# Would better policing of metabolic status help you avoid medicolegal worries?

**Christopher P. Marett, MD, MPH, and Douglas Mossman, MD**

Dear Dr. Mossman,

All the psychiatrists at our clinic agree: It is hard to remember when our patients who take an antipsychotic are due for metabolic monitoring, and it's even harder to get many of them to follow through with timely blood tests. For many, stopping their medication would be a bad idea. If we keep a patient on an antipsychotic and a metabolic problem results, how serious is our malpractice liability risk?

Submitted by "Dr. V"

Antipsychotics, the mainstay of treatment for schizophrenia,[1] put patients at risk of gaining weight and developing metabolic syndrome, including type 2 diabetes mellitus, hypertension, and dyslipidemia.[2] Second-generation antipsychotics are the biggest offenders, but taking a first-generation antipsychotic also can lead to these adverse effects.[3]

Most psychiatrists are aware of these risks and prefer that their patients do not experience them. However, many psychiatrists neglect proper monitoring or, like Dr. V, find it hard to ensure it happens and thus worry about clinical deterioration if patients stop taking an antipsychotic.[4] If you are in the same situation as Dr. V, what medicolegal risks are you facing?

To answer this question, we will:

- review the clinical guidelines and standards for monitoring metabolic effects of antipsychotics
- examine how well (or poorly) physicians adhere to these standards
- discuss what "standard of care" means and how a practice guideline affects the standard effects
- propose how psychiatrists can do better at policing the metabolic effects of antipsychotics.

## I'll be watching you: Following guidelines

Several medical specialty societies have published guidelines for monitoring the metabolic effects of antipsychotics.[5-8] These guidelines instruct physicians to obtain a thorough personal and family history; consider metabolic risks when starting a medication; and monitor weight, waist circumference, blood pressure, glucose, hemoglobin $A_{1c}$, and lipids at various intervals. They also advise referral for management of detected metabolic problems.

Although the recommendations seem clear, many physicians don't follow them. A 2012 meta-analysis of 48 studies, covering >200,000 antipsychotic-treated patients, showed that baseline measurements of cholesterol, glucose, and weight occurred in <50% of cases.[9] A more recent review found that, among adults with a serious mental illness, the rate of lipid testing varied from 6% to 85% and for glucose monitoring, between 18% and 75%.[10] In the first years after anti-

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**Douglas Mossman, MD**
Department Editor

**DO YOU HAVE A QUESTION ABOUT POSSIBLE LIABILITY**

▶ Submit your malpractice-related questions to Dr. Mossman at dmossman@frontlinemedcom.com.

▶ Include your name, address, and practice location. If your question is chosen for publication, your name can be withheld by request.

## Clinical Point

**Uncertainty about who should monitor metabolic status has been a commonly cited reason for insufficient monitoring**

Table 1

### Variables that increase the likelihood that a court will find a practice guideline to be the prevailing standard of care

| |
|---|
| Guideline is directly relevant to the case |
| Guideline comes from a reliable source |
| The medical treatment is not complex or controversial |
| Clinical recommendations are clear and specific |
| Scientific evidence supported the guideline when it was created |
| Available guidelines concur about the same treatment |
| Treatment proposed by the guideline is cost-effective |
| Employer uses the guideline for training on a clinical policy |
| Guideline comes from a medical society rather than a health maintenance organization or malpractice insurer |
| Recently updated |

**Source:** References 33-35,39,41

psychotic monitoring guidelines were established, they had only a modest impact on practice,[9,11] and some studies showed the guidelines made no difference at all.[12-14]

Monitoring compliance varies with the type of insurance coverage patients have but remains suboptimal among the commercially insured,[11] Medicaid patients,[14-16] and veterans.[17,18] Studies on antipsychotic treatment in children, adolescents, patients with dementia, and patients with an intellectual disability show insufficient monitoring as well.[9,14,17,19-21] The reasons for these gaps are manifold, but one commonly cited factor is uncertainty about whether the psychiatrist or primary care physician should handle monitoring.[22]

## Every claim you stake: The 'standard of care'

In a medical malpractice case, the party claiming injury must show that the accused physician failed to follow "the generally recognized practices and procedures which would be exercised by ordinary competent practitioners in a defendant doctor's field of medicine under the same or similar circumstances."[23] In the studies mentioned above,[9-14] a large fraction of psychiatrists—many of whom, we can presume, are "competent practitioners"—don't follow the antipsychotic monitoring guidelines in actual practice. *Could failing to follow those guidelines still be the basis for a successful lawsuit?*

**The answer seems to be 'yes.'** Published legal decisions describe malpractice lawsuits alleging physicians' failure to follow antipsychotic guidelines,[24,25] and online advertisements show that attorneys believe such cases can generate a payout.[26,27] This may seem odd, given what studies say about psychiatrists' monitoring practices. But determining the "standard of care" in a malpractice case is not an empirical question; it is a legal matter that is decided based on the testimony of expert witnesses.[28] Here, customary practice matters, but it's not the whole story.

