MANIPULATING BEHAVIOR: DEFINING THE ETHICAL LIMITS OF BEHAVIORAL CONTRACTING IN THE HEALTHCARE SETTING

BY

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INTRODUCTION

Healthcare providers are known to sometimes implement contractual arrangements with their patients in order to encourage and facilitate certain behaviors. These behavior contracts typically lay out a very specific set of required and prohibited patient actions. When the patient signs the contract, she affirms that she will adhere to the terms and undertake or refrain from the specified actions in exchange for receiving a certain therapy. For example, pain management physicians who regularly utilize addictive opioids to alleviate chronic pain will sometimes draw up a contract that dictates dosing and other guidelines in an attempt to diminish the chance that the patient will develop addictive behavior or otherwise misuse the drugs. The patient must agree to adhere to the guidelines in order to continue receiving prescriptions, knowing full-well that non-adherence might result in the termination of therapy or some other consequence. In another example, physicians ask patients to sign contracts prior to undergoing stem cell transplants. In this case, the terms of the contract dictate rules to which the patient must adhere, not only to be eligible for the therapy, but also to maximize the chances that the transplant will be a success.

In certain rare cases, however, a physician might also invoke a special sort of contract in order to address problematic, unforeseen patient behaviors in order prevent them from recurring. This thesis draws from a small pilot study on contracts that I undertook at a university health system in the Southeast. The study followed a controversial ethics consult involving the attempted “firing” of a patient who violated one such behavior contract. The case involved a male in his early thirties who suffered from aggressive Crohn’s disease and short gut syndrome (SGS). Because of the SGS, the patient’s body was unable to adequately process food ingested by mouth and he therefore

required total parenteral nutrition (TPN) on a daily basis, which he received through an indwelling line in his chest. The TPN was critical to the patient's survival and he likely would have survived less than a week without it, since he was also dependent on it for hydration, as well as for supplemental nutrition. To complicate matters further, the patient had been in and out of the health system for various reasons over the years and routinely tested positive for drug use, which had been known to include cocaine, amphetamine, and methamphetamine.

In an attempt to address the patient's drug use and other problematic behaviors, his healthcare providers contrived a contractual arrangement that mandated several terms. First, the contract mandated that in order to remain in the care of both the health system and the physician who was prescribing TPN to him, the patient was required to abstain from illegal drug use, for which he would periodically be screened upon visiting the health system. Second, the physician would continue to sign off on the TPN orders as long as he had the approval and guidance of the TPN nurse, who was charged with monitoring and managing the patient's TPN therapy and nutritional needs. Third, the TPN nurse would cease to assist with TPN management in the event of another positive screen for drug use, thus resulting in the physician no longer writing TPN prescriptions for the patient. Fourth and finally, the contract dictated that any non-adherence with the listed terms would result in a patient firing, that is to say, that a violation of the contract would result in the patient's being dismissed from both the physician's care and the health system.

Without any further information, this case is already troubling for a number of reasons and raises a multitude of ethical questions, including questions regarding the

nature and legitimacy of the aforementioned contract. Many of these issues involve various intersections of ethics, law, and neuroscience, and will fall outside the scope of this thesis. But for the sake of illustrating the complexity of the issue, one needs only to look at the central ethics questions at the heart of this case, which deal with whether or not it was permissible for the healthcare team to threaten the cessation of care for this very problematic patient in light of his repeated violations of the contract terms. The ethics considerations become quite complex as one delves into them.

On the one hand, it is true that the patient had not abided by the terms of the document, which expressly and explicitly threatened him with end of care if he tested positive for drug use. Proponents of patient firing might argue that due to the reverence we hold in our society for the status of written agreements between persons, one could justify patient firing because he consented to the terms of the document and consequently broke his word by engaging in drug use after ultimately agreeing not to do so. In actuality, the healthcare team argued at one point that it was within their right to cease participating in the patient's care due to some sort of conscientious objection or moral scruple against not only the violation of the contract, but also against his poor lifestyle decisions. While this is certainly a stretch in the interpretation of the law, conscientious objection clauses in many states do permit some healthcare providers to refrain from participating in therapies that they find to be morally objectionable. On an entirely separate note, though, proponents might also invoke notions of distributive justice and fair allocation of healthcare resources in order to argue that the devotion of TPN and the healthcare providers' attention to such a problematic patient is ethically unsound. It is not uncommon for bioethicists to look to principles of justice in the distribution of therapies,

medications, and the like to non-adherent patients.[1] But this in turn simply raises additional questions about when, if ever, a healthcare provider should make value judgments regarding both the lives of their patients and who is ultimately the most "deserving" of receiving certain treatments and therapies.

In stark contrast to positions held by proponents of patient firing, the opponents in this case might cite literature pointing to the inherent difficulties that drug addicts face in controlling their addictive behaviors. The opponents might then make an argument that the patient's inability to control his urges ultimately negated the legitimacy of the contract, since it might not have been within his power to abide by the terms in the first place. Additionally, opponents might argue that because of the oft-acknowledged special nature of the medical profession, the healthcare team had an ethical obligation to continue treating the patient, regardless of his non-adherence to the contract. In order to deflect appeals to distributive justice, they might argue that such an appeal undermines the patient's value as an individual human being and that appeals to distributive justice and societal benefit are simply not sufficient to override a prima facie duty of the physician to treat a sick patient. Finally, in addressing the conscientious objection argument, opponents of patient firing would simply deny the assertion that moral objection to lifestyle could possibly preclude a patient from continuing to receive life-saving care. Ultimately, whether or not conscientious objection was justifiable in this particular case,

[1] Tom Beauchamp & James Childress, *Principles of Biomedical Ethics*, (New York: Oxford University Press, 2009), 272-281.

the healthcare providers' desires to stop caring for the patient were rendered moot due to the lack of any other healthcare providers who were willing to take over his care.

We can delve still deeper into the ethical questions by examination of the options that the medical team had at its disposal. There are three obvious courses of action from which the team might have chosen in their determination of how best they could have moved forward with this patient. First, the physician and nurse might have continued to provide care for the patient, despite their opposition to his behavior, his non-adherence with the terms of his therapy, and his continued drug use, with no modifications to the relationship between them and the patient. This, ultimately, would have amounted to simply maintaining the status quo. Second, they might have sought to alter their relationship with the patient in some way, perhaps by attempting to draw up a new contract with different terms, or by introducing other medical professionals into the relationship in an attempt to diminish and ultimately shift their roles and duties toward a more shared model of responsibility. The team did in fact seek to have the patient admitted to an inpatient rehabilitation facility, but their efforts proved unsuccessful due to the patient's complex medical situation and lack of a facility willing to admit him. Third and finally, and what ultimately occurred in our case example, was that the team began the process of dismissing the patient from their services upon consulting with members of the health system's administrative staff. They thus sought, within the scope of the law, to permanently end their relationship with the patient.

Much of the hesitation and difficulty around the decision to end the relationship with the patient had to do with the inability of the team to find another outpatient care provider. Were the team to dismiss the patient from care, thus resulting in his harm from

deprivation of needed medical therapy, the team would have certainly been legally liable for abandoning him. Additionally, firing the patient might have only worsened many of the aforementioned dilemmas because emergency departments (EDs) are open to all patients under federal law and thus most likely, the patient would have presented to the ED as his health situation worsened. A significant fear expressed by his providers was that, were the patient to present to the ED, he could have fallen into a sort of indefinite and costly in-patient limbo until another willing healthcare provider could be identified, whenever that may have been. In other words, they did not want the patient to become a sort of "permanent resident" of the health system, were he to be dismissed from their care.

I offer the aforementioned case merely as an illustrative example of the complex ethical considerations that arise as a result of the use of behavior contracts to deal with patient non-adherence. The pilot study that succeeded this ethics consult involved a series of semi-structured interviews with several healthcare providers, social workers, and hospital administrators, who were aware of behavior contracts or had first-hand experience using them. For the sake of the investigation and to account for as wide a degree of variation as possible, I initially defined behavior contracts as any oral or written arrangement between a person and a healthcare provider that outlines how a person must act in order to receive something that a healthcare provider can offer. My research questions were simple and dealt with examining behavior contracts within the context of the samples I discovered, categorizing the types of behavior contracts that existed, exploring how they were used and how they came into existence, and examining how their use was perceived by employees within the health system. Responses from the

interviews greatly varied between a range of lukewarm approval of contract use to vehement disapproval. Additionally, and as expected, my interview findings also suggested a wide range of variation in the goals of these contracts and their uses in healthcare.

Following my completion of both the interviews and the content analysis, I began to review literature on the history of behavior contracting and its use in the healthcare setting. It was much to my shock that there was not much literature available on healthcare behavior contracts at all. Consequently, I began to look at the use of behavior contracts in other contexts and discovered that these documents bore a strong resemblance to forms of psychotherapies and other contract-based behavior therapies. Gradually, I developed the suspicion that behavior contracts in healthcare actually have their roots in psychotherapeutic behavior manipulation. From there, I began to examine the data from our study within that psychotherapeutic framework. Many questions then arose in my mind regarding the ethical uses of these documents, given the fact that upon comparison, many of them are difficult to distinguish from contract-based cognitive behavioral therapies. I concluded ultimately that while it might not necessarily be appropriate to call behavior contracts "psychotherapies," the psychotherapeutic framework provides a useful lens for examining very pertinent ethical questions that emerge due to their use. Thus, within the scope of this thesis, I hope to examine some of the ethical difficulties associated with the use of these documents under the scope of this psychotherapeutic lens, and hopefully, to provide some overarching guidelines for their use within healthcare.

This thesis, therefore, is laid out as follows. In Chapter 1, I provide an overview of the available literature on psychotherapeutic, contract-based therapies, devoting

special attention to the works of Karl Menninger, Daniel S. Kirschenbaum, and others, who wrote extensively on the use of contract-based behavior interventions between the years 1960 and 1990. I examine these theoretical models of behavior promotion in an attempt to offer both additional depth and context to behavior contracts as methods of healthcare behavior promotion. In Chapter 2, I examine healthcare behavior contracts specifically, drawing from an older work by Timothy Quill who proposed a contract-based model to healthcare interactions between patients and physicians. By drawing on this work, I then propose a specific definition of what healthcare behavior contracts actually are. This definition differs slightly, yet purposefully, from the definition I used to guide my pilot investigation. Third and finally, in Chapter 3, I provide a brief overview of some of the emergent themes from my research study and then examine ethical issues around behavior contracting within the context of its uses in healthcare and its psychotherapeutic roots. I then re-examine the case study that I presented in this chapter and end this thesis by providing general guidelines for behavior contract use within the clinical setting.

