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PERSPECTIVE

Power and control: contracts and the patient–physician relationship

Editor's Choice

Contracts with patients have become increasingly common in clinical practice and the medical literature. These include behavioural contracts for managing 'difficult patients' (1), opioid contracts (2–5), suicide prevention contracts (6,7) and healthy living contracts (8). Some physician practices have even asked patients to sign contracts promising not to litigate or postdefamatory comments on the Internet (9). Despite widespread adoption, few have stopped to consider the potential risks and ethical concerns with using these documents. This perspective will describe how patient contracts are ultimately about power and control, and if not used carefully could damage the patient–physician relationship.

What are patient contracts?

The definition of a contract according to the Oxford English Dictionary is a 'mutual agreement between two or more parties that something shall be done'. Patient contracts stray far from this definition and serve many other purposes beyond agreement over a course of action. As shown in Table 1, the intent of contracts varies by clinical situation (10). Nonetheless, they share one common feature: they are created by physicians and signed by patients.

Many good reasons to use them

Many contracts are driven by harsh realities: physicians must regulate opioid prescribing, fairly allocate organs for transplantation and prevent maltreatment of clinic personnel (Table 1). Thus, contracts in these settings are intended to clarify expectations and foster transparency (2). For example, contracts for opioid prescription establish rules of behaviour and limit misunderstandings. In the setting of organ transplantation, a written substance abuse contract seeks to make patients explicitly aware of eligibility criteria for transplant listing. However, in other situations contracts have less regulatory – and more therapeutic – intent. Some contracts can help doctors assess risk and express concern for a patient, as in the case of suicide prevention contracts (7). Others are intended as educational tools, with the patient's signature used to reinforce the importance of assimilating the information (11). Finally, some contracts are used to foster patient responsibility for improved health and motivate behavioural change. In this way, they can be likened to 'Ulysses contracts' – signing a contract helps patients bolster the willpower of their 'future selves' (12).

Power: a relationship between unequals

At first glance, these reasons may seem perfectly valid justification for using patient contracts. However, let us consider the method by which these documents are used. In most cases, patients are asked to sign a standard form drafted by the physician or medical staff, without opportunity for negotiation of terms. This resembles what is known in the legal literature as an 'adhesion contract' – a 'standardised contract, which imposed and drafted by the party of superior bargaining strength, relegates to the subscribing party only the opportunity to adhere to the contract or reject it' (9). In most areas of life (e.g. applying for a home mortgage), the subscribing party is freely able to walk away from these contracts if they choose. Such is not the case for patients, who by virtue of illness, knowledge base and social hierarchy are the less powerful party in a patient–physician relationship (13). Moreover, many patients have limited choices of healthcare providers, because of constraints by geography, insurance and financial resources.

Control: the true aim of contracts

While patient contracts have myriad stated goals, they share a common theme: physicians attempting to control the behaviour of their patients. In some instances, this is done in the patient's best interests in an attempt to reach therapeutic aims. In other instances, controlling behaviour is important to protect health care staff, to use scarce resources more

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Table 1 Common types of patient contracts. Some contracts are intended primarily as therapeutic interventions to motivate behaviour change, while others have external justification such as maximising use of scarce organs or preventing narcotic diversion

Contract type	Clinical setting	Aim	Therapeutic intent
Suicide prevention contract	Mental health	To assess risk of suicide. To engage patient in preventing suicide.	High
Addiction treatment contracts	Treatment of addiction	To engage patient in preventing recidivism.	High
Transplant substance abuse contracts	Organ transplantation	To communicate substance abuse criteria for receipt of organ transplant.	Low
Opioid contracts	Chronic narcotic prescription	To educate about medication side effects. To prevent misuse and trafficking in narcotics.	Low
Safe treatment contracts/drug monitoring	High-risk medication (e.g. immunosuppressants)	To educate about medication side effects. To increase adherence to laboratory monitoring.	Moderate
Healthy-living contracts	Lifestyle modification (diet, exercise)	To engage patient in goal of lifestyle modification.	High
Difficult patient contract	Disruptive patients	To clarify rules of the clinic. To engage patient in goal of decreasing disruptive behaviour.	Moderate

effectively and to avoid problems such as opioid drug trafficking. Attempts to modify patient behaviours are perfectly acceptable in a milder form, termed *persuasion.* Every day, physicians must persuade patients that their diagnosis is correct and the proposed treatment plan is a good one. Physicians respect patient autonomy by giving patients reasons to choose a proposed therapeutic course and together physician and patient come to an agreement on a plan of action. But turning these informal agreements into formal documents, presented to the patient without opportunity for negotiation, turns persuasion into control and even coercion. In other words, patients may feel forced to sign a clinical contract for fear of jeopardising their relationship with their physician and not receiving the medical care they need.

