
General Practitioner

Report on Opinion - Case 97HDC8716

Complaint

The Accident Rehabilitation and Compensation Insurance Corporation ("ACC") advised the Medical Council of a finding of medical error by the provider, a General Practitioner, in relation to the care he provided to the consumer. As required by the Medical Practitioners Act 1995 the Medical Council referred the matter to the Health and Disability Commissioner.

The complaint was that:

In mid-November 1996 the provider, against the manufacturer's recommendation for administration, gave the consumer an intra-muscular injection of Voltaren into her left thigh for the treatment of a unilateral headache. This resulted in an infection at the injection site that has left the consumer with a scar approximately the size of a 5c piece.

A claim to ACC followed with the subsequent finding that the infection and resulting scar were caused from the Voltaren injection being given in the wrong place.

Investigation

On 16 September 1997 documentation was received by the Commissioner from the Medical Council and the Commissioner commenced an investigation on her own initiative. Information was obtained from the provider.

Documentation relating to ACC's assessment of the consumer's claim for medical error was viewed and medical advice was obtained. Product information from Novartis, the manufacturers of Voltaren, was also reviewed.

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Outcome of Investigation

The consumer had a history of migraine and consulted the provider at an After Hours Medical Centre one day in mid-November 1996 suffering from a unilateral headache of three hours' duration. The provider treated the consumer's headache with an intra-muscular injection of Voltaren injecting 75mg of Voltaren into the consumer's left thigh. In his response to ACC the provider stated "*I do note that the manufacturer's recommendation for Voltaren is to inject the drug into the buttock area and most of the time I do utilise this route... I cannot explain to you why I have chosen the thigh as the preferred site of injection in the above case...*"

The consumer advised that following the injection her thigh became swollen and painful to touch. Approximately two weeks later the swelling had started to abate and a large bruise appeared. As the bruise began to resolve a scab developed over the site of the injection.

Approximately one month later the consumer returned to the same medical practice and was seen by a different doctor. The advice given at this consultation was that this outcome can occasionally occur with intra-muscular injections of non-steroidal anti-inflammatory drugs and that the situation would resolve itself over time.

One week later the consumer sought a second opinion after the wound began to develop an infection under the scab. At this consultation the consumer was advised she had an infection at the original injection site. The consulting doctor removed the scab, cleaned and packed the wound, and the consumer was required to attend the clinic every two days for approximately one month to have the wound redressed. The consumer has been left with a scar the size of a 5 cent piece.

Information obtained from Novartis, the manufacturers of Voltaren, states "*the only site approved for Voltaren IM injections is deep into the upper outer quadrant of the gluteal muscles*".

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**Code of
Health and
Disability
Services
Consumers'
Rights**

*RIGHT 4
Right to Services of an Appropriate Standard*

- 2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*
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**Opinion:
Breach**

In my opinion there has been a breach of Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

The provider had an obligation to provide the consumer with services that met professional standards. In order to meet his obligation he needed to follow the manufacturer's recommendation for the approved site for injection of Voltaren. The provider acknowledged his awareness of the manufacturer's instruction that intra-muscular Voltaren should be administered into the gluteal muscles and was unable to offer a reason for his failure to comply with this.

Actions

I recommend that the provider:

- Review the procedures he has in place to ensure his compliance with manufacturers' guidelines for the appropriate administration of medication. On evidence of the procedural review to the Commissioner this file will be closed.

A copy of this opinion will be sent to the Medical Council of New Zealand for their information and a copy with identifying information removed will be sent to the Royal New Zealand College of General Practitioners.

The Commissioner will publish this opinion with identifying information removed in order to raise awareness of this issue.