CHAPTER 1: PSYCHOTHERAPEUTIC BEHAVIOR MODIFICATION

In my introduction, I noted that it seems that very little theoretical work has been done *specifically* on contracting in non-psychotherapeutic clinical healthcare scenarios and thus, the distinction between a healthcare behavior contract and a psychotherapeutic behavior contract might be difficult to ascertain. I propose that a key difference between a healthcare behavior modification and a psychotherapeutic behavior modification is that the former seeks to alter a behavior as a means to a *separate* end while the latter seeks to alter a behavior as an *end in itself*. In fact, upon closer examination, one can only distinguish between many of these methods of behavior modification by the nature of the ends that they seek to achieve. This perspective was inspired, in part, by one of my research subjects who described non-compliance of patients who have psychosocial issues as types of treatment co-morbidities. In fact, he spoke of a discrimination against the treatment of psychosocial "comorbidities" in the medical community and further argued that treating problematic behaviors as comorbidities allows for greater degrees of physician objectivity. I extrapolated his position further and reached a separate conclusion that if adverse behavioral issues should be treated like comorbidities within a clinical context, then attempting to change them invariably makes healthcare behavior contracts even more treatment-like.

To further illustrate the distinction between a means to an end versus an end in itself, suppose that a patient in a psychotherapeutic setting were to contract with his therapist for the purpose of losing weight. Losing weight is the patient's final goal and the goal is therefore an *end in itself*. This is different from losing weight where the weight loss is a condition, or a means, of achieving some separate goal, such as becoming eligible for a lap band or an organ transplant, in either case of which the patient must

weigh below a certain threshold to be eligible for the therapies. Rather than contracting to lose weight for the sake of losing weight, the patient contracts to lose weight for the purpose of receiving a secondary therapy. The weight loss is therefore a *means to an end*, rather than an *end in itself*. I find the distinction between a *means in itself* and a *means to an end* to be a useful scheme for separating psychotherapeutic behavior modification from healthcare behavior modification. That being said, the latter type of behavior modification almost certainly has its origins in the former. I explore the connection between the two in this chapter in order to offer additional depth to the discussion of behavior contracts as therapeutic tools. I begin this chapter with a brief introductory overview to psychotherapeutic contracts and then delve further into cognitive behavioral therapy, a particular school of psychotherapy that I believe captures the spirit of what the healthcare behavior contract seeks to accomplish.

In *Theory of Psychoanalytic Technique*, Dr. Karl Menninger alludes to the difficulties of nailing down a precise definition of what constitutes "psychotherapy" and then defines it descriptively as a "formal treatment of patients distinguished by its dependence upon psychological rather than physical or chemical agents…. The psychological methods referred to are conventionally understood to be those using principally verbal communication. All treatment aims at ameliorative change of the patient by something done or said by the therapist…. [and furthermore] all treatment is transactional and contractual."[2] To illustrate the nature of this transactional and contractual arrangement further, Menninger begins by comparing a patient first to a

[2] Karl Menninger, *Theory of Psychoanalytic Technique*, (New York: Basic Books, Inc., 1962), 16-17.

customer, while the therapist is characterized as the qualified, authorized, prepared, and willing broker of essential skills and services. The patient approaches the therapist and explains the nature of his symptoms.[3] The therapist attends to the patient and "makes a decision as to whether or not he—the doctor—can justifiably accept the responsibility of attempting to help this person as a patient." Upon accepting the patient's case, a contractual relationship exists, whereas if the therapist decides not to take the patient's case, no contractual relationship exists. Immediately, we already see overlap between the roles of the therapist—who may in fact be a physician acting in a psychotherapeutic capacity—and the roles of the physician in the healthcare setting. Just as the patient might approach a therapist in order to expressly alter an "ailment" of behavior or a sickness of the mind, so also does a patient approach a physician in order to seek out aid for a physical ailment. In either case, the therapist and physician both act as brokers of essential skills and services and an implicit contractual relationship emerges when the patient agrees to accept their services.

In the case of the psychotherapeutic relationship, however, it is not uncommon for the behavioral intervention to take on the form of a deliberated, explicit, written contract that details how the patient will achieve the goals that he seeks. That being said, the psychotherapeutic contract has a few key differences and similarities when compared to other contractual transactions, such as the implicit contractual agreement between a healthcare clinician and a patient, or an explicit healthcare behavior contract such as that mentioned in the introduction.[4] First, in psychotherapy, the relationship between the

[3] Menninger 20.
[4] Menninger 22.

therapist and the patient "[comes] very close to being the goal [itself]" of the therapy. In other words, "the relationships are the most tangible elements of the transaction," whereas in the healthcare setting, the tangible elements of the relationship are the patient's physical betterment. Second, whereas ordinarily transactions between people occur at a single point in time or have set time limits, a psychotherapeutic contract exists as "an open-ended venture" so long as "the goal of psychotherapy is betterment—or amelioration or growth or maturation…."[5] In contrast, the patient-physician relationship typically, but not always, has expressed, finite goals. Third, in a psychotherapeutic contract, "though the focus is on the two parties, [the patient and the physician], the transactions are not limited to a two-party space." That is to say, the contract need not be confined just to two people and can additionally include family members and the patient's familiars. Fourth and finally, psychotherapeutic treatments can be categorized metaphorically as either *additive*, *subtractive*, or *manipulative* therapy.[6] For example, the therapies might accomplish such goals such as giving a patient hope (additive), removing a fear (subtractive), or redirecting a patient in regard to some other goal (manipulative). In that sense, while psychotherapy "partakes of the same modalities as medical and surgical treatment," it differs from medical or surgical treatment because there is "no laying on of hands, no utilization of instruments, [and] no administration of medicines."

With the aforementioned overall characteristics of psychotherapy in mind, I devote the rest of this chapter to narrowing my focus and offering an exposition of two specific schools of behavior manipulation that I felt best captured and illustrated the spirit

[5] Menninger 23.
[6] Menninger 24

of the healthcare behavior contract and its purposes, which I describe in further detail in Chapter 2. I will focus on Rational Emotive Therapy, which was originally pioneered by Albert Ellis and Alfred Adler in the 1950s, and Cognitive Behavioral Therapy, which was, and continues to be pioneered by Aaron Beck. By giving an exposition and overview of these two specific schools of psychotherapy, I hope to continue to show in the next chapter to show that healthcare behavior contracts are similar enough to them that many of the principles pertinent to the ethical conduct of behavior modification can and should be applied to the use of behavior contracts both the psychotherapeutic and the healthcare setting. The significance of this claim, which I will elaborate upon in further detail in a later discussion, is that the use of manipulative behavioral techniques in healthcare, "in the absence of a firm theoretical framework, can lead to confusion on the part of the patient… in addition to the decreased efficacy in addressing the initial complaint [or problem behaviors] and any [other] confounding issues."[7] That is to say, poorly executed behavior contracts, whether in healthcare or not, may create even more problems than they are able to resolve.

Rational Emotive Therapy (RET) was developed by Albert Ellis and Alfred Adler in the mid-1950s. RET practitioners—which are now interchangeably referred to also as Rational Emotive Behavior Therapy (REBT) practitioners—typically acknowledge an influence in their school of practice by the ancient Stoic philosophers Marcus Aurelius and, more specifically Epictetus, who wrote in *The Enchiridion* that "Men are disturbed

[7] Anne Marie Albano. "Getting Back to Basics: Primers in Cognitive and Behavioral Therapy." *Primers in Cognitive and Behavioral Therapy* (2003): PDF. 198.

not by things, but by the view which they take of them."[8] The similarities between the different schools of RET end, however, with that unifying theme. Adler himself was a neo-Freudian for instance, while Ellis was a behaviorist. Ellis is additionally known for popularizing what is known as the ABC model of emotions and for rebranding RET as REBT in the 1990s. Ellis first defined RET in a 1969 presentation of the Divisions of Psychotherapy and of Clinical Psychology of the American Psychological Association, claiming that RET was "a comprehensive approach to psychological treatment that unusually stresses the cognitive aspect of human disturbance" while also dealing "with its emotive and its behavioral aspects."[9]

Essentially, RET essentially proposes that "most of what we label our 'emotional reactions' are caused by our conscious and unconscious evaluations, interpretations, and philosophies."[10] Based on the assumption that we can change those evaluations, interpretations, and philosophies through sheer, unadulterated force of will, it follows then that "there are virtually no legitimate reasons why human beings need make themselves terribly upset, hysterical, or emotionally disturbed" when they can alter these experiences through guidance and cognitive training. Furthermore, Ellis argued that psychological problems arise in part from persons' "dysfunctional motorial or habitual behavior patterns, which enable them to keep repeating nonadjustive responses even when they know that they are behaving poorly."[11] In other words, adverse behaviors

[8] History of Cognitive-Behavioral Therapy. NACBT. 2008. Web. 2 June 2014. <http://nacbt.org>

[9] Albert Ellis. "Rational-Emotive Therapy." Journal of Contemporary Psychotherapy 1.2 (1969): 83. PDF.

[10] Ellis 84.

[11] Ellis 84.

might very well be the consequence of habit, which must then be broken through willful changes to the behavioral patterns. In that context, the goal of the psychotherapist is to introduce gradual changes through the contracting process to the patterns of problem behavior, using the contract as a tool for outlining a plan of action to which the patient must then adhere for guidance. The contract would outline terms that would facilitate the gradual correction of a patient's "evaluations, interpretations, and philosophies" regarding the world around him in order to correct problematic patterns of behavior that the therapist and patient have identified.

RET and REBT differ only slightly from Cognitive Behavioral Therapy (CBT), which, as mentioned previously, has its origins in the work of Aaron Beck. In the 1960s, Beck developed a second psychotherapeutic approach called Cognitive Therapy (CT), which is based on what he alluded to as the "deceptively simple idea" that "perceptions of ourselves, the world and the future shape our emotions and behaviours."[12] This particular cognitive model is based on the claim that "if we evaluate and modify any dysfunctional thinking [about ourselves or our environments], we can profoundly affect our emotional wellbeing."[13] This is very comparable to the assertions made by Ellis and Adler. But additionally, this particular school of therapy has at its fundamental core two basic assumptions: first, that the development and maintenance of personality disorders has biological, psychological, and social contexts, and that these various contexts are not competing, but rather complementary forces in terms of explaining behavior. In other

[12] William Kuyken and Aaron T. Beck. "Cognitive Therapy." *Handbook of Evidence-Based Psychotherapies*. Ed. Chris & Power, Mick Freeman. (West Sussex: John Wiley & Sons Ltd., 2007). PDF. 15.

[13] Kuyken and Beck 16.

words, compared to RET/REBT, CBT might in some senses be considered more comprehensive. That being said, Beck argues that "even though a client's presenting problems arise in a "biopsychosocial" context, the client's perspective and agency are seen as the main focus" and ultimately, the true facilitator of change. Based on that assumption, CBT aims "to enable clients to identify, evaluate, and respond to maladaptive thoughts, beliefs and behaviors," typically with the therapist in "an active and educative role" as a guide who engages with the client in a process of joint problem-solving.[14] With the therapist as a guide, the client then essentially motivates himself out of his problem behavior. This process, overtime, is then seen to empower the patient to eventually generalize his new attitudes and perceptions until he is able to ultimately run his own therapy. Thus, like RET/REBT, CBT is "an approach to therapy targeting the behavior and cognitions of a client."[15]

I specifically chose to examine clinical behavioral contracts within the context of RET/REBT and CBT because the cornerstone of these two psychotherapeutic methods are the processes by which patients and therapists establish treatment goals in the form of an explicit treatment contract, which is either a written agreement or an oral understanding between them. But more importantly, I was compelled by the fact that RET specifically focuses on the assumption that it is up to the patient to alter his patterns of problematic behavior through force of will, with guidance from the therapist. In some sense, this is essentially the process that occurred in the introductory case study when the

[14] Kuyken and Beck 20.

