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The stage-value model: Implications for the changing standards of care

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ABSTRACT

The standard of care is a legal and professional notion against which doctors and other medical personnel are held liable. The standard of care changes as new scientific findings and technological innovations within medicine, pharmacology, nursing and public health are developed and adopted. This study consists of four parts. Part 1 describes the problem and gives concrete examples of its occurrence. The second part discusses the application of the Model of Hierarchical Complexity on the field, giving examples of how standards of care are understood at different behavioral developmental stage. It presents the solution to the problem of standards of care at a Paradigmatic Stage 14. The solution at this stage is a deliberative, communicative process based around why certain norms should or should not apply in each specific case, by the use of "meta-norms". Part 3 proposes a Cross-Paradigmatic Stage 15 view of how the problem of changing standards of care can be solved. The proposed solution is to found the legal procedure in each case on well-established behavioral laws. We maintain that such a behavioristic, scientifically based justice would be much more proficient at effecting restorative legal interventions that create desired behaviors.

This paper discusses the use of behavioral value and hierarchical complexity in relation to the legally binding standards of care and the fact that they continuously change in meaning and practical application. The changing standards of care create a problematic relation between the legal system and psychiatric practices. This problem is discussed from the perspective of the Model of Hierarchical Complexity and value in behaviorism. The paper consists of four parts.

In Part One the general problem is discussed and outlined and a Model of Hierarchical Complexity perspective of the issue is introduced.

In Part Two, a Paradigmatic Stage 14 solution is proposed: to build a framework of metanorms ("norms about norms") and base the legal communicative process on an ongoing application of these metanorms.

Part Three discusses the possibility of a Cross-Paradigmatic Stage 15 solution to the problem of changing standards of care. This solution builds largely on applying what is known from the behavioral sciences in terms of behavioral reinforcement (value), learning and development (stages using the Model of Hierarchical Complexity). The aim of such a behaviorally founded solution is to give legal institutions a clear and empirically based framework that is flexible enough to handle each particular case. At the heart of the Cross-Paradigmatic Stage 15 solution is the interaction of stage and value, where what is valuable to the legal parties changes with the complexity of the tasks and the developmental stages of the individuals.

In Part Four, the notion of "free will" is discussed and the concluding end note summarizes some of the main points of the paper.

1. Part One: hitting a moving target

Standards of care function in an ever changing environment as society, technology and science change. In a society with rapid social change, innovation, growth and an increasing impact of disruptive technologies, i.e., the society of the foreseeable future, this holds doubly true. This is likely to lead to an increase in the administrative duties that psychiatrists and physicians must abide to and an increase of "managed care" where psychiatrists and physicians are monitored and controlled in greater detail (Appelbaum, 1993).

The first inherent problem of this development is the pressure on psychiatrists and other medical professionals that comes increasing liability combined with the unpredictability of health care. This tendency is likely to foster overly risk aversive decision making in the medical profession, providing perverse incentives for professionals to avoid liability rather than to optimize risk taking in their medical practices. Optimizing health care includes the balancing of the possible gains with possible risks. Thereby this problem can be hypothesized to decrease the quality of care in complex and hazardous psychiatric and medical issues.

The second and perhaps most fundamental problem has to do with the legal outcomes of the standards of care. If a standard of care is legally

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set and the circumstances change, then the rule can have effects that were unforeseen or counterproductive. The application of rigid standards of care can have consequences that are inconsistent with public and professional notions of justice.

Hence no absolute standard of care can be set that is fully consequential, functional, and working according to a preset "intention" of the law. Essentially, laws and standards fail to "hit a moving target". The "hitting a moving target" metaphor refers to two things: a) The difficulty, if not impossibility, of anticipating and taking into account changes in science, technology and society; b) The sensitivity in each legal case toward its unique "initial conditions".

We will exemplify both of these points below. The first point is specific to a highly complex, rapidly changing society. The second point is more general, and has its mathematical rationale in chaos theory. Any complex system by necessity has "sensitive initial conditions", meaning that small shifts in details have dramatic consequences for the shifts in outcome.

2. Example 1: Schilling v. Ellis Hosp, 2010

The following excerpt is from Schilling v. Ellis Hosp (2010):

> "In March 2006, plaintiff's son […] was admitted to the psychiatric unit […] due to manic behavior associated with his bipolar mania. During his eight-day stay at Ellis [the hospital], [the psychiatrist] increased [the patient's] dosage of Risperdal, a psychotropic drug. […] At the time he was admitted to Ellis, [the patient] was taking two milligrams per day, which [was gradually increased]. After [the patient] was released, [his other psychiatrist] maintained the eight-milligram dosage until late June 2006, at which time he ceased prescribing Risperdal after diagnosing [the patient] with gynecomastia, or enlargement of the breasts, which [the other psychiatrist] concluded would have to be treated with plastic surgery."

