A prescriber recognises that inappropriate prescribing (which may include indiscriminate, excessive, or reckless prescribing) is clinically and ethically unacceptable'.

Medical centre1's SOP on Prescriptions and Repeat Prescriptions

16. Medical centre1's SOP[8] on prescriptions and repeat prescriptions requires clinicians to review a patient's active medication list, alerts, and previous prescribing instructions before issuing or renewing any prescription. Prescribers must confirm that each medicine is

[6] MCNZ Good prescribing practice – 2024.
[7] NCNZ004-Medicines-Sept-2024-FINAL-2024-09-17.pdf.
[8] The SOP applies to all clinical staff and contractors involved in delivery of Tend Health Services – GPs, NPs, Designated Registered Nurse Prescribers in Primary Care and Specialty Teams (DNP), Registered Nurse Prescribers in Community Health (RNPCH) and Prescribing Pharmacists (PP).

clinically appropriate, that it is being used for a suitable medical condition, and that higher-risk medicines are prescribed with appropriate safeguards. For repeat prescriptions, the SOP requires review of the original prescriber's plan, confirmation that the medicine remains suitable, and documentation of any changes or clinical considerations before authorisation. Certain medicines with known safety risks are excluded from routine repeats, and all requests must be reviewed by a qualified prescriber.

Medical centre1's Continuity of Care policy

17. Medical centre1's Continuity of Care policy requires that medicines reconciliation is undertaken routinely when patients are seen in a consultation or request repeat prescriptions, including reviewing all current medications to ensure they are accurate, appropriate, and up to date. This process involves reconciling different sources of clinical information, identifying discrepancies or risks, tracking side effects and ensuring appropriate investigations are reviewed for safe dosing. The policy also requires medication updates to be made when clinical correspondence is received, with a follow-up task generated where this cannot be completed at the time, and that audits of medicines reconciliation form part of medical centre1's Clinical Quality Framework.

The pharmacy's SOP on Prescriptions and Repeat Dispensing

18. The pharmacy's SOP outlines a structured process for receiving, checking, and supplying prescriptions, including repeats. Pharmacists are required to verify a prescription's authenticity and legality in accordance with the Medicines Regulations 1984, confirm the patient's identity, and ensure accurate entry of prescribed items into the dispensary system. Each prescription undergoes both a clinical and an accuracy check before supply, including assessment of the medicine's suitability, strength, and dosage. For repeat prescriptions, pharmacists must review the dispensing history, confirm that the medicine remains clinically appropriate, and reconcile any changes in the dose or regimen before dispensing. The SOP also emphasises the importance of providing counselling at the time of supply and ensuring that patients understand the correct use and potential risks of their medicines.

Responses to the Provisional Opinion

19. Miss A was provided with an opportunity to comment on the provisional opinion. She outlined the impact of the prescribing error on her, including the implications of being prescribed acitretin instead of isotretinoin and the associated requirement to avoid pregnancy for an extended period. Miss A disagreed with the view that no harm had occurred and raised concerns about how the prescribing error occurred and continued across multiple consultations and repeat prescriptions. Miss A told HDC that, "While there may not have been a physical injury the emotional and life-planning impacts have been significant."

20. Dr B was provided with an opportunity to comment on the provisional opinion. He acknowledged the impact on the complainant but noted, 'we are all human and no-one can be right 100% of the time, but the system does not seem to acknowledge this. I made a very simple error in the context of a busy clinical day'. He apologised to the complainant once the error was identified, and an internal review was undertaken that resulted in process changes and notification of prescribers. Dr B did not agree with the findings in the report.

21. Medical centre1 and NP C were provided with an opportunity to comment on the provisional opinion. Where relevant, the comments of medical centre1 and NP C have been incorporated into this report. Medical centre1 told HDC it acknowledged the impact of the prescribing error on Miss A and remained committed to supporting her. Medical centre1 submitted that adverse comments with respect to medical centre1 and NP C were not fair or proportionate to the circumstances of this case.

22. The pharmacy was provided with an opportunity to comment on the provisional opinion and, where relevant, its comments have been incorporated into this report. It outlined steps taken since the incident to increase vigilance when dispensing to women of childbearing age and to provide additional written information regarding risks where appropriate. The pharmacy also told HDC that, having understood the medicine to be a continuation of therapy and in the absence of clinical concerns, it did not consider that further detailed counselling about long-term pregnancy avoidance was required at the time, noting that more comprehensive counselling is typically provided when medicines are newly initiated.

Opinion

Dr B – breach

23. As a healthcare provider, Dr B was responsible for providing services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). Right 4(2) of the Code states that 'Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards'.

24. Prescribers in primary healthcare[9] are expected to take all reasonable steps to mitigate the risk of error before issuing a prescription. The MCNZ's 'Good prescribing practice'[10] sets out the checks and balances that should be undertaken by a GP, including being satisfied that the patient understands how to take or use any medicine prescribed and is able to take it or use it. In addition, when a medicine carries a heightened risk profile, extra care and explicit verification is required prior to transmission to the pharmacy. In this case, the error occurred at the point of prescription selection and transmission — core steps within a prescriber's control.

25. Dr B's prescribing error represented a significant departure from the accepted standard of care required under medical centre1's SOP, MCNZ's 'Good prescribing practice' and the principles for quality and safe prescribing practice. The incorrect selection of acitretin, a potent retinoid that can cause birth defects or foetal abnormalities and that remains in the body for three years, was inconsistent with the requirement to prescribe safely, accurately, and within an evidence-based framework. Given Miss A's intention to start a family, the error exposed her to a potentially serious and entirely avoidable clinical risk.