[15] William O'Donohue and Jane E. Fisher. "Introduction." *Cognitive Behavior Therapy: Applying Empirically Supported Techniques in Your Practice*. Ed. William T. O'Donohue, Jane E. Fisher, and Steven C. Hayes. (Hoboken: John Wiley & Sons, Inc., 2004). PDF. 48.

patient's problematic behaviors were expressly spelled out by his physician and nurse in a contract. A key difference is that in the case study, the patient was expected to make alterations to his patterns of problem behaviors through sheer force of will, but with very little guidance from the physician who, in a psychotherapeutic setting, might have known best how to set achievable goals so that the patient could then accomplish the behavior changes being sought.

Although some of the more intricate aspects of RET/REBT and CBT seem to occasionally be at odds with one another, we see that both schools of therapy compare in that they seek to change problematic behaviors by addressing a patient's negative thoughts and misconceptions about the world around him, thus facilitating better behavior as a consequence of correcting those cognitive defects. Both seem to be useful lenses through which we can examine behavior contracts in healthcare. Additionally, and most importantly to this thesis, they give us insight into possible approaches to the successful development of future healthcare behavior contracts since they incorporate a wide range of philosophical, biological, theoretical, methodological, assessment-oriented, and even technological perspectives into explaining problematic patient behaviors. In the context of CBT specifically we see that by understanding the multiple layers of causes that lead to problematic patient behaviors, a therapist or physician can better attempt to determine a course of action that would work best in a given scenario where multiple factors come into play.[16] I turn now to an examination of these courses of action, which manifest themselves in the form of behavior contracts. I will describe the components of these contracts that psychotherapists might use to facilitate behavior changes. This is a general

[16] O'Donohue and Fisher 1.

overview of the psychotherapeutic contract and I do not believe it is expressly limited to one school of psychotherapy over the other.

The first piece of literature I examine is a lengthy 1983 piece by Daniel S. Kirschenbaum and Randall C. Flanery of the University of Wisconsin that is entitled "Behavioral Contract: Outcomes and Elements." This document was originally an essay that the authors followed up with a 1984 expansion that specifically addressed the psychology behind psychotherapeutic behavioral contracting. They found that "evidence pertaining to the efficacy of the variants of therapeutic contracting… have revealed several rather substantial gaps in our understanding about the nature of this ubiquitous clinical tool" and how its components contribute to successful outcomes.[17]

Looking first to the 1983 piece, we find that Kirschenbaum and Flanery sought to more fully address both the effectiveness of psychotherapeutic contracting, as well as the conditions under which contracts are most likely to facilitate the behavior change being sought.[18] To do so, they argued, two issues must be addressed that have previously "interfered with attempts to answer [those] crucial question[s]." First, "definitions of contracting vary widely from one application to another" and second, "prior reviews [have not] examined all of the studies purportedly using variants of behavioral contracts." In other words, there was no universally accepted definition of what constituted a psychotherapeutic contract and there was little information about how they were to be applied to address and alter patterns of behavior. By examining examples of two

[17] Daniel S. Kirschenbaum and Randall C. Flanery. "Behavioral Contracts: Outcomes and Elements." *Progress in Behavior Modification.* Vol 15. (New York: Academic Press, 1983). 218.

[18] Daniel S. Kirschenbaum and Randall C. Flanery. "Toward a Psychology of Behavioral Contracting." *Clinical Psychology Review* (1984). 597.

contracts, Kirschenbaum and Flanery were able to develop an initial working definition of what we might consider a behavioral contract, therefore addressing the first of the two problems.

The first case example offered in the text was a powerful case involving a school psychologist named Jean who could not bring herself to complete her thesis for her master's degree. Because she was running out of time and would soon reach the maximum period allotted by her employer for completing her degree, she sought out the assistance of the Behavior Contracting Service (BCS) at the Center for Behavioral Studies at North Texas State University. The BCS then attempted to formulate a contract with Jean that "specified behaviors that were well within [her] repertoire, not too difficult, and accessible for frequent observation… adequately considered setting conditions to ensure that the contracted actions were feasible given [Jean's] resources… incorporated consequences that were potent and immediately, completely, and consistently regulated by the BCS; and involved negotiation between [Jean] and the BCS about the key elements." These elements were summarized by Kirschenbaum and Flanery specifically as "target behaviors, [scheduling], and nature of contingency for consequation." In summary, the result of the contract, as acknowledged through a citation from their 1981 work "Behavioral contracting: Arranging contingencies of reinforcement" was that "Jean finished her thesis with time to spare" and was in fact "amazed at how easy the contract had made the effort. Before the contract, the task seemed so enormous that she thought she would never be able to finish it. With the tasks

broken down into several smaller segments and consequences established for their completion, it was in her words, 'a breeze.'"[19]

The second case example involved adult remedial education students who needed help self-motivating and getting accustomed again to being in a school environment. The major problem in this case "was motivating students to sustain months of consistently high levels of involvement and work output to promote change from illiteracy… to the level of academic competence required to pass the General Educational Development examination (GED)." Contracts were negotiated with two students, Anne and Naomi, who agreed to increase their classroom participation and attend social studies class every day.[20] The summary of findings indicated that Anne and Naomi increased classroom participation in their social studies course, "substantially improved their performances on standardized high school equivalency practice tests," and "passed the actual high school equivalency achievement test soon after completion of [the] experiment."[21] However, the researchers found that despite the improvements in targeted behaviors in the social studies course, "the only generalization of effects noted across behaviors (homework accuracy, lateness, and absenteeism) or settings (social studies to English) was a small increase in participation seen subsequent to baseline in the English class."[22] In other words, the effects of the contract on the social studies class, while significant, only slightly carried over to the English class in terms of performance improvements.

[19] Kirschenbaum and Flanery (1983) 221.
[20] Kirschenbaum and Flanery (1983) 221.
[21] Kirschenbaum and Flanery (1983) 223.
[22] Kirschenbaum and Flanery (1983) 222.

Taking into account the variation in form, goals, and targeted behaviors within the two case examples that they provided, Kirschenbaum and Flanery propose that "*a behavioral contract is an explicit agreement specifying expectations, plans, and/or contingencies for the behavior(s) to be changed*."[23] The lack of rigidity in this definition allows for the incorporation of a variety of agreements between parties, including verbal agreements as types of behavior contracts, since they "probably follow similar psychological principles and affect behavior in the same manner as do written contracts." Additionally, contracts must stipulate "the behaviors of interest in terms of topography, frequency, and setting" and further indicate consequence for compliance or non-compliance. They may also be bilateral, multilateral, or unilateral in the sense that they may exist between two people, multiple people, or between the client and herself. Of note also is that Kirschenbaum and Flanery explicitly exclude what they call "implicit social contracts," such as "an individual seeking therapy and by a therapist agreeing to see him." They do not elaborate further on why this type of agreement is to be excluded, but I interpret their exclusion to be a result of the fact that the client-therapist relationship is non-negotiated and bound by professional standards and thus seems to be a separate entity unto itself as opposed to the negotiated contract-type under examination. In relation to healthcare, the relationship between the patient and his physician when a patient establishes his or her relationship with a provider would certainly be an example of this sort of implicit contract.

[23] Kirschenbaum and Flanery (1983) 224.

Table I: Behavioral Contract Definition and Elements [24]

"A behavioral contract is an explicit agreements specifying expectations, plans, and/or contingencies for the behavior(s) to be changed."	
Elements	**Description**
Contract Form	Written or verbal; negotiated or non-negotiated; individualized or standard; public or private
Contract Participants	Contract participants are "the individuals to whom the contract applies" including, but not limited to "spouses, parents and children, therapists and clients." Contracts may also be unilateral.
Target Behaviors	The behaviors to be changed, "specified in terms of topology, frequency, and situations in which they occur."
Consequences	Positive and negative reinforcements, response costs, and punishment paradigms for delivering monetary or social consequences.

Although most of the examples that make up the rest of the discussion deal with behavior contracts in education and inter-personal relationships, there are a few additional findings and points that Kirschenbaum and Flanery make that are still relevant to the scope of this paper. The various contracts that the authors examined with regard to numerous target outcomes certainly varied greatly in terms of form, element, and population. To summarize their findings, Kirschenbaum and Flanery found that "contracting consistently facilitated behavior change across all behavioral domains under investigation when compared to minimal or no-treatment controls. Unfortunately, the effects appeared to be significant in most cases only in the short-run," although the authors further assert and qualify that "such time-limited effects need not unduly

[24] Kirschenbaum and Flanery (1983) 224-225.

discourage us about the clinical promise of behavioral contracts at this juncture." [25] In their discussion of the effectiveness of contracts, the authors addressed three health-related psychotherapy contracts that specifically dealt with weight loss, smoking cessation, and physical exercise. Again, distinguishing these types of health contracts from the contracts examined in my research project is critical. The contracts examined by these authors serve to specifically alter certain patient behaviors as an *end in themselves*, whereas the majority of the contracts that I examined alter behaviors as a means for reaching another type of end, namely the success of medical therapy. With that said, it is still useful to look at these contracts and their effectiveness.

Regarding the subject of contract-based weight loss, results of the studies were mixed. Contracting, combined with other therapies, was found to improve weight loss more than no treatment at all, although there was no evidence to indicate that contracting was more or less effective than other non-contracting behavioral treatments.[26] On the other hand, contracts to improve physical exercise specifically have "shown considerable promise" while "smoking cessation contracts… produced disappointing results" with no evidence whatsoever that contracting has proven effective outside of the duration of the contract itself.[27] Significantly, the authors found that aside from a single study, there was no evidence to indicate any long-term benefits of the contracting therapy.[28] This would further seem to indicate that these contracts do not lend themselves to generalization after the terms and duration of the contract have ended. Regarding the topic of smoking

[25] Kirschenbaum and Flanery (1983) 259.
[26] Kirschenbaum and Flanery (1983) 259.
[27] Kirschenbaum and Flanery (1983) 260.
[28] Kirschenbaum and Flanery (1983) 261.

cessation specifically, the authors attribute a lack of success to either "the extreme difficulty of changing smoking behavior" or possibly the investigator's "lack of imagination in devising contracts in this area." This may be relative to the discussion of other forms of addiction, particularly within the context of the introductory case study that I presented earlier on.