The 15 year old boy had grown enlarged breasts, probably as a side effect of taking Risperdal, and his mother sued the hospital and the doctor. The defense was dismissed by the court and the doctor was held responsible. The doctor claimed to have followed a standard of care that had been accepted for a longer period of time, but was nevertheless held responsible for breaking the standard of care by not informing the boy and his parents of the risks of gynecomastia. The doctor had failed to establish "informed consent".

The key issue here is that the information about the drug had changed, meaning that the standard of care had changed along with the new information. What had been in accordance with the "standard of care" some years earlier was now considered as an illegal break of the standards of care. This places the medical practitioner in an overly precarious situation, creating incentives for exaggerated caution in medical practice.

3. Example 2: The People v. Sheehan, 2013

"Jenna's Law" regulates the so called battered person syndrome, when the offender of a violent crime has herself been subjected to domestic violence by the victim. The following excerpt is from The People v. Sheehan (2013).

> "In 'Jenna's Law' […] the Legislature provided an exception, contained in a new Penal Law § 60.12, which allows a court to sentence a first-time violent felony offender to an indeterminate term of imprisonment if the victim's domestic violence against the offender was a factor in the offender's commission of the crime."

These judges are referring to a recent change in the law, where "Jenna's Law" refers to the legal implementation of the battered woman syndrome, which had up until this case not been successfully used. When Sheehan was charged with the murder of her husband, a retired ex-police officer in New York, her defense claimed the "battered woman" or "battered person" defense. The defense succeeded in getting her acquitted from the murder charges by displaying evidence of a long period of serious abuse. The battered person syndrome explains why the accused did not take another, non-violent, course of action, like leaving her husband or going to the police. A person suffering from the syndrome is thought to be unable to act independently of her abuser. It can be used as a defense even for violence that is not directly linked to immediate self-defense. Sheehan received a 3.5 year sentence for "criminal possession of a weapon in the second degree", the two pistols she had taken from her husband when she shot him a total of eleven times while he was shaving in the bathroom.

This case displays how psychiatric reasoning plays an increasingly vital role in the legal system, affecting notions of justice, crime and punishment. The fact that the battered person syndrome can be explained by a summoned expert witness underscores that the application of the law changes independently of the decisions made by legislators. However, the battered person syndrome, while existing in the psychiatric literature, is not a standard within the psychiatric community and is a still an area of dispute (Downs, 2005) (Noh & Lo, 2003, August 16). Once used in a legal case, the syndrome takes on a life of its own as case law.

The indeterminacy of rules and regulations hence goes both ways: the rules and regulations take on new effects in e.g., psychiatric practice, while psychiatric discourse in turn shapes the rules and regulations. This creates a weak foundation for the relationship between psychiatry and law. The standard of care essentially rests on a self-referential system, where psychiatry in some cases is influenced by legal developments and vice versa.

4. Example 3: the legal uses of DSM-5

There are several differences in the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2013) from the earlier DSM-IV-TR (2000). The differences include dropping Asperger syndrome as a distinct classification; loss of subtype classifications for variant forms of schizophrenia; dropping the "bereavement exclusion" for depressive disorders; a revised treatment and naming of gender identity disorder to gender dysphoria, and changing the criteria for posttraumatic stress disorder (PTSD).

The DSM-5 is based on the study of symptoms rather than causes or a dimensional analysis of mental health, personality and functionality. The descriptions of symptoms are used to make categorizations of psychiatric diagnoses to harmonize treatment and make treatment more consequential. In the legal system, these categorizations are what determine the legal responsibility of individuals for their actions.

While sensitivity to subcategories and scales is certainly present in the DSM-5, the manual still works with categories that are fundamentally binary, such as schizophrenic or non-schizophrenic even though there is usually a four point scale, not at all to very serious. These categories are subject to change of both definition and interpretation, which reveals another source of inconsistency in the relationship between psychiatry and the law. The fact that these categories and their clinical application have real legal consequences in courts introduces a whole area in which the use and interpretation of the law falls outside the hands of legislators.

Again, this relationship short-circuits the relationship between psychiatry and the law, where psychiatry is subject to the law and the law paradoxically is subject to the developments of psychiatry, including changes in psychiatric standards that have implications for the standards of care. The standards of care can change as the psychiatric diagnostics change, making any rigid rule or regulation less consistent and reliable. In practice, then, psychiatric practitioners can hardly be held accountable with by one uniform standard, as the diagnostics upon which the standards and rules rest are subject to redefinition and change. Essentially, any rigidly held standard of care must attempt and eventually fail to hit a moving target. This compromises the