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Health Insights

Coroner's findings emphasise the potential risks of relying on telehealth without in-patient review

Recently we published an article outlining some of the risks and limitations for medical practitioners using telehealth to provide care for patients during the COVID-19 pandemic. In particular, we discussed the need for practitioners to consider and assess whether a consultation is safe and clinically appropriate to be conducted via telehealth, or whether an in-person consultation with the patient is necessary. The potentially tragic realisation of the risks associated with relying on telephone consultations was recently flagged by the Coroners Court of Victoria, in findings concerning the death of a 33 year old woman.

Jessica Higgins suffered chronic pain and had a long history of treatment with opioids. In an effort to reduce her use and reliance on opioids, Ms Higgins was admitted to hospital to receive a ketamine infusion. She was discharged on 23 May 2017 with a prescription for 10mg tablets of methadone. The instructions printed on Ms Higgins' box of 20 methadone tablets said to "Take HALF a tablet TWICE a day, in addition take HALF a tablet every SIX hours when required[.] Maximum of 3 tablets in 24 hours"[1] – ie, 30mg maximum. (For completeness, we note that during the coronial investigation Ms Higgins' pain specialist "Dr T" clarified that the "every SIX hours" component of these instructions was incorrectly written, and should have said "a regular dose of 5mg twice per day and allowed up to 5 mg three times per day in addition" – ie, 25mg maximum).

After she was discharged home, Ms Higgins' mother noticed that the medications made her daughter "drowsy and disoriented". She recalls her slurring her speech and that she would fall asleep at various times including at the dinner table[2]. Her mother had the impression that "Ms Higgins was made so drowsy by her medication that she was not fully aware of when she had taken her pills and how many pills she was taking.[3]"

Two days later on 25 May, Ms Higgins attended an in-person consultation with her primary medical practitioner for her chronic pain management, "Dr B". He made a clinical note that her current prescription was "[Methadone] 5mg BD [twice per day] allowed to take extra 5mg up to 15/day (25mg total)". Dr B did not make any notes relating to drowsiness, but included the comment "feels better than before". He also noted that she was taking "[Diazepam] 5mg tds [three times daily] prn [as needed]"[4] and that she was seeing her pain specialist Dr T on 30 May.

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[1] Finding into death of Jessica Higgins without inquest, dated 16 April 2020, paragraph 37.
[2] Ibid, paragraph 42.
[3] Ibid, paragraph 43.
[4] Ibid, paragraph 44.

The next day on 26 May, Ms Higgins telephoned Dr T. He did not make a note of their conversation but recalled it as follows:

> *"We had a discussion about Ms Higgins' pain and the side effects from the medication as well as the reasonableness of bumping up the medication. She felt that pain was still intrusive and in discussion we together elected to increase the dose of her methadone."*[5]

Ms Higgins then telephoned Dr B. He did not make a note of that conversation either, but made a retrospective note on 29 May to the effect that Ms Higgins had called him for a script as she had called Dr T to say that her pain wasn't in control. Ms Higgins advised Dr B that Dr T had suggested a whole tablet (10mg) instead of half. Dr B confirmed this with him via text message. The text message said "just confirming you have advised Jessica to increase [methadone] from 5mg to 10mg [tds]". Dr T replied two minutes later by text message with the word "Correct".[6]

Dr B wrote a script for 'methadone' 10mg tds [three times daily] and Ms Higgins attended a pharmacy that same afternoon and was dispensed one box of 20 tablets of 10 mg methadone with the instructions "Take ONE tablet THREE times a day".

Tragically, the following morning Ms Higgins' mother found her daughter unresponsive on the couch. She was transferred to hospital via ambulance and placed on life support, however after clinical examinations suggested that she had suffered a severe hypoxic brain injury, Ms Higgins' family made the decision to withdraw active life-support measures and she was declared deceased on 4 June 2017.

Coroner McGregor found that Ms Higgins' death was caused "directly or indirectly by the prescription of medications, in particular methadone, in circumstances where her methadone dose had been increased on the day before her fatal overdose and she had been provided with a script for 20 tablets of 10mg methadone[7]". Although His Honour commented critically about a number of aspects of Ms Higgins' care following the ketamine infusion, he focussed primarily on the care provided by both Dr B and Dr T on 26 May 2017 and in particular, on the quality of the communication between the practitioners and the decision to increase Ms Higgins' methadone dosage based on a telephone consultation without requiring an in-person review.