The aforementioned discussion by Kirschenbaum and Flanery, again, serves to highlight the complexity in variation, form, and function of these documents, all of which must be taken into account when examining and evaluating their successes as clinical tools for manipulating behavior patterns. In a subsequent 1984 piece on the psychological aspects of contracting, Kirschenbaum and Flanery again define a behavioral contract as "an explicit agreement specifying expectations, plans and/or contingencies for the [identified] behavior(s) to be changed." [29] In an attempt to include as many variants of this description as possible, the authors suggest that the relevant elements to be examined in the discussion of these documents should include the form of the contract, who the contract participants are, the target behaviors to be addressed, and the consequences of non-compliance. Examination of the form element, for instance, suggests that contracts might be written or verbal, negotiated or imposed, individualized or standard, and public or private. Because there might be multiple parties involved in the arrangement, a contract might be said to be unilateral, bilateral, or multilateral in nature. When the architect of the contract outlines target behaviors, he identifies not only the behaviors to be changed, but also their frequency, situational context, and outcomes. And then finally,

[29] Kirschenbaum and Flanery (1984) 598.

consequation serves as the "vehicle for administration" of the behavior contract and also provides a mechanism of enforcement, i.e. of consequation.

Alluding to their prior review of the contracting literature, Kirschenbaum suggests that the results of contracts generally "support the overall promise of behavioral contracting" as "applied to a great diversity of target behaviors and settings." Specifically, the evidence from their review suggested that therapeutic outcomes were improved in the short-run by using *negotiated* contracts that addressed both process and outcome target behaviors while including *self-administration* of the consequences "by the client and/or significant others." This might be contrasted to an *imposed* contract that addresses target behaviors, but includes administration of the consequences by the therapist instead of via the mechanism of self-administration to which Kirschenbaum alluded. "Many issues remain unresolved," though, argues Kirschenbaum, "about the parameters and processes that determine the efficacy of behavioral contracting." [30] Because the interventions have so many relevant variables that might impact outcomes, previous attempts "to dissect behavioral contracting to find its pacemakers" have only met with limited success.

Briefly reviewing the origins of the behavior contract model, Kirschenbaum additionally points out that its origins lie in operant conditioning and that the model's origins serve as "yet another major barrier to understanding" the contract as a clinical tool. Because operant models of behavior therapy in psychiatry have not traditionally included the active elements believed to encourage better contract outcomes and compliance (e.g. negotiation of a contractual arrangement), the operant model does not

[30] Kirschenbaum and Flanery (1984) 598.

seem sufficient. The solution, argues Kirschenbaum, is a behavior contract model "that incorporates cognitive *as well as* behavioral principles in order to expand the range of variables considered by practitioners and researchers who use the procedure." [31] Of note throughout this document is Kirschenbaum's careful deference toward evidence-based contracting and his emphasis on the importance of "active elements" in the client-therapist negotiation, which seems to involve a rejection of any models that involve a unilateral imposition of terms or designate the physician or therapist as an authoritative expert who imposes change on the patient.

The rest of the Kirschenbaum article is dedicated to defining and describing his proposed "sequential model," of contracting, which describes the steps of drawing up a behavior contract between a therapist and his or her patient. I have provided Table 2 as a brief graphical overview of this model. The authors first conceptualize the contracting process in terms of six "phases" beginning with "the decision to change behavior to the programming of facilitators of generalization." These phases in their sequential order are: the initial decision-making; the generation of expectations, goals, and plans; the identification of target behaviors and setting goals; the monitoring of progress; the delivery of consequences; and finally, the program generalization, or, a long-term, permanent change in behavior. The initial decision-making phase concerns the events that led up to a client making a conscious choice to change his behavior. Taking this phase into consideration, a behavior contract might therefore be considered a product of this conscious decision- making process.[32] The first step for the therapist then, if

[31] Kirschenbaum and Flanery (1984) 599.
[32] Kirschenbaum and Flanery (1984) 599.

Table II: The Kirschenbaum and Flanery Sequential Model [33]

Phase	Phase Description and Components
Formulation of Initial Decision to Change	The decisional "initiation" upon which a client commits to change a certain behavior.
Generation of Expectations, Goals, and Plans	The development of generalized expectancies, i.e. the beliefs about how reinforcements should be expected. The development of efficacy expectations, i.e. expectancy self-statements about one's ability to execute behaviors to achieve certain outcomes. The development of goals, with special attention to setting goal difficulty, goal specificity, and recognizing other moderators that might influence the goal-performance relationship. The development of end-state, outcome goals and process goals to achieve the end-state, outcome goals.
Identification of Target Behaviors and Setting Events	The process by which the contractor selects the specific target goals with the contractee and assesses the impact of the contractee's personal functioning and environment.
Monitoring of Progress	The determination of how, and whether or not the client will self-monitor or if someone else will monitor the client's behaviors.
Delivery of Consequences	The determination of how, and whether or not the client will self-administer consequences or if someone else will administer the consequences of the client's behaviors.
Program Generalization	The process by which the client's altered behaviors become routine in order to eliminate self-regulatory failures.

[33] Kirschenbaum and Flanery (1984) 599.

the client has not yet made a decision, is to utilize a behavior change method that encourages the client to move toward making that first decision to change the behaviors that the therapist has identified. It is unclear how direct or indirect a role the therapist should play in order to push a patient toward that initial decision-making, although the authors present several methods to facilitate the process, which are briefly outlined in Table 4.

Following the decision to seek out a change in behavior, the client and the therapist establish both generalized and efficacy expectations. Generalized expectations refer to "beliefs about how and under what conditions reinforcements may be expected" while efficacy expectations address "convictions about one's ability to successfully execute the specific behaviors required to produce the [desired] outcomes.[34] These expectations are different, however, from the goals of the contract, which instead are the desired outcomes themselves. Kirschenbaum mentions that the literature at the time of the publication of his essay suggests that setting specific, hard goals has statistically led to better performance, although he willfully acknowledges that this certainly varies from client to client depending on the status of each person's "personal standards." [35] After a determination of goals and expectations, and "armed with knowledge about how to facilitate initial decision-making and types of expectations, goals, and plans that generally facilitate behavior change," the therapist as the contractor then "begins the

[34] Kirschenbaum and Flanery (1984) 603-604.
[35] Kirschenbaum and Flanery (1984) 605.

difficult process of selecting specific target behaviors or goals for, and with, the contractee." [36]

Table III: Methods for Facilitating a Behavior Change Process [37]

Method	Description
Persuasive Communication	Use of prestige, credentials, perceived competence, and "expertness" to influence a client.
Socratic Method	Asking people about their perceptions of their actions in order to facilitate logical consistency and decrease a client's wishful thinking.
Values Clarification	Helping the client clarify his values or beliefs with the goal of encouraging value-behavior consistency.
Exposure to Alternatives and Consequences	The presentation of ideas that are discrepant to a client's attitudes. Might include one-sided exposure to fear-arousing information.
Induction of Small Changes	Encouraging small changes in order to later facilitate more dramatic changes in attitudes or behaviors.
Challenging Rationalizations	Confronting head-on the rationalizations and justifications presented by the client.
Role-Playing	Encouraging people to enact the part of someone who suffers aversive consequences.

One quote from the passage that I particularly enjoyed and found poignant was the common maxim, "If the only tool you have is a hammer (you tend) to treat everything

[36] Kirschenbaum and Flanery (1984) 610.
[37] Kirschenbaum and Flanery (1984) 600-601.

as if it were a nail." The implication of this illustrative metaphor is that while the contractor must take great care to not treat every issue as if it were a "nail," he is likewise responsible for making sure he has developed an appropriate arsenal of knowledge at his disposal so that the intervention can be as comprehensive as possible and that he can use more than just a "hammer" if something else is needed. Additionally, per the next phase in the sequence, a means of monitoring must be established alongside the contract in order to keep track of whether or not the client is meeting his targeted behaviors. Again, while Kirschenbaum acknowledges that the tracking method will vary from contract to contract, he asserts that evidence indicates that self-monitoring and reporting by the client is more beneficial than monitoring by the therapist.

Now approaching the end of the discussion, Kirschenbaum addresses the issue of consequation, i.e. the determination of what consequences, if any, should follow the meeting of the goals or failure to do so. Again, alluding back to the behavior contract's operant parentage, he claims that although "it would be difficult to imagine an application of behavioral contracting that omitted contingently applied consequation," the issue still demands a justification.[38] Although he does not address the case for consequation within the context of the paper, Kirschenbaum does argue that at the very least the contractor "can delineate some general guidelines for the application of contingent consequation." [39] Specifically, a set of "10 groundrules" might be incorporated based on the behavior contract as a form of operant conditioning. These rules, at the very least, should "improve

[38] Kirschenbaum and Flanery (1984) 612.
[39] Kirschenbaum and Flanery (1984) 613.

the effectiveness of contingent consequation" and maximize the potential for the positive, desired outcomes. Table 4 outlines these ten rules for applying consequation.

Table IV: Homme's Guidelines for Applying Consequation [40]

1.) Reward immediately after execution of desired responses.
2.) Reward small approximations to desired target behaviors.
3.) Reward frequently and use small amounts of rewards.
4.) Reward performance accomplishments, not obedience.
5.) Reward the performance only after it occurs.
6.) Use fair rewards.
7.) Clearly specify the nature of the desired behaviors and the contingencies to be applied.
8.) Carry out the pre-stated arrangements both immediately and in accord with the pre-statements.
9.) Specify contingencies for the occurrence rather than for the nonoccurrence of undesirable behaviors.
10.) Systematically apply contingencies so that desirable behaviors are generally rewarded and undesirable behaviors are generally punished.

To briefly recap this chapter, I began by claiming that a key difference between a psychotherapy contract and a healthcare behavior contract is the distinction between the ends of each. Psychotherapies seek to alter problematic behaviors as ends in themselves while healthcare behavior contracts seek to promote certain behaviors in order to achieve a secondary end, such as to qualify a patient for a needed therapy. Menninger's descriptive overview of psychotherapy provided evidence for a distinction between contract types through his acknowledgment that psychotherapeutic contracts differ from other contractual transactions in the sense that they are open-ended ventures in which a patient seeks to alter a certain behavior for no other ends than his or her own betterment, amelioration, growth, or maturation. I proceeded to the work of Kirschenbaum and

[40] Kirschenbaum and Flanery (1984) 613.

Flanery who offered a useful definition for behavior contracts as any written, explicit agreement that specifies expectations, plans, and contingencies for behaviors that are being changed. The authors provided a wealth of information, as well as two case studies, that shed light on the contracting process, the process' key elements, and methods that encourage successful contract deployment. The process by which a behavior contract is created for the purpose of facilitating a behavior change is called the "sequential model" and consists of the decision to make a change, the generation of expectations and goals, the identification of target behaviors, the monitoring of progress, the delivery of consequences, and the generalization of the behavior. Finally, it seems that certain methods of facilitating a behavior change process are more effective than others and there are useful guidelines for both contract deployment and consequation that encourage the best possible outcomes.

