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How telehealth consults can go seriously wrong: study

Leading GP academic Professor Trish Greenhalgh says errors are rare but need examining.

Carmel Sparke

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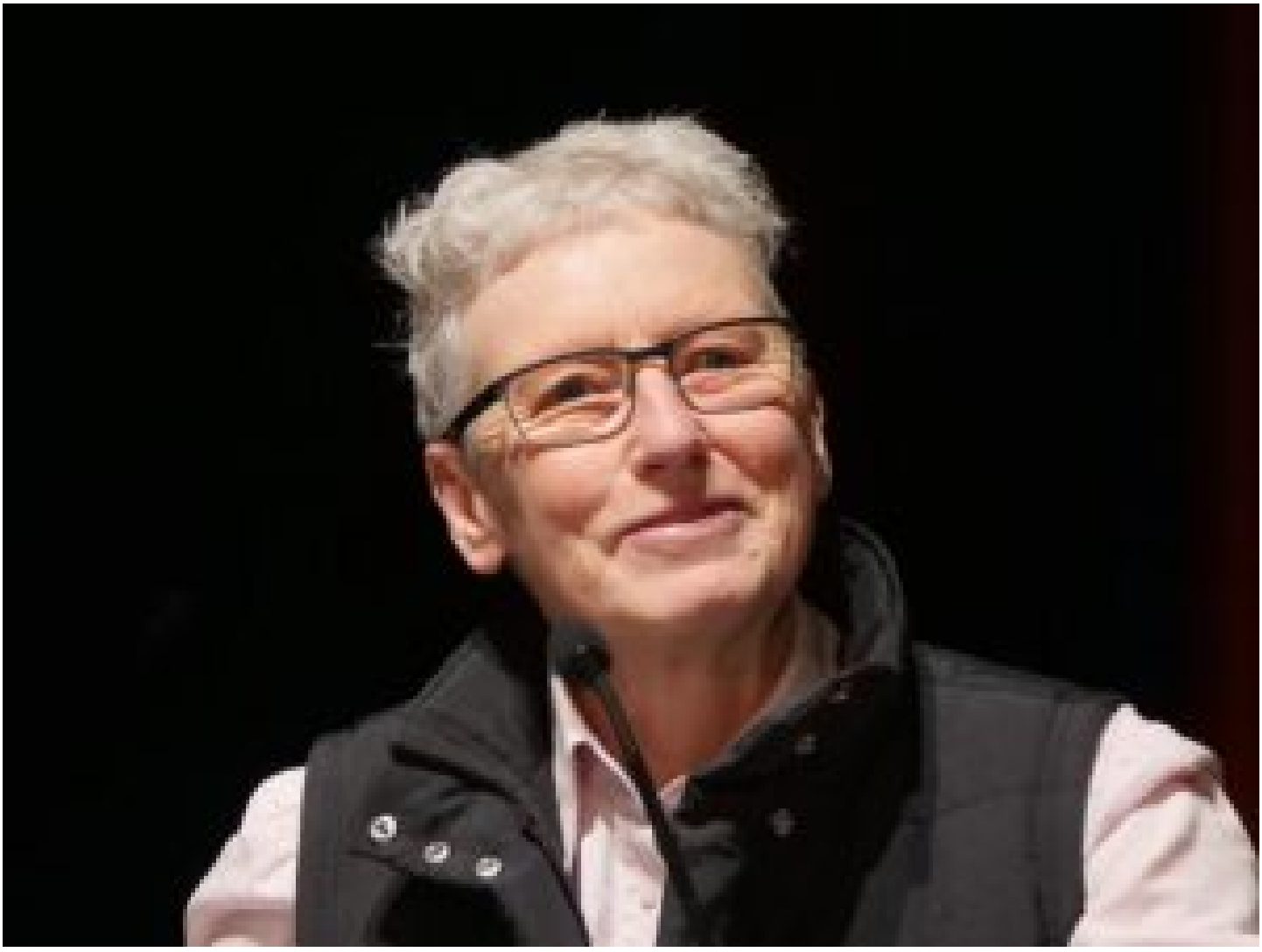

Professor Trish Greenhalgh.

