Published in final edited form as:

Lancet. 2012 January 7; 379(9810): 7–9. doi:10.1016/S0140-6736(11)60170-0.

Patient Contracts in Clinical Practice

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Written documents called “contracts” are appearing with increasing frequency in clinical practice and the medical literature. There are behavioral contracts for managing “difficult patients,”¹ opioid contracts,² suicide prevention contracts,³ and healthy living contracts.⁴ Some practices have even asked patients to sign contracts promising not to litigate or post defamatory comments on the Internet.⁵ Despite this widespread adoption, the use of contracts in medicine has been subject to relatively little critical appraisal. As shown in Table 1, patient contracts do different things in different clinical situations. Some serve “administrative” goals, like deterring patients from mistreating clinical personnel or diverting narcotics. Others are educational; they draw the patient’s attention solemnly to information. Others clarify expectations and foster transparency, as when a prospective organ recipient agrees to substance-abuse rules. Others – like suicide-prevention contracts – help doctors express their concern for their patients. Finally, some “Ulysses contracts” help patients hold themselves to better health practices by bolstering their willpower through a written commitment. (Ulysses in Homer’s *Odyssey* had his men to tie him to the ship’s mast so he could not respond to the Sirens’ song.)

Not only do “patient contracts” have myriad purposes, they have uncertain success. A Cochrane review analyzed thirty randomized trials in addiction, weight-control or medication-adherence settings.⁴ The endpoints included processes (e.g., adherence to treatment) and targets (e.g., blood pressure). Results were mixed, with fifteen endpoints showing a benefit of contracts compared to usual care, six favoring standard care, and twenty-six endpoints showing no difference. Even less is known about other kinds of contracts. A review of eleven observational studies found weak evidence that opioid contracts reduced narcotic diversion or misuse.⁶ Contracts with other aims (like suicide prevention) have not been empirically studied.⁷

To some extent, any patient encounter can be viewed as contractual, whereby the patient and physician agree on mutually accepted responsibilities.⁸ But here the term “contract” becomes problematic. In the legal context, what makes a contract different from an agreement is that contracts are intended to be enforced. So turning informal agreements into formal documents emphasizes the consequences of breach, whether explicit or implied. In some clinical settings, these consequences are clear: the doctor will no longer prescribe

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Disclosures: all authors participated in the intellectual development and writing of this paper. No funding was obtained for this work, and none of the authors has any conflicts of interest.

narcotics, or the patient will not get a liver transplant. However, does adherence to terms of the contract also become a pre-condition for continued medical care? If so, many would argue this violates physicians' ethical obligations to not abandon patients.⁹ 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 risk fundamentally altering the patient-physician relationship – a relationship traditionally founded on unconditional loyalty.¹⁰ If patients feel their medical care could be terminated at any time for perception of 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 opportunity for negotiation of the terms. And a unilateral or authoritarian style of implementing contracts may cause patients to feel threatened or coerced, and perhaps even view the contract as a "prelude to abandonment."¹¹

Given the inconclusive evidence of the success of these contracts and the disadvantages they can present, we have some recommendations. First, clarify terminology. Written patient-physician agreements often do not fit the usual definition of a contract, and they serve varied purposes. Second, clarify aims. For example, where the primary aim is stating non-negotiable terms (like substance-abuse criteria for transplant candidacy), it is franker to label the document an "Acknowledgement of Clinic Policies." Third, treat the "contract" as part of a therapeutic process. A boilerplate contract is one thing, *helping patients set and meet goals* is another. This is the principle behind "motivational interviewing," a technique with strong empirical support¹². Finally, patients should be given resources and assistance in meeting these goals. For example, structured weight loss programs work better than just telling patients to "go diet and exercise."

In sum, "contract" is a misleading term for documents which are increasingly used in a wide variety of clinical situations, with myriad purposes and uncertain effectiveness. Although the aims of contracting may be sound, physicians need to understand the limits of contracts 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 patient, and presented in a way that signals ongoing commitment. Otherwise we risk alienating patients and damaging the therapeutic alliance.

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Table 1
Common Types of Patient Contracts

Some contracts are intended primarily as therapeutic interventions to motivate behavior change, while others have external justification such as maximizing use of scarce organs or preventing narcotic diversion.

CONTRACT TYPE	CLINICAL SETTING	AIM	THERAPEUTIC INTENT
SUICIDE PREVENTION CONTRACT	<ul style="list-style-type: none"> Mental Health 	<ul style="list-style-type: none"> To assess risk of suicide To engage patient in preventing suicide 	High
ADDICTION TREATMENT CONTRACTS	<ul style="list-style-type: none"> Treatment of Addiction 	<ul style="list-style-type: none"> To engage patient in preventing recidivism 	High
TRANSPLANT SUBSTANCE ABUSE CONTRACTS	<ul style="list-style-type: none"> Organ Transplantation 	<ul style="list-style-type: none"> To communicate substance abuse criteria for receipt of organ transplant 	Low
OPIOID CONTRACTS	<ul style="list-style-type: none"> Chronic narcotic prescriptio 	<ul style="list-style-type: none"> To educate about medication side effects To prevent misuse and trafficking in narcotics 	Low
SAFE TREATMENT CONTRACTS/ DRUG MONITORING	<ul style="list-style-type: none"> High risk medication (ex: immunosuppressants) 	<ul style="list-style-type: none"> To educate about medication side effects To increase adherence to laboratory monitoring 	Moderate
HEALTHY-LIVING CONTRACTS	<ul style="list-style-type: none"> Lifestyle modification (diet, exercise) 	<ul style="list-style-type: none"> To engage patient in goal of lifestyle modification 	High
DIFFICULT PATIENT CONTRACT	<ul style="list-style-type: none"> Disruptive patients 	<ul style="list-style-type: none"> To clarify rules of the clinic To engage patient in goal of decreasing disruptive behavior 	Moderate