CHAPTER 2: HEALTHCARE BEHAVIOR MODIFICATION

The case study involving the problematic patient that I mentioned in the introductory section of this thesis involved a contract-based approach to behavior manipulation within the context of healthcare. In the previous chapter, I gave background information on other types of behavior modification therapies in an attempt to offer additional depth and breadth to the discussion about behavior contracts in healthcare. In this chapter, I turn my focus specifically toward contact-based approaches to behavior modification in the healthcare setting. I begin with an exposition of a useful framework provided by Timothy Quill and then move into an overview of my qualitative research study, to which I briefly alluded in the introduction of this thesis. In doing so, I seek to show that many of the considerations taken into account by Quill are similar to many of the thematic elements that emerged during the research study and subsequent content analysis. By discussing a number of the major findings after a discussion of Quill's framework, I hope to show that the way that healthcare providers talk about the use of behavior contracts seems to have many common elements across various institutions and is thus at least an interesting phenomenon worthy of more study. I return to Quill's article in Chapter 3, where I examine ethics issues associated with the use of contracts in healthcare.

The primary framework upon which I will draw to examine healthcare behavior contracts comes from a 1983 article published in *Annals of Internal Medicine* in Quill discusses a theoretical and practical approach to behavior contracting between physicians and patients. He begins his article by remarking upon what he calls the "fascinating but often frustrating range of problems" associated with the limits of traditional medicine in

its encounters with "more difficult patient problems."[41] In his own illustrative example, Quill presents a complicated case involving a 58-year old insurance salesman who had a 35-year history of chronic back pain and had experienced multiple complications with abdominal operations and a transurethral resection of his prostate. The patient had seen over thirty doctors for his pain and "was taking high doses of a narcotic analgesic and a tricyclic antidepressant," the former of which carried a high risk of addiction. In addition to having a complicated medical history, the patient also angrily presented to Quill and queried whether or not Quill would be as incompetent as the thirty other doctors that he had already seen for his lower back and flank pain.

Commenting that he was aware of his own limitations as a physician, Quill indicates that he decided to establish a relationship with the patient, wary though that he might still fail where thirty other physicians had already failed. He issued a proposal to the patient, saying that he would be willing to continue prescribing the narcotic, provided that the patient would administer the medicine to himself every four hours, instead of as needed, and that the patient would met with Quill once a month on a regular basis for a "non-symptom dependent visit." The patient agreed to the proposal and the two worked out a contract with the terms of their agreement. Quill remarks that in working out the contract, he made it clear to the patient that he "was not trying to take his pain away, but rather to do no harm through unnecessary [treatments] and help him learn to live with his pain. [Quill] made [his] limitations and expectations clear, but [the patient was] free to end [their] relationship and seek another physician if he [wished] more aggressive

[41] Timothy E. Quill, "Partnerships in Patient Care: A Contractual Approach," *Annals of Internal Medicine* (American College of Physicians: Vol 98:1983), 228.

treatment…."[42] Importantly to his discussion, Quill says, "the contract needed compromise on both our parts, but it also provides explicit guidelines about what we can expect from each other." In doing so, the negotiated operating principles "allowed [them] to control medical problems that at first glance seemed overwhelming and out of control."

The working definition that Quill utilized to describe the contract that he established with his troubled patient was "an 'explicit bilateral commitment to a well-defined course of action.'" The nature of this definition implies that the patient and Quill both agreed on a goal and means of achieving that goal, and that "both participants [stood] to gain something by working together.[43] Rather than establishing a relationship in which the physician dominated interaction, the contract model emphasizes an interaction between the physician and the patient as an interaction between two autonomous adults. This type of relationship diverts in some sense from more paternalistic models of medical practice and recognizes instead that both the patient and the physician have rights as individuals. The physician's knowledge and expertise "give him the right to speak with authority, but not to be authoritarian," according to Quill.[44] Conversely, the patient "has a right to question, to propose alternatives, or to seek a second opinion or another physician should he choose to do so." The purpose of a contract, therefore, is not to grant authority to one participant over the other, but rather to create obligation after the parties have agreed to the terms. In doing so, physicians "must begin to reexamine their relationships with patients, and experiment with other types of

[42] Quill 228.
[43] Quill 229.
[44] Quill 229.

care that can retain the strengths of traditional medical care while allowing increased patient autonomy."

In order to examine the theoretical nature of a physician-patient contract in more detail, Quill devotes the rest of his paper to describing four "contractual assumptions" that underlie and guide the contracting process. First, the physician and the patient both have unique responsibilities to themselves and to each other. Second, the doctor-patient relationship is consensual and must be recognized as such. Third, both the doctor and the patient must be willing to negotiate terms of care with one another. Fourth and finally, the physician and patient each must gain something in their encounters, i.e. there must be an element of mutual gratification.

A contractual relationship begins when a patient seeks to establish a relationship with a physician so that the physician might help him to alter his condition in some way, be that to treat a syndrome or to alleviate his pain. The patient does not enter into a relationship with a physician, however, without responsibilities. In order for a physician to treat a patient, the patient must define "as clearly and honestly as possible the nature of the problem" as well as "the type of intervention being sought from the physician."[45] On the other hand, the physician offers both "expertise and willingness to treat the sick and suffering." In other words, the physician's responsibilities include "keeping abreast of new developments in medical science, maintaining technical skills" and properly using diagnostic technology and techniques to "ascertain as exactly as possible the nature of the problem and the kind of intervention that is in the patient's best interests." Upon presenting all options to the patient, the patient must then "consider seriously, but need

[45] Quill 229.

not follow, the recommendations made by the physician. As soon as the patient and the physician agree upon a course of action to achieve their goals, they become "partners with well-defined obligations on both parts."

Table V: Quill's Four Assumptions [46]

Responsibilities	The patient defines the nature of the problem and the type of intervention being sought. The physician offers expertise and willingness to provide his services. The patient then carefully considers the recommendations made by the physician.
Consensual Relationship	The relationship between the physician and the patient may not be obligatory. The patient does not have to submit to treatment against his judgment. The physician speaks with authority because of his expertise, but may not be authoritarian.
Negotiation	The patient and physician identify conscious desires, expectations, capabilities, and limitations. Through compromise, they achieve a mutual understanding to guide future encounters.
Gratification	The patient is relieved of suffering while the physician gets satisfaction from using his skills and payment.

With the nature of their responsibilities recognized, Quill then asserts the consensual nature of the relationship into which the patient and physician will enter. He begins by stating that it is important to remember that the relationship is consensual, not obligatory. Obligation only enters into the equation once an agreement on treatment has

[46] Quill 229-230.

been reached with the patient. Until then, the patient may "question, propose alternatives, or… seek a second opinion." Likewise, the physician, "except in life-threatening emergencies or in situations where alternative medical care is not available" may or may not consent to treatment. Quill notes that although the physician-patient relationship model has progressed from a "parent-submissive child" model more toward mutual interaction, neither the patient nor the physician need be submissive to one another. The "spirit of mutual participation expresses the willingness [of both the physician and patient] to influence one another to govern the direction of treatment." The relationship may develop quickly, arduously, or not at all.

Once responsibilities have been laid out and a consensual relationship has been agreed upon, a negotiation then occurs between the patient and the physician in order to form a contract. Negotiation requires that both parties identify "conscious desires, expectations, capabilities, and limitations" in order to attempt to "achieve a common understanding that will guide future encounters." At that point in the interaction, either differences are resolved or they are not resolved. If the differences cannot be resolved, there is no agreement and no contract is possible since the relationship must be consensual. As soon as differences are resolved, mutual terms are laid out, and both parties accept the terms of the arrangement, the terms then become obligations. When "areas of agreement and disagreement" between the patient and physician are made clear, the patient can make known what he is willing and able to do while the physician can "help the patient understand realistically what the physician can do." [47]

[47] Quill 230.

Lastly, while negotiating the mutual terms of what will become a consensual relationship, the terms must benefit both parties. The patient "may get some relief from [biological, psychological, social, and spiritual] suffering," while the physician may "get pleasure from being helpful… intellectual and personal satisfaction from solving a problem," and furthermore, he gets paid. It is this receipt of payment, according to Quill, that "puts the tangible benefits to be gained in the encounter on an equal footing" between the physician and the patient.

The four assumptions that Quill lays out for his readers not only describe the underpinnings of a specific, token example of a single interaction that he had with a patient, but also an entire theoretical approach to patient-physician interactions that Quill advocates. He argues that unlike other models that acknowledge the "biopsychosocial reality" of medicine, the contractual approach has several strengths. First, it allows the physician to see patients in a time-limited setting because it is based on a transactional process in which the patient presents a problem and requested intervention of his choosing to the physician while the physician then responds in a way that is consistent with his own beliefs, training, and expertise. In other words, whereas the biopsychosocial model of practice does indeed serve to expand the limits of clinical practice rather than to restrict them, it is not possible for the physician who sees patients every fifteen minutes to take into account so many various levels of diagnostic analysis over the course of a single meeting. The physician might use the contract-based model to overcome this challenge by encouraging the patient to be as explicit as possible about the problems that he wishes to explore in the limited time that the two share together. In that case, "the

options and potential are not isolated to one dimension" but rather to the patient's own desires, wishes, and imagination.[48]

Additionally, although the contract-based approach "emphasizes the distinct but equally important responsibilities of physicians and their patients," it also allows the doctor-patient relationship to be idealized as a partnership that is "guided by the requests of the patient and the medical expertise and clinical experience of the physician."[49] Consequently, there is an important "element of dependence on the physician to act with medical competence in the patient's overall best interest" whenever a patient presents who is either "more comfortable putting their care totally in the expert hands of the physician," or else so sick that they are unable or unwilling to participate in their own care as an equal partner.[50] In that sense, the contract-based approach might be fluid and fluctuate between an ideal scenario in which the patient and physician share a relationship with a spirit of mutual participation and partnership, versus a scenario in which the physician dominates the decision-making process. Thus, the contract-based approach allows for flexibility where it is needed.

Unfortunately, while the contract-based approach has strengths, it also has weaknesses. In certain extreme circumstances, a contract cannot be successfully negotiated between a patient and the physician. Quill comments that "although negotiations can often be complex and arduous, eventually a definition of the problem and general plan of approach must be agreed upon" before a contract can exist.[51] If the

[48] Quill 230.
[49] Quill 231.
[50] Quill 230.
[51] Quill 232.

patient and physician cannot reach an agreement, consideration should be given to ending the relationship between them, particularly if the needs of the parties involved are not in alignment with one another in any workable fashion. The relationship should not be "continued under the illusion of a therapeutic alliance that does not exist" otherwise both the patient and the physician "may suffer the consequences" according to Quill.[52]

Quill ends his article by acknowledging that it is not clear that the contract-based model accurately represents all aspects of certain patient-physician interactions. Some more uncooperative patients just have a psychodynamic "need to be sick and suffer" whereas some physicians are content only "in relationships where they are taking care of and controlling others."[53] The patient-physician relationship is also generally considered to be open-ended, even in the case in which there might be no financial remuneration if a patient is critically sick or injured. The physician's "obligation to the community, when combined with the ethical obligation to treat the sick and suffering, mandate that physicians must treat some patients who cannot directly pay for their services." As a result, "the same contractual assumptions should apply to any patient, but the repayment to society would be the physician's direct compensation." In other words, a physician's compensation for services provided might very well take the form of repayment to the community when indigent care is involved.