When a GP heard a 16-year-old girl's symptoms of lethargy, fever and poor oral intake during a telehealth appointment, he thought it was likely glandular fever.

So they spoke to the patient's older sister, advising rest, but the teenager later died of sepsis in a hospital ED.

The case was highlighted in a UK study on how to make telehealth triage and appointments safer.

The authors stressed that such sentinel events were rare but that, with telehealth now here to stay, serious near misses required detailed examination.

"The recent widespread expansion of remote triage and remote consulting in primary care means that a wider range of patients and conditions are managed remotely, making it imperative to re-examine where the risks lie," wrote University of Oxford Professor Trish Greenhalgh and co-authors.

Some mistakes related to conditions "which would likely have been readily diagnosed with an in-person examination", the study found.

“Several safety incidents involved clinicians assuming that a diagnosis made on a remote consultation was definitive rather than provisional.”

The study looked at data from 95 UK safety incidents between 2020 and 2023, including formal complaints, settled compensation claims and sentinel event reports.

It also included information from 12 GP practices and interviews with practice staff to identify how practices could improve telehealth services.

In one case, a receptionist was supposed to ask a GP to call a patient in her 70s regarding her “sudden breathlessness”.

“[The receptionist] informed the patient that she would place her on the doctor’s list for an emergency callback,” said the study, published in *BMJ Quality and Safety*.

“The receptionist was distracted by a patient in the waiting room and did not do so. The patient deteriorated and died at home that afternoon.”

In another case, an elderly woman contacted her GP after being diagnosed with constipation by an out-of-hours service.

The GP prescribed laxatives without seeing the patient, but the patient was eventually admitted to hospital, dying during surgery with an obstruction secondary to an incarcerated hernia.

Professor Greenhalgh found that some GP consults were riskier for certain patients, including those with urgent conditions, such as new chest or abdominal pain, palliative care, physical injuries or diabetes.

Errors were characterised by an “inappropriate choice of appointment modality”. But there were also issues of poor rapport building, limited clinical assessment, inappropriate clinical pathway and failure to take account of the patient’s social circumstances.

“These led to missed, inaccurate or delayed diagnoses; underestimation of severity or urgency; delayed referral; incorrect or delayed treatment; poor safety netting; and inadequate follow-up,” the authors said.

They found remote consulting was also be riskier for patients who struggled to understand how the health system worked or if they lacked technology, such as a smartphone, or struggled to use it.

In one case, a 40-year-old woman, who had undergone a caesarean six weeks previously, contacted her GP with shortness of breath, increased heart rate and dry cough.

She was advised to get a COVID-19 test and to call emergency services if she developed a productive cough, fever or pain.

The following day, she collapsed and died at home. The post-mortem revealed a large pulmonary embolus. “

“On reviewing the case, her GP surgery felt that, had she been seen face to face, her oxygen saturations would have been measured and may have led to suspicion of the diagnosis.”

There were also cases where GPs and reception staff did the right thing by patients.

These included when a GP took a phone call from a father who was fairly unconcerned about his child and “underplaying it”.

“Then when I did a video call, you know this child … had intercostal recession … looked really, really poorly,” the GP recalled.

“And it was quite scary actually that, you know, you’d had the conversation, and if you’d just listened to what Dad was saying, actually, you probably wouldn’t be concerned.”

The focus on the safety of telehealth comes amid the ongoing debate about its role in Australian GP care.

Last month, Professor Paul Glasziou spoke about multiple reviews comparing telephone, video and face-to-face consultations that he had assessed for the Department of Health and Age Care.

“The overall conclusion about telehealth was that it was pretty much equivalent to face to face for the management of ongoing conditions … which is a lot of clinical practice.

“For telephone versus video, it’s again pretty similar.”

The director of the Institute for Evidence-Based Healthcare at Queensland’s Bond University, he added: “Diagnosis of acute conditions … can clearly be more difficult over the telephone.

“But there is the old adage that about 80% of diagnosis is done by history, and there are a few reasonable studies that support that.

“The upshot would be that telehealth is probably adequate, just as good as face to face or video, for the vast majority of GP consultations.”

A “subset” of consultations that require physical examinations, he says.

More information: *BMJ Qual Saf* 2023; 28 Nov.

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Reply to A/Prof Chris Hogan OAM

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