26. In addition, the consequence of this error has had a profound impact on a young woman who had to defer her plans to start a family for at least three years after completing the last course of acitretin. This loss of reproductive autonomy is serious and was entirely avoidable

[9] This is professional healthcare received in the community and is usually delivered by a GP or practice or district nurse.

[10] This specifically states that it may be used by '… the Health and Disability Commissioner as a standard by which your conduct is measured'.

through adherence to safe prescribing procedures, including accurate medicine selection, appropriate risk verification, and compliance with relevant regulatory and professional standards.

27. Dr B acknowledged the impact of the error on Miss A and noted that, had the error not been identified, the consequences could have been far more serious. He remains of the view that his written apology for the prescribing error, along with actions taken by medical centre1, adequately addressed the matter.

28. I consider that Dr B failed to provide services to Miss A that complied with professional standards. Accordingly, I find Dr B in breach of Right 4(2) of the Code.

29. MCNZ notified this Office that Dr B does not currently hold a practising certificate. MCNZ has advised that all available information regarding this matter will be held on file and considered by the Council in future should Dr B apply for a practising certificate.

NP C – adverse comment

30. NP C authorised a repeat prescription for acitretin. This represented a missed opportunity to identify and prevent the continuation of the prescribing error. Although NP C did not initiate the original prescription, it remained their responsibility to adhere to NCNZ's 'Principles for quality and safe prescribing practice' and to ensure that any repeat prescription was clinically appropriate and consistent with the patient's diagnosis, treatment plan, and overall prescribing needs. This included undertaking medicines reconciliation in accordance with medical centre1's Continuity of Care policy to ensure that the patient's medication list was accurate and appropriate at the time of prescribing. I acknowledge that NP C identified the need for a face-to-face review and issued the prescription in the meantime to ensure continuity. However, the instructions communicated to arrange that review did not clearly convey the need for it to occur promptly, and a face-to-face review did not take place prior to Miss A collecting the repeat incorrect medication.

31. Medical centre1's SOP required NP C to review Dr B's prescribing instructions. Issuing a repeat prescription for acitretin to a woman of reproductive age being treated for acne meant that NP C did not identify the inconsistency between the medicine prescribed and the patient's clinical indication and consequently did not appreciate that a further clinical review was warranted. I therefore make an adverse comment regarding this lapse in clinical vigilance by NP C.

Medical centre1 – adverse comment

32. Medical centre1 appropriately classified the incident as a sentinel event, conducted an internal investigation, reviewed its electronic prescribing systems, and implemented staff education. These are positive and constructive actions that reflect organisational accountability. Medical centre1's SOP required clinicians to review the active medication list, prescribing alerts, and the original prescriber's plan before issuing or renewing any prescription and to ensure that medicines with higher-risk profiles are prescribed with appropriate safeguards. I acknowledge Medical centre1's comments that the error occurred despite established prescribing processes and therefore reflected individual error in their application. However, in my view, the fact that multiple medical centre1 clinicians were

involved in the prescribing error indicates that the prescribing environment and system controls did not operate in a way that provided adequate safeguards to avoid prescribing errors. The lack of additional or effective verification measures for high-risk medicines meant that the intent of the SOP, to ensure prescriptions remain clinically appropriate and subject to adequate review, was not effectively met in practice.

33. I therefore make an adverse comment that medical centre1's safeguards were insufficient to prevent or intercept this error and that it should have had appropriate safeguards and additional measures, in line with its SOP, in place to ensure electronic and repeat prescribing processes operated safely and reliably.

The pharmacy – educational comment

34. Although the pharmacy dispensed the prescription it received, there was a missed opportunity at the point of first supply to ensure that the significant risks associated with acitretin, including the requirement to avoid pregnancy for three years after cessation, were explicitly reinforced and confirmed as understood by Miss A. I note the pharmacy's position that the medicine was understood to be a continuation of therapy and that counselling was provided on that basis, and that more detailed counselling was not considered necessary in the circumstances. Under the pharmacy's SOP, pharmacists are required to conduct a clinical check of each prescription, and the Pharmacy Council of New Zealand competence standards for pharmacists (2023)[11] emphasise the application of medicines-safety principles and professional judgement. In this case, confirming patient awareness of the serious teratogenic risks would have strengthened the safeguards in the dispensing process.

35. I acknowledge that a pharmacist's primary responsibility is to ensure that a prescription is dispensed accurately and safely, rather than to question the validity of the prescribing decision itself. However, where medicines carry well-recognised and significant risks, the point at which that medicine is dispensed provides an important opportunity to reinforce key safety information and confirm patient understanding. This applies regardless of whether the medicine is new or a continuation of treatment, particularly where medicines carry significant teratogenic risk. Doing so supports safe practice and aligns with the profession's medicines-safety role. While I acknowledge the reflections provided in this case by the pharmacy, I take the opportunity to emphasise the importance of medicines counselling at the time of dispensing.

Proposed recommendations and follow-up actions

36. Noting that apologies have already been offered, and remedial actions have been implemented as a result of this event, I recommend further that:

- Medical centre1 should provide HDC with confirmation of the actions it has taken to strengthen its electronic prescribing safeguards and repeat-prescribing processes, and evidence that staff have received targeted education on the safe prescribing of retinoids. This information is to be provided to HDC within three months of the date of this report.

[11] Competence-Standards-for-Aotearoa-New-Zealand-Pharmacists.pdf.

37. An anonymised copy of this report will be placed on the HDC website (www.hdc.org.nz), for educational purposes.

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