I turn now to a discussion of the qualitative interview study mentioned in the introduction to this thesis. Several of the primary themes that emerged from the interviews overlap conceptually with Quill's observations. The interview process was

[52] Quill 233.
[53] Quill 233.

meant to be semi-structured, but the majority of the conversations took on lives of their own. I typically began the interview with a presentation of a case study in order to provide the subject with more background regarding the purpose and scope of the project. Prompted by some of the initial questions, the subjects themselves, more often than not, directed the discussion, focusing on their own experiences and opinions about behavior contracts. Of particular interest and focus were specific circumstances under which behavior contracts were created and what the terms of the contracts typically entailed.

My faculty advisor and I coded each interview and contract example for dominant emergent themes. We then reviewed individual case studies within the scope of the interview responses, noting particularly the language and rhetoric that the individual subjects used to describe the cases and the events as they were recalled. The theme of the contract as a means of communication occurred the most frequently in all ten interviews. This theme has three sub-themes: the contract as a result of discussion, the contract as a laying down of law, and the contract as a means of facilitating clarity and/or transparency in the communication process with patients. As the titles of the sub-themes indicate, opinions varied greatly regarding the nature of how a contract facilitates communication, with "result of discussion" connoting a more mutual approach between the patient and the physician, while the "laying down of law" connotes a more unilateral, sometimes legalistic perspective. This aptly characterizes the wide spectrum of responses that we recorded, with some professionals taking a more traditional, paternalistic view that is historically characteristic of the medical practice, while others took a more cooperative, mutualistic view.

One illustration of the "discussion" sub-theme was offered to us by a nurse who recalled a rather heartbreaking case of a young, single mother with leukemia who was believed to be drug-seeking. A behavior contract with her stated that she could ask for pain medication at certain intervals and that the staff would provide it to her on those intervals, with the condition that she would not request the medication outside of those allotted intervals of time. Although the contract anticipated no idiosyncratic need for pain control outside the prescribed schedule, the contract was viewed by staff as helping to empower and respect the patient by providing a clear care plan. Another contract, with the parents of a toddler who suffered from renal agenesis, stated that the child would be considered for a kidney transplant if her blood pressure could be successfully managed and if she were not admitted to the ICU for six months. It was acknowledged that the child was never a candidate for a renal transplant, yet because of the contract the parents refused ambulance transportation during a life-threatening situation, fearing that the child would be taken to the ICU and thus be rendered ineligible for a kidney transplant for another six months. Our interviewee concluded that the contract should be a product of discussion, rather than a replacement for discussion between the physician and family.

An example of the "laying down of law" approach is found in the strict terms of care contracts signed by patients who are potential candidates for a hematopoietic stem cell transplant (HSCT). The need for imposition of these unbending, unilaterally imposed terms as a condition of beginning the treatment relationship is based in knowledge of the conditions for maximizing the chances of success without life-threatening complications. Contracts dealing with HSCTs take into account everything from health and wellness requirements to socioeconomic requirements. It is the goal to get every patient to

transplant through a combination of everyone's team efforts. But this success is dependent on crystal clear explanation and discussion. Of note in the case of these documents is that, while they may be mistakenly regarded as legally definitive, behavior contracts are neither contracts nor legally enforceable in court, owing to their lack of specific contractual language and clearly defined terms. Their power comes not through any threat of legal action against the patient or physician, but rather through the ability of written documents to inspire parties to a certain action. Nonetheless, the best way to effect change is to develop a relationship.

The second most common theme that emerged in interviews was the notion of the contract as a means of empowering the parties – not only the patient, but more often, empowering the physician, not the patient. Empowering the physician often meant describing the behavior contract as a weapon to be wielded by the physician and other care providers. Contracts were described as both offensive and defensive mechanisms. Empowering the patient was best illustrated by the aforementioned case involving the young woman with leukemia, as reported not by the patient but by her care team, who regarded the contract as a sort of codification of respect. The interviewee concluded, however, that creation of the contract actually made the patient worse off in the end, by creating an illusion of control through an agreement that was shattered when other care providers ultimately failed to uphold it.

Physician empowerment and weaponized contracts is illustrated by a case of a noncompliant teenager with kidney disease whose parents were poor at caring for their child. The requirements in place for receiving a kidney transplant require that the patient and family demonstrate adherence to a care plan, since non-adherence can be dangerous

for transplant recipients. This example also illustrates the realities of imperfection; many interviewees acknowledged that patients, at times, are not able to fully comply with the terms of their treatment protocols due to any number of reasons that may lie within or outside their domain of control. One interviewee discussed the need to utilize contracts that allowed for "some laxity for non-perfection" and some "room to act out." The contract itself determines the dividing line between patient autonomy and physician authority.

I find that Quill's assumptions generally overlap nicely with the three dominant themes that emerged in interviews: communication and dialogue, empowerment, and patient imperfection and boundary-setting. First, the idea of the healthcare behavior contract as a product of communication and dialogue between the physician and the patient overlaps nicely with Quill's assumptions of responsibility, consensual relationship, and negotiation. The idea that the contract is the product of such communication and dialogue mirrors Quill's assertions that both parties to the contract bring a deck of cards to the table that they then show to one another. But when the contract is a vehicle for communication and dialogue instead, it seems to capture the same principles, but with more focus on the contracts as tools for, rather than the natural consequences of, negotiation and consensual relationship. Second, the notion that the contract is a means of empowering both the physician and the patient is reflected, perhaps, by all four assumptions. By laying out the responsibilities of all parties in the negotiation process, a consensual relationship thus emerges and all parties experience gratification as a result of the transaction. Third and finally, patient imperfection and

boundary setting parallels the need of all parties to make clear in the negotiation process what they are able to do and what they are willing to do.

CHAPTER 3: CONTRACT-BASED APPROACHES TO BEHAVIORAL CHANGE AND ETHICS

There are several ethical issues with some degree of significance to discuss in this final chapter. To recap where we have come from in the discussion so far, I first gave an exposition of behavior contracting within the context of its psychotherapeutic origins, focusing on RET/REBT and CBT as specific types of psychotherapy to which we could compare healthcare behavior contracting. I also borrowed from the work of Karl Menninger and accepted his definition of a general behavior contract as any explicit agreement that specifies expectations, plans, and contingencies for certain behaviors to be changed. Second, in the context of the Menninger definition and the psychotherapy literature, I outlined a discussion from Timothy Quill about the use of contract-based approaches to behavior changes as they apply to healthcare. To recall, Quill argued that the healthcare behavior contract is comparable to the psychotherapy contract in the sense that they both emerge in similar fashions and have many overlapping features or assumptions.

It is my assertion that the similarities between the methods used in healthcare behavior contracting and psychotherapeutic behavior contracting are close enough that they both raise a number of significant ethical conundrums and questions about how and when these contracts should even be used to begin with. I do not assert that healthcare behavior contracts and psychotherapeutic contracts overlap perfectly, but rather that many of the lessons from the latter can be applied to the use of the former. That being said, the waters separating these interventions become incredibly murky when one tries to concretely distinguish between the two. In this conclusory chapter, I address several

ethical issues that commonly arise as a result of psychotherapeutic interventions in an attempt to show that those ethical considerations can be applied to the use of behavior contracts in the healthcare setting, and specifically within the context of the initial case study. To begin, however, and to elaborate upon the difficulty of distinguishing these contract types from one another, I will revisit the distinction I made earlier in Chapter 1 between contracts where the goal of the contract is the end in itself versus other contracts where the goal is instead a means of achieving a secondary objective, or end. Further elaboration upon the distinctions between these two metaphysical distinctions should prove useful.

For the sake of discussion, a goal might be said to be therapeutic when it is designed to contribute to patient betterment. We can recall from the previous literature that psychotherapeutic contracts are the same as healthcare behavior contracts in that they both have the end of achieving the patient's overall betterment. The goal of the psychotherapeutic contract is to better the patient by getting him to make a behavioral change that he wishes to make. He and the therapist have both agreed that the behavioral change is a noteworthy and acceptable goal. Together, both patient and therapist then come up with a plan of action, the terms of which are usually set out in a written contract. In this sense, the goals of the psychotherapeutic contract are usually the *psychological* betterment of the patient rather than the *physiological* betterment of the patient. With psychotherapeutic contracts, there is no laying on of hands, utilization of instruments, or administration of medicines. Instead, the development of a behavioral change or even the development of a relationship itself between the therapist and the patient is the actual goal. In contrast, healthcare behavior contracts might facilitate a behavioral change, but

the behavioral change has the purpose of contributing to the success of, or of reaching some other, secondary *physiological* goal where the physician seeks to better the patient's body.

Table VI: Psychotherapeutic vs. Healthcare Behavior Contracts

Psychotherapeutic Contract	**Healthcare Behavior Contract**
Behavior change is the primary goal. The change in behavior is therefore an end in itself. **Example**: A psychiatrist creates a contract with his patient in which the goal is to help the patient overcome her fear of flying. The patient agrees to meet with the psychiatrist on a regular basis and take incremental steps toward eventually getting on an airplane for the first time ever.	Behavior change is required to reach a secondary physiological goal. The change in behavior is therefore a means to an end. **Example**: A physician creates a contract with his patient in which the patient agrees to stop his consumption of alcohol in order to be eligible for a liver transplant.
Both psychotherapeutic and healthcare behavior contracts are interventions. Both psychotherapeutic and healthcare behavior contracts involve a change in behavior. In both psychotherapeutic and healthcare behavior contracts, the patient and the physician agree upon terms that are usually enumerated in a written contract. The goal of both psychotherapeutic contracts and healthcare behavior contracts is patient betterment. Both, therefore, are therapeutic.	

Healthcare behavior contracts do not facilitate behavioral change simply for the sake of facilitating a behavioral change. A behavior contract that has the primary goal of changing patient behavior should only be said to be a psychotherapeutic contract, not a healthcare behavior contract. Conversely, a behavior contract that has the primary goal of facilitating behavior change in order to achieve a secondary, *physiological* betterment of

the patient should be called a healthcare behavior contract, and not a psychotherapeutic contract. Keeping the stark distinctions and muddy similarities between these two contract types in mind, I turn first to the work of Toksoz B. Karasu, who addressed some of the fundamental ethics issues surrounding the use of psychotherapeutic contracts. Although psychotherapeutic and healthcare behavior contracts are distinct, I believe that they are similar enough that many, if not all of the ethical principles explored within the Karasu article can be applied in many cases to the use of healthcare behavior contracts. In Table 6 below, I provide a brief, but hopefully illustrative summary of where we have come so far in our discussion.