The Coroner considered that the text message sent from Dr B to Dr T confirming the dose change on 26 May was unacceptably vague. The words "increase [methadone] from 5mg to 10mg [tds]" could be interpreted as replacing the twice daily component of the original dose, or the three times-daily component, and that either interpretation would "represent a significant and clearly unsafe increase in her dosage of methadone.[8]" It also raised the question as to what was communicated to Ms Higgins about the dose change in her telephone conversations with the doctors. In the absence of any clinical records, and in light of the unclear text message, the Coroner's view was that if similar shorthand was communicated to Ms Higgins there was ample opportunity for her to be confused. His Honour also found that the use of text

[5] Ibid, paragraph 46.
[6] Ibid, paragraph 48.
[7] Ibid, paragraph 68.
[8] Ibid, paragraph 88.

message to share information between medical practitioners was unsatisfactory, because it did not adequately convey the clinical decision-making of one doctor to another and allowed them to act on "unwarranted assumptions regarding Ms Higgins' state when determining jointly that her dosage of methadone should be increased.[9]"

The Coroner's second major criticism of both Drs B and T, related to their failure to require Ms Higgins to attend an in-person review before increasing her dose of methadone on 26 May. In response, Dr T said that:

> *"…he accepted that it would have been wise to review Ms Higgins in person prior to advising her GP of the dose increase. If there was any evidence of sedation, then I would not have increased the dose. Given that she had seen Dr B the day before on 25 May 2017, I accepted that this was not the case."*[10]

Dr B similarly said that although an in-person consultation on 26 May would have been "ideal", given that he had reviewed Ms Higgins the day prior and noted no concerns (and where he held no concerns about the dose change and because Ms Higgins was due to be reviewed four days later by Dr T), he was comfortable with providing the prescription.[11]

Coroner McGregor was unconvinced, and suggested that Ms Higgins was a high risk patient having received a ketamine infusion in circumstances where her opioid consumption had recently escalated, and that this ought to have made Dr T more careful in his involvement in her post-discharge care.[12] Further, while the increase in dose (as it was understood by both Drs B and T) was within accepted guidelines, such an increase might not be acceptable if Ms Higgins' sedation levels (as recalled by her mother) prior to the change in dosage had been taken into account[13]. In His Honour's view:

> *"…this was a missed opportunity to detect whether Ms Higgins' methadone dose was causing dangerous side effects and whether increasing it would put her in danger of overdose…the failure to require an in-person review before increasing her dosage impaired the ability of both practitioners to properly assess the dangers of this increase. This contributed substantially to Ms Higgins' risk of fatal overdose, which was realised."*[14]

The Coroner considered that the "qualified acknowledgements" made by both practitioners did not address the "severity of the failures in Ms Higgins' care[15]", and he made the decision to notify both of them to AHPRA for further investigation.

There is no doubt that the circumstances of Ms Higgins' death represent a worst case scenario as to what may occur if telehealth is used inappropriately or without careful consideration as to whether an in-patient review is also warranted. However, it ought to provoke reflection for health practitioners who may be using

[9] Ibid, paragraph 96.
[10] Ibid, paragraph 99.
[11] Ibid, paragraph 105.
[12] Ibid, paragraph 76.
[13] Ibid, paragraph 86.
[14] Ibid, paragraphs 103 – 104.
[15] Ibid, paragraph 106.

telehealth for the majority of their patient consultations at present, and serve as a reminder to be wary of assumptions which may be more easily formed when telehealth, as opposed to an in-patient review, is conducted. In particular, it highlights the need to assess the particular vulnerabilities of individual patients and the possibility of "missing an opportunity" to provide better or more appropriate clinical care in-person.

Meridian Lawyers regularly provides advice and assistance to practitioners and organisations who may be involved in coronial investigations or inquests. This article was written by Principal Kellie Dell'Oro and Associate Anna Martin. Please contact us if you have any questions or for further information.

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