

Contracts with patients in clinical practice



Published Online
April 15, 2011
DOI:10.1016/S0140-6736(11)60170-0

Written documents called contracts are increasingly present in clinical practice and medical publications. There are behavioural contracts for management of so-called difficult patients,¹ opioid contracts,² suicide prevention contracts,³ and healthy living contracts.⁴ Some practices have even asked patients to sign contracts in which they promise not to litigate or post defamatory comments on the internet.⁵ Despite widespread adoption, the use of contracts in medicine has had little critical appraisal.

Patients' contracts do different things in different clinical situations (table): they can serve administrative purposes, by deterring mistreatment of clinical personnel or diversion of narcotic drugs; some are educational, drawing patients' attention formally to information; and others clarify expectations and foster transparency, such as when a prospective organ recipient agrees to respect rules on substance misuse. Other contracts—eg, for suicide prevention—can help doctors to express concern for their patients, or help patients hold themselves to better health practices, by bolstering willpower with a written commitment (Ulysses contracts).

The effectiveness of contracts in general is uncertain. A Cochrane review analysed 30 randomised trials of contracts used in addiction, weight-control, and medication-adherence settings.⁴ Endpoints included processes, such as adherence to treatment, and targets, such as blood pressure. The results were mixed; 15 endpoints showed a benefit from contracts compared with usual care, six favoured standard care, and 26 showed no difference between the groups. Even less is known about other kinds of contract. A review of 11 observational studies reported weak evidence that opioid contracts reduced narcotic diversion or misuse.⁶ Contracts with other aims, such as suicide prevention, have not been empirically studied.⁷

To some extent, any encounter between physician and patient can be viewed as contractual, where they agree on mutually accepted responsibilities.⁸ But then the term "contract" becomes difficult. Legally, what makes contracts differ from agreements is that contracts are intended to be enforced. So to turn informal agreements into formal documents emphasises the consequences of breaches, whether explicit or implied. In some clinical settings, these

consequences are clear: the doctor will no longer prescribe narcotic drugs, or the patient will not get a liver transplant. However, does adherence to the terms of the contract also become a precondition for continued medical care? Many would argue that such a position violates physicians' ethical obligations not to abandon patients.⁹ Even if the physician is not intending to threaten abandonment, the consequence of a contractual breach might not always be clear to patients, who might assume from the use of the word contract that the relationship would be terminated.

Because of the implied consequences, contracts can fundamentally alter the relationship between patient and physician—a relationship traditionally founded on unconditional loyalty.¹⁰ If patients feel that their medical care could be terminated at any time for perceived non-adherence, how can they openly communicate with their physicians? This risk is heightened when, as is common, patients are asked to sign a standard form drafted by the physician, without an opportunity for negotiation of terms. A unilateral or authoritarian style of implementing contracts might cause patients to feel threatened or coerced, and perhaps even to view the contract as a "prelude to abandonment".¹¹

	Clinical setting	Aim	Therapeutic intent
Suicide prevention	Mental health	Assess risk of suicide and engage patient in prevention of suicide	High
Addiction treatment	Treatment of addiction	Engage patient in prevention of recidivism	High
Transplantation and substance abuse	Organ transplantation	Communicate substance-misuse criteria for receipt of organ transplant	Low
Opioid use	Long-term opioid prescription	Educate about drug side-effects, prevent misuse and trafficking of opioids	Low
Safe treatment, drug-monitoring contracts	High-risk drug (eg, immunosuppressants)	Educate about drug side-effects, increase adherence to laboratory monitoring	Moderate
Healthy living	Lifestyle modification (eg, diet, exercise)	Engage patient in goal of lifestyle modification	High
Difficult patient	Disruptive patients	Clarification of clinic rules, engage patient in goal of decreasing disruptive behaviour	Moderate

Some contracts are intended mainly as therapeutic interventions to motivate behavioural change, whereas others have external justification (such as to maximise use of scarce organs or to prevent narcotic drug diversion).

Table: Common types of patients' contracts

In view of the inconclusive evidence about the effectiveness of these contracts and their possible disadvantages, we have some recommendations. First, clarify terminology; written patient-physician agreements generally do not fit the usual definition of a contract. Second, clarify aims; for example, if the main aim is to state non-negotiable terms (such as substance-misuse criteria for transplant candidacy) it would be franker to label the document an acknowledgment of clinical policies. Third, treat the contract as part of a therapeutic process—a standard form contract is one thing, and helping patients set and meet goals is another. This is the fundamental principle behind motivational interviewing, a technique with strong empirical support.¹² Finally, patients should be given resources and assistance to meet their goals; for example, structured weight-loss programmes work better than advice to diet and exercise.

Although the aims of contract use might be sound, physicians need to understand contracts' limits and the ways they can be misunderstood, to the detriment of the patient-physician relationship. Whenever possible, written agreements should be bilateral, tailored to the individual patient, and presented in a way that signals continuing commitment. Otherwise, we risk alienating patients and damaging the therapeutic alliance.

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We declare that we have no conflicts of interest.

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