In his 1980 piece on ethics issues in psychotherapeutic in, Dr. Karasu argued that perhaps one of the most fundamental ethical questions associated with the use of psychotherapeutic behavioral interventions is "whether to encourage the patient to rebel against a repressive environment or to adjust to his or her condition." [54] In other words, where a patient needs a behavioral intervention, there is a question as to whether or not the patient should be encouraged to either change his behavior or else take steps to accommodate his environment to account for his behavior. The example of this distinction that Karasu offered is antiquated by today's standards, but still illustrative. At the time that he authored the article in 1980, "therapists generally [regarded] homosexuality as undesirable, if not pathological. On the less theoretical plane of actual treatment goals, the therapist may be obliged to take a position… as to whether a heterosexual orientation is a valid ultimate goal for the patient or the patient should

[54] Toksoz B. Karasu, "The Ethics of Psychotherapy." *American Journal of Psychiatry*, Vol 137:12 (1980): 1504.

maximize the quality of his or her life adjustment as a homosexual." [55] In other words, a patient might be encouraged to change his situation or else adjust to his situation as best as possible.

We can look to respect for patient autonomy as an ethical guideline upon which we might further base an examination of this issue. Respect for persons and patient autonomy demand that the behavioral contract not only be as less restrictive as possible so as to be respectful of the patient's free agency, but also that it not be imposed unilaterally. Supposing that these contracts are in fact forms of psychotherapy, it seems that consent to participation, i.e., an informed consent given free from coercion, is at least a basic and necessary requirement for these contracts to be ethically grounded. If a behavioral contract is coercive, or imposed unilaterally upon a patient, it is not respectful of his or her autonomy. But it is also disrespectful of a patient's autonomy when terms are imposed that have an intrusive effect on the patient's life or liberty seemingly without a purpose relating to the goals of treatment. Turning again to the initial case study, it seems very unclear whether a blanket ban on the use of all illicit substances had any medical justification whatsoever in the case of this patient. Although there was certainly some concern that the patient had been self-medicating with narcotics for which he had no prescription, there was no apparent medical justification for banning his use of all illicit substances. The criminality of using illicit substances in itself does not seem to be a compelling argument. Ensuring a patient's compliance with law seems to be more the responsibility of a legal professional than of a physician. Indeed, one might argue even

[55] Karasu 1504.

further that a proper respect for autonomy implies a respect for a patient's rights to make decisions for himself, whether they are good or bad decisions.

In stark contrast to the initial case study however, there seem to be instances in which more seemingly-restrictive terms are ethically permissible, depending on the gravity of a patient's situation. For instance, it does not seem to be the case that a ban on drug use is intrusive in the case of the hematopoietic stem cell transplant recipient, in which case there is a very clear and very strong medical indication against using illicit substances in that particular case. The "ban" on illicit substances in this case is usually captured in an initial treatment agreement, which usually includes a mutual discussion between the patient and healthcare provider about the dangers of using illicit substances while immunocompromised. Essentially, because illicit substances are unregulated, they might easily be adulterated with contaminants or microbes that might place the stem cell transplant recipient's life in grave danger following the procedure. This is particularly the case with marijuana, the leaves of which contain millions of microbes and fungal spores that can kill an immunocompromised patient. The difference between this case and the initial case study is that there is a clear medical justification for strong regulation in hematopoietic stem cell contracts whereas there was no such clear indication in the case-study patient.

According to Karasu, the physician in the initial case study should have considered whether it was ethically preferable to encourage the patient to permanently cease his drug addiction, or to help him take steps to alleviate as best as possible its negative repercussions. Although complete abstinence from drug abuse certainly might have been beneficial, it is not entirely clear that the patient had the ability to give up his

drug-seeking behaviors without considerable intervention from an outside party. Thus, the contract drawn up by the physician perhaps should instead have attempted to promote healthier behavior. Behavior change as prescribed by the therapist or physician should be within the patient's power, clinically significant, and supported by a body of evidence. The contract in the case study might have been less intrusive, and there might have been less enmity between the patient and the physician, had it contained only such terms.

The inability of the patient in the case study to cease his drug-seeking behavior leads directly into a second ethical question from psychotherapy: It is wrong for the therapist to set unrealistic goals and demand that the patient undertake unrealistic tasks. Karasu writes that "misleading impressions may be imbued by [physicians] when their need to instill hope in the patient and the omniscience endowed them [as authority figures] become intertwined…. This can perpetuate unrealistic expectations and goals that are ultimately deleterious to the patient." In the case study, we can see how giving the patient unrealistic goals and expectations surrounding his drug addiction did little more than create additional enmity and strife between the patient and his care providers. Karasu points out further that "such tendencies are often compounded by the failure to discuss, describe, or even acknowledge the reality of goals during treatment or when the stated goals are too broad or obscure." By presenting to the patient goals, either implicitly or explicitly, that he or she is not able to accommodate, the physician "fosters false hopes of speedy progress that cannot be realized if the patient actually requires [some alternative] treatment." [56]

[56] Karasu 1505.

In other words, setting the bar too high not only results in non-adherence to the plan, but perhaps serves to be counter-productive by creating additional conflict and strife between all of the parties involved. A patient's ability to adhere to a prescribed care plan has numerous implications for the course of a patient's treatment, as well as his relationship with his healthcare providers. For example, in the introductory case study, the patient was deemed to be "ungrateful" by the healthcare providers, after he expressed willingness to adhere to the care plan but then failed to do so, either as a consequence of his addiction, or through a sheer lack of will. However, lack of gratitude in itself does not seem to be a strong enough reason for altering the patient's care.

A third ethical question in psychotherapy deals with the nature of the therapeutic relationship between the patient and the physician. Karasu discusses the debate regarding "the degree to which the therapeutic relationship is authoritarian versus egalitarian, or, more specifically, to what extent the pervasive power of the therapeutic relationship… is balanced by a true 'therapeutic alliance' or 'therapeutic partnership.'"[57] Because psychotherapeutic interventions often depend on the therapist to serve as an authority figure in whose expertise the patient must confide in order to seek relief, this role has potential to conflict to some extent with modern understandings of medical practice. This conflict seems best captured by an examination of the differences between the biomedical model of medical practice, which is traditionally considered to be more authoritative and paternalistic, and the biopsychosocial (BPS) model of practice, which is more common today and generally considered to be more patient-centered.[58]

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[57] Karasu 1505.

[58] George L. Engel. "The Clinical Application of the Biopsychosocial Model." *The American Journal of Psychiatry*, 137:5, 1980. 535.

Under the BPS model of medical practice, the role of the physician has evolved beyond the paternalistic days of yore in which the physician authoritatively treated the biological causes of sickness with little consideration for anything else. Where healthcare providers once merely ordered chemotherapy and radiation for dying cancer patients, they now also offer social support groups and counseling. Where they once prescribed expensive retroviral drugs in an attempt to curb the spread of HIV infection, they now also educate vulnerable populations on safe sex practices. The latter therapies in both cases align with the BPS model by attempting to alleviate or eliminate non-biological factors that might adversely influence the outcome of the patient's illness. Not only should biological contributors to sickness be taken into account according to the model, but so also should psychological and social causes of pain and suffering. Just as the patient's health outcomes might be dependent on his white blood cell count at the time of an infection, so also might they be dependent on his social status, home environment, and family support. If a diabetic patient for instance is unable to care for herself, her chances of successfully managing her disease diminish considerably if she does not have a strong social network of family and friends.

The biomedical model of medical practice "represents the application to medicine of the classical factor-analytic approach that has characterized Western science for many centuries." [59] George Engel points out that "the most obvious fact of medicine is that it is a human discipline, one involving role- and task-defined activities of two or more people." [60] Consequently, the roles and tasks of the patient and physician "are defined in

[59] Engel 535.
[60] Engel 536.

a complementary fashion." Where the biomedical model fails, according to Engel, is where it "does not include the patient and his attributes as a person, a human being." Though based on scientific knowledge and the scientific method as the means of achieving the goals of patient care, the approach fails to take into account that "in the everyday work of the physician the prime object of study is a person, and many of the data necessary for hypothesis development and testing are gathered within the framework of an ongoing human relationship…." Because the biomedical model cannot take this consideration into account, it can "make provision neither for the person as a whole nor for data of a psychological or social nature…. Hence, the very essence of medical practice perforce remains 'art' and beyond the reach of science."

According to Karasu, "it is not only the nature of the therapeutic alliance that is critical, but the degree to which it is made explicit. Often within its non-explicit nature lies the ethical rub of psychotherapy." A psychotherapeutic contract, within the context of the BPS model, is required to "establish a mutually agreed on and explicitly articulated working plan… the essence of which is how each agent will ultimately use or restrict his or her use of power." In other words, the terms of a behavioral modification contract must explicitly define the roles and task-defined activities of the parties involved, paying special attention to the role of the patient as a free and autonomous human being who is capable of entering into a role-defined partnership. How this therapeutic relationship manifests "also relates to one of the most prominent negative effects of the traditional therapeutic relationship," however, in the sense that sometimes there is "insufficient regard for the patient's intentionality or will" which can then be exacerbated by the

careless therapist. [61] "For example," writes Karasu, "in the analyst's fervent search for the unconscious determinants the therapy may soon become an end in itself" and ultimately lead to deleterious effects for the patient. [62]

Under no circumstances should the existence of a contract itself become the primary justification for a physician's course of action. The ethics of each individual term of the contract, as well as the ethics of the contract as a whole, must be sound. Behavioral contracts, when unilaterally imposed on patients, have the capacity to create an adversarial situation and negative relationship between the patient and the healthcare providers where there may not have been any conflict to begin with. On the contrary, behavior contracts must be entered into as the natural result of a dialogue between the patient and the physician, following the establishment of a mutual relationship between the two parties. The special nature of the patient-physician relationship requires that the physician give priority first and foremost to the patient's care and overall wellbeing. When the physician ceases to do so for the sake of nothing more than fulfilling a contract, the relationship between him and his patient ceases to be mutual, as does the behavior contract. In order for any behavior contract to be ethically grounded, it must be the product of dialogue between two persons in a mutual relationship.

