Pain contracts can undermine patient trust, critics say

■ A new article cautions that although the documents improve care when done right, an adversarial approach is "corrosive" to the doctor-patient relationship.


As the misuse of opioids has grown, more physicians have urged patients to sign so-called pain contracts in an effort to prevent medication diversion.

But these contracts, also called opioid treatment agreements, can be used indiscriminately and harm rather than enhance the physician-patient relationship, according to an article by a panel of physicians and pain-policy experts in the November issue of *The American Journal of Bioethics*.

"It is not that any of us disagree with the notion that agreements can, in fact, be very helpful in certain circumstances," said Myra Christopher, co-author of the article. She noted that patients with a history of substance abuse or mental illness may be aided by documents that inform them of the risks and benefits of opioids and set out a care plan.

"But," she said, "what is becoming common practice in many pain specialty clinics is using a preprinted, standardized form that says, 'If we're going to treat or prescribe controlled substances to you, these are the conditions under which we'll do so -- and sign this document, and if you fail to do so, then we'll fire you from our practice.'"

That kind of adversarial approach is "corrosive to the relationship" and threatens patients in need with abandonment, said Christopher, CEO of the Center for Practical Bioethics, a think tank in Kansas City, Mo., that convened an April meeting on pain contracts. The center also publishes the bioethics journal.

Though pain agreements vary, they often involve urine screening for medication levels and specify the number and frequency of prescription refills. How physicians discuss the agreements with patients is critical, said Will Rowe, who wrote a guest editorial in the journal and is chief executive officer of the American Pain Foundation, a Baltimore-based patient advocacy organization.

"Just think about how it's presented -- unless you sign this, you won't get your medications," Rowe said. "That, to me, is crossing the line. ... It's basically a document that says, 'You do this, or I've gotcha.' That's basically interfering with what should be a trusting relationship between the patient and the practitioner."

**Scope of the problem**

The American Academy of Pain Medicine, the American Pain Society and the Federation of State Medical Boards have recommended that physicians consider using opioid treatment agreements.

A written agreement, when used without coercion and for the purpose of promoting the patient's health, is in line with "fundamental ethical principles," said Perry G. Fine, MD, president of the American Academy of Pain Medicine.

Many doctors, who are concerned about high-profile prosecutions of physicians treating patients with chronic pain, use the documents as a way to protect themselves legally while making clear to patients that they will not tolerate diversion -- a growing problem.

The number of Americans 12 and older who used prescription pain relievers recreationally grew from 11 million in 2002 to 12.5 million in 2009, according to the Substance Abuse and Mental Health Services Administration. Only 7% of people misusing opioids surveyed by the agency said they received the medications directly from physicians. Most got their medications from friends or family, or bought them from a drug dealer.
Fatal opioid overdoses tripled to nearly 14,000 from 1999 to 2006, according to the Centers for Disease Control and Prevention. The CDC estimated in June that emergency department visits involving opioids more than doubled to nearly 306,000 between 2004 and 2008.

More research needs to be done on the effectiveness of pain contracts, but when done correctly, they can serve patients' best interests, said Seddon R. Savage, MD, director of the Dartmouth University Center on Addiction, Recovery & Education and president of the American Pain Society.

"Because opioids are complex medications that may serve to distort judgment in some patients, a prospectively implemented [opioid treatment agreement] helps assure that the best judgment of the patient will continue to be served if his or her perceptions or cognition are altered by the medications," Dr. Savage wrote in an article that also appeared in the bioethics journal. Such documents should be "patient-centered," she added, writing as an individual.

Doctors struggling to treat patients in pain while avoiding legal scrutiny should avoid the quick fix promised by one-size-fits-all pain contracts, Christopher said.

"I can fully understand why the primary care doctor will say, 'I don't want to be in trouble with the medical board. [Pain agreements] seem to be a trend, and then if I get asked by the medical board about this I can say, 'Look at all these contracts I have in my medical charts,' " she said.

"But if the question is how do I best help my patients, how do I build trust with my patients, then that's a more complex proposition."

EXTERNAL LINKS