Consequences of breach

When used in the legal context, contracts revolve around the exchange of something valuable, called 'consideration.' In some clinical settings, the consideration is clear: continued prescription of narcotics, or eligibility to receive a liver transplant, in exchange for the patient adhering to terms of the contract. But what consideration is given for suicide prevention or healthy living contracts? In other areas of life, breach of a contract ends the relationship between the parties. In medicine, does the 'consideration' provided in exchange for contract adherence includes continued medical care? If so, many would argue that this stipulation violates physicians' ethical obligations not to abandon patients (14). Even if not, the consequences of breach may not always be clear to patients, who may assume from the word 'contract' that the relationship would be terminated.

Because of these implied consequences, contracts run the risk of fundamentally altering the patient–physician relationship – a relationship that has traditionally been founded on unconditional loyalty (15). If patients feel that their medical care could be terminated at any time for perception of non-compliance, how can they openly communicate with their physicians or participate in shared decision making? Patients may feel threatened or coerced, and perhaps even view the contract as a 'prelude to abandonment' (11). Furthermore, requiring patients to sign a contract for entering into a treatment relationship may send a message of distrust, which could harm not only the relationship, but also the patient's sense of self-efficacy (3).

Conclusion

In summary, the word 'contract' is a misleading term for documents which are being increasingly used in a wide variety of clinical situations. To avoid harm to the patient–physician relationship, we have a number of suggestions as shown in Table 2. In cases where the contract is serving primarily a regulatory purpose (e.g. opioid prescription), we suggest replacing the

Table 2 Recommendations for using physician–patient agreements in medicine: the A, B, C's

Recommendation	Definition/Explanation
A = No abandonment	No threat of abandonment. The physician should continue to provide for the patient, but may be limited in the type of care that can be given.
B = Bilateral agreement	Both parties sign agreement. Both parties have obligations to uphold that are clearly outlined in agreement.
C = Informed consent	Clear, explicit terms stated in simple language. Patient educated in: Actions that he/she must perform. Actions that the physician/healthcare team will carry out. Consequences for breach of agreement (i.e. description of how care will be altered).
D = No discrimination	Selection of behaviour demanded of patient is not based on stigmatisation. Justification provided as to why agreement targets the specific behaviour/action in question and not others.
E = Equal opportunities	Patient should be educated on how to carry out his end of the agreement. All patients have access to services/resources needed for behavioural change and improved health. (e.g.) Substance abuse counselling, weight loss programme, etc.
F = Fair terms	Patient provided enough time to understand agreement. Patient provided enough time to carry out his/her obligations Achievable goals/terms for patient. Avoid extreme limitations on personal liberties. Patients cannot waive their rights completely when it comes to reporting medical grievances/malpractice.

implication-laden term 'Contract' with something like 'Acknowledgement of Clinical Policies.' Policies need to be clearly stated in simple, understandable language and they should be explained to patients to maximise understanding. Clinic policies should not discriminate against certain patient populations. Patients should be provided enough time to understand the policy, ask questions and carry out their obligations. It is not enough to inform patients of the policy itself; healthcare professionals must also inform patients of resources and ways to achieve these goals. Ultimately, policies should emphasise that physicians will not abandon patients at any point, but may be limited in the type of care they can deliver based on the policy. Finally, for situations where the primary intent is behaviour change, we urge physicians to instead use alternative methods of persuasion. An example of such an alternative would be motivational interviewing, a technique with strong empirical support and fewer negative connotations (16). We hope that these suggestions will foster improved patient–physician communication and help engage patients in assuming responsibility for their health.

Disclosures

The authors have no conflicts of interest to disclose.

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