A fourth ethical question in psychotherapy deals with the therapist's conflicting allegiances to the patient, to society, and to others. It is necessary to determine whether behavioral contracts might include restrictions on the behavior of third parties. Karasu writes that sometimes there is a "confusion of the therapist's allegiance" that "inheres in

[61] Karasu 1506.
[62] Karasu 1506.

the nature of the psychotherapy he or she is conducting—individual-, family-, or society-oriented." [63] While "individual-oriented psychotherapy may limit itself to the more orthodox dyadic goals within the private framework of the patient's inner thoughts and feelings, other goals may be more society-oriented and may use the information communicated between therapist and patient to influence the patient's social milieu." For instance, "a serious question that often arises is the therapist's role and responsibility to the family of the patient" while "on the other side of the coin are instances in which dynamic psychotherapists so strongly believe in utmost confidentiality and individual privacy… that they fail to divulge… information with family members that may prove vital to the welfare of the patient." [64]

Contractual impositions on third parties (i.e., non-patients) may still be justified. For instance, in organ transplantation contracts, a family member must sign and agree to be the person's primary caretaker following the transplant. As primary caretaker, that person is responsible for ensuring that the patient takes any medications he needs to take, maintains the prescribed diet, and makes it to all of his post-operative appointments. When I spoke with a representative from the bone marrow treatment clinic in my interviews, the interviewee mentioned that there was a vast body of evidence that suggested that social factors, such as having a strong social net and designated caretaker, were nearly as important in the determination of a transplant's success as any other relevant medical or biological factor. Consent is nonetheless required out of deference to the principle of respect for autonomy and the freedom of the persons involved. Consent

[63] Karasu 1507.
[64] Karasu 1507.

and strong medical justification are sufficient conditions for imposing restrictions on a patient or third party's behavior and placing limitations on their freedom.

As elaborated upon in *History and Theory of Informed Consent*, the obligation to receive an informed consent is grounded in principlism, that is, the assertion that the moral basis for ethical claims rests in prima facie moral principles.[65] Under this schema, rights are correlative to duties, and "for every duty there exists at least one correlative right" while "duties and rights are [both] grounded in principles."[66] These assertions were additionally summarized by W.D. Ross in *The Right and the Good,* in which Ross proclaimed the statement "rights and duties are correlative" may stand for any particular or any combination of the following statements:

1.) A right of A against B implies a duty of B to A.

2.) A duty of B to A implies a right of A against B.

3.) A right of A against B implies a duty of A to B.

4.) A duty of A to B implies a right of A against B.

Of the four aforementioned propositions, only "the first appears to be unquestionably true" and subsequently, the statement "rights are correlative to duties" can be taken to mean that given two persons A and B, then "A's having a right to have a certain individual act done to him by B implies a duty for B to do that act to A." [67] In other words, where A has a prima facie right to autonomy, the right of A to autonomy implies a duty of B to respect that autonomy, and the same can be said wherever an individual is

[65] Ruth R. Faden, Tom L. Beauchamp, and N.M. King. *A History and Theory of Informed Consent.* (New York: Oxford University Press, Inc.: 1986) 7.

[66] Faden, Beauchamp, and King 6.

[67] W.D. Ross. *The Right and the Good.* (New York: Oxford University Press, Inc., 1930). 48.

perceived to have a fundamental right. It is at the heart of this correlativity theory where prima facie rights and ethical principles have their foundations.

Faden, Beauchamp, and King outline the three main principles that support informed consent. Those principles are respect for autonomy, beneficence, and justice. Respect for autonomy focuses on the autonomous action of an individual person and the authors make a subtle, yet critical distinction "between persons who have the capacity to be independent and in control" and "the actions that reflect the exercise of those capacities." [68] Additionally, there is a difference between being autonomous and being respected as autonomous. "To respect an autonomous agent," the authors argue, "is to recognize with due appreciation that person's capacities and perspective, including his or her right to hold certain views, to make certain choices, and to take certain actions based on personal values and beliefs." Because autonomous persons are to be treated as ends in themselves, "the burden of moral justification rests on those who would restrict or prevent a person's exercise of autonomy." The principle of respect for autonomy is formulated as follows: "Persons should be free to choose and act without controlling constraints imposed by others." Although "several issues about the proper limits of the obligation remain unsettled," it is generally accepted that the obligation on a physician or healthcare provider to obtain informed consent in the clinical context is grounded in this principle of respect for autonomy.

Beneficence is the second "foundational value" according to Faden, Beauchamp, and King, and contains four complex key elements, "all linked through the common

[68] Faden, Beauchamp, and King 8.

theme of promoting the welfare of others." [69] These key elements are: "one ought not to inflict evil or harm; one ought to prevent evil or harm; one ought to remove evil or harm; one ought to do or promote good." The principle of beneficence manifests itself in the Hippocratic oath to "do no harm," where "do no harm" is "not [a pledge] never to cause harm but rather to strive to create a positive balance of goods over inflicted harms." Beneficence might be thought of then as the "obligation to weigh and balance benefits against harms, benefits against alternative benefits, and harms against alternative harms."[70] Unfortunately, the relationship between beneficence and informed consent is contentious, as the principle by itself does not imply a proper authority for decision-making. "In health care, professionals and patients alike see the authority for some decisions as properly the patient's and authority for other decisions as primarily the professional's" and "decisions regarding who ought to serve as the legitimate authority… can turn decisively on what will maximally promote the patient's or subject's welfare." However, the "promotion of the value of autonomous choice in medical decisionmaking by patients is often justified by arguments from beneficence to the effect that decisional autonomy by patients enables them to survive, heal, or otherwise improve their own health." As Faden, Beauchamp, and King further point out, "these arguments range from the simple contention that making one's own decisions promotes one's psychological well-being to the more controversial objection that patients generally know themselves well enough to be the best judges… of what is most beneficial to them." [71] I will assume that allowing a patient to make his own decisions fulfills beneficence, either because

[69] Faden, Beauchamp, and King 10.
[70] Faden, Beauchamp, and King 13.
[71] Faden, Beauchamp, and King 14.

patients know themselves well enough to be the best judges of what is most beneficial to themselves, or because it promotes psychological well-being, whereas going against a patient's choice causes distress and consequently, a psychological harm.

The third and final principle is justice, which might be best illustrated by the claim that "a person has been treated in accordance with the principle of justice if treated according to what is fair, due, or owed." Faden, Beauchamp, and King assert that "the major moral and conceptual problems about informed consent are not justice-based and do not directly confront issues of social justice," and consequently, "[have] nothing like the prominence of the other two principles." [72]

The previous discussion of principles serves to underscore the need for consent within the clinical context. Even if not for the sake of justice, consent is required, given the previous formulations of respect for autonomy and beneficence. Because behavior contracts are a behavior modification, they require an autonomous consent from the participants to the contract. Consequently, they may not generally be imposed unilaterally by a physician on a patient as a condition of receiving a life-dependent therapy. It is interesting to note that the same would apply even if these contracts are simply contracts not connected with medical treatment or psychotherapy. Because the documents are organized intentionally to be presented as contracts, their authority might stem in part from the respect that our society holds for written agreements, based on the assumption that the parties have agreed to mutually beneficial terms and have affixed their signatures as evidence of this agreement. Wherever there is coercion, a written agreement becomes suspect as the mutuality of the document is questioned.

[72] Faden, Beauchamp, and King 16.

A fifth ethical question in psychotherapy deals with termination of the relationship between the physician and the patient. Generally speaking, patient firings are acceptable when it is in the best interests of the patient and the physician for the therapeutic relationship to end. This can occur when negotiations between the patient and the physician fail to reach a general "definition of the problem and general plan of approach." When negotiation fails, "consideration should be given to ending the relationship." Quill comments that "the consensual nature of the relationship by definition requires that there is an agreement that the relationship exist… but too often the doctor or the patient persists in a counter-therapeutic relationship because of an exaggerated sense of obligation or duty." [73] In short, although a physician is expected to act in the best interests of his patient and to generally place the wellbeing of his patients above personal gain, this selflessness does not translate into a duty to maintain a relationship when neither party can continue to benefit from it. "In these situations, it is appropriate" according to Quill, "for the relationship to end." [74]

[73] Quill 232.
[74] Quill 233.

SUMMARY GUIDELINES

I want to offer some general guidelines for the use of healthcare behavior contracts within the clinical setting. These are not all meant to be treated as all-encompassing sets of rules that govern exactly how, when, and why these documents may be used, but rather are recommendations based on many of the ethics issues previously examined in this section, as well as in the previous two chapters of this thesis document.

First, in seeking to alter a problematic patient behavior, the physician should decide first whether or not the problem behavior itself can be altered or if it might be better to instead aim for mitigation of the problematic behavior's effects and encourage other positive behaviors. In other words, the terms of the contract must be within the powers of the parties to fulfill. It benefits no one when the physician targets behaviors that are not within the power of the patient to fulfill. As we saw in the case study, such an arrangement did little more than create enmity between the physician and the patient when the patient was unable to adhere due to his drug addiction, and the physician threatened consequences due to the patient's inability to adhere to terms of a contract that was imposed upon him. Furthermore, the physician did not offer concrete steps or means of achieving the goals set out in the contract and consequently, the patient did not have a realistic chance of being able to adhere.

Second, a good behavior contract must be the result of a dialogue between the patient and his healthcare providers in which the goals and terms of the contract have been laid out and agreed upon by all parties. We know from the psychotherapy literature that the contract itself must be comprehensive and lay out terms clearly and in detail to all

parties involved, including terms of consequation, while avoiding ambiguity as best as possible. While we saw instances of comprehensive behavior contracts in examples provided to us by the transplant clinics, it would seem that the behavior contract used in our case study was woefully inadequate in this light, detailing only the demands made by the patient's care providers and the consequences for non-adherence to that given list of demands.

Third, all parties must offer a free and voluntary, informed consent to the contract. The physician is encouraged to reject the temptation to pursue an authoritarian role and impose terms on a patient through any coercive means. Again, a good behavior contract must be the result of mutual, meaningful dialogue and open communication between the patient and the physician. Again, the contract from our case example was essentially imposed coercively on the patient and the patient had to accept as a term of continuing to receive therapy from the providers involved. The providers simply laid out in writing their demands and then demanded that the patient adhere to them with what was likely very little input or dialogue. In that sense, the behavior contract might not even truly be considered a behavior contract at all, but rather a coercive list of demands.

Fourth, where behavior contracts fail, a physician may consider creating a new contract. If not, then the physician may consider termination of the professional relationship with the patient, but only so long as he believes it is in the best interests of the patient to be treated by some else, and only so long as he makes appropriate arrangements for the patient's continuity of care. This fourth recommendation is contrasted nicely by the inability or else unwillingness of the providers in our case study to regroup and to consider a second, perhaps better planned and more comprehensive

behavior contract for him. Instead, they continually demanded that he adhere to the contract despite his inability to adhere and then began the firing process over a year later.

Fifth and finally, because many of the principles of psychotherapeutic behavior interventions likewise apply to healthcare behavior contracts, the physician must, in his attempts to "treat" a problematic patient behavior, utilize a methodology that is best supported by evidence-based medicine. In other words, it would behoove a physician who seeks to develop a behavior contract for a problematic patient to review the work of Kirschenbaum, Flanery, and others, who asserted that these documents not only fail entirely in some circumstances, but must be negotiated between the patient and the physician, have targetable behaviors within the patient's power to change, encourage active participation by all parties, and encourage some form of self-consequation in order to have any remote chance of being successful. Had there been deference for previous work done on these documents within the psychotherapy literature, the patient mentioned in our case study might have had a very different outcome. Consequently, it is up to the physician to stay abreast of the available literature on behavior manipulation and dealing with various problem patient behaviors.

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