Although the standard of care against which courts measure a physician's actions "is that of a reasonably prudent practitioner …, The degree of care actually practiced by members of the profession is only some evidence of what is reasonably prudent—it is not dispositive."[29] To support their opinion concerning the standard of care, testifying medical witnesses sometimes use practice guidelines. In this case, an explanation of why a particular guideline was chosen is crucial.[30]

**Using guidelines to establish the standard is controversial.** On one hand, using guidelines in malpractice litigation allows for some consistency about expectations of practitioners.[31,32] Although guidelines are not identical to evidenced-based medicine, they generally reflect an evidence-based expert consensus about sound medical practice. If a hospital uses a guideline to

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train its employees, the guideline provides the courts with clear information on what should have happened.[33,34] Laws in some states allow clinicians to invoke their adherence to a guideline in defense against malpractice claims.[35]

On the other hand, critics contend that guidelines may not set an accurate standard for the quality of care, nor do they necessarily reflect a proper balance of the conflicting interests of patients and the health care system.[36] The American Psychiatric Association states that its practice guidelines "are not intended to serve or be construed as a 'standard of medical care.'"[37]

Conformity is not the only measure of prudent practice, and following guidelines does not immunize a clinician from lawsuit if a particular clinical situation demands a different course of action.[32] Guidelines can be costly to implement,[36] compliance with guidelines generally is low,[35] and national guidelines do not necessarily improve the quality of care.[38] Last, relying on guidelines to determine the standard of care might stifle innovation or development of alternate approaches by silencing viewpoints.[39,40]

***Table 1***[33-35,39,41] (***page 60***) summarizes variables that make a guideline more indicative of the standard of care.

## Every step you take: Better monitoring

Medical professionals often are slow to update their practice to reflect new knowledge about optimal treatment. But practice guidelines influence the court's views about the standard of care, and Dr. V's question shows that he and his colleagues agree that metabolic status needs to be better monitored when patients take antipsychotic drugs. The following discussion and ***Table 2***[42-45] offer suggestions for how psychiatrists and their practice settings could better accomplish this.

**Electronic health records (EHRs).** Monitoring health indices often is the largest hurdle that health care professionals face.[46] However, large health care systems with EHRs are in a good position to develop and implement automated computer routines that track which patients need monitoring and note due dates, abnormal results, and management interventions.[42] Some studies suggest that monitoring rates in both inpatient[47] and outpatient[48] settings improve with built-in EHR reminders. However, if a system uses too many reminders, the resulting "alert fatigue" will limit their value.[22] Providing individual feedback about monitoring practices may enhance physicians' buy-in to reminder systems.[48]

**Integrated care systems** can improve patient outcomes, particularly antipsychotic monitoring. Advantages include shared funding streams, a unified medical record, coordinated scheduling of psychiatric and primary care appointments, and addressing blood-draw refusals.[43] More frequent primary care visits make antipsychotic monitoring more likely.[11] Ultimately, integrated care could resolve problems related to determining which clinicians are responsible for monitoring and managing adverse metabolic effects.

continued

**Table 2**

### Ways to improve metabolic monitoring

| |
|---|
| Use an automated computer system to track and alert clinicians about due dates |
| Consider practicing in an integrated care setting |
| Develop relationships with primary care doctors |
| Use managed care interventions to your advantage |
| Choose and implement "physical health months" |
| Provide or obtain feedback on individual performance compared with colleagues |
| Keep an instructional tool handy (eg, www.cqaimh.org/pdf/tool_metabolic.pdf) |

**Source:** References 42-45

**Clinical Point**

**Using a guideline allows for some consistency about expectations of practitioners and provides the court with procedures**

## Clinical Point

**Use an automated computer system to track and alert clinicians about due dates to follow-up with patients taking an antipsychotic**

**Third-party payers.** Managed care interventions also could improve monitoring rates.[44] Prior authorization often requires physicians to obtain appropriate lab work. Insurers might contact physicians with educational interventions, including free webinars, provider alerts, and letters about monitoring rates in their region. Some insurers also provide disease management programs for patients and their caregivers.

**Individual and small group practices.** Psychiatrists who practice outside a large health care system might designate 2 months each year as "physical health months." In the "Let's Get Physical" program,[45] physicians were given longer appointment times during these months to address metabolic monitoring, provide education about managing side effects of medication, and encourage better diets and exercise.

Overall, the best techniques might be those implicit to good doctoring: clear and open communication with patients, effective patient education, respect of informed consent, and thorough follow-up.[49]

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## Bottom Line

Although many psychiatrists don't monitor the metabolic effects of antipsychotic medications, they should. Checking patients' vital signs and following basic lab work require relatively modest investments of time and money, and the potential benefits—preventing serious illness, reducing disability, and avoiding possible legal liability—are large.

### Clinical Point

**Designate 'physical health months' to address metabolic monitoring, provide education, and encourage better diet and exercise**

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