What processes have you put in place to make interactions with patients on chronic narcotics less confrontational?

1. Thus far, I have refused to use a pain contract and haven't had significant problems. I contend that a contract implies that the patient has an inherent right to narcotics and I have an obligation to provide them and I disagree with both. Having a separate contract for narcotics instills in patients that these are "special medicines" as opposed to simply a part of a comprehensive management plan. I have an obligation to provide the treatments that are appropriate in my professional opinion, which may change over time as the patient's condition changes.

I advise all patients up front that anyone on narcotic medications will have regular OBNDD reports run to identify anyone who might try to obtain narcotics from other physicians. We focus on functional issues that they want to accomplish, not on the pain that prevents them, and emphasize chronic vs. acute methods to address their pain. I will only provide a 2 week Rx for chronic meds on a new patient until all records are obtained from the previous PCP. I've found that most of these patients are no longer interested in keeping their appointment when asked about the other physicians on their OBNDD report.

I had a chance to discuss this with a pain management specialist in Tulsa at the OAFP Scientific Assembly. He only partially concurred with my thoughts. He stated that most pain contracts were way too comprehensive and should be simplified to be only 1-2 paragraphs and highlight a few key points. He also said that he would recommend identifying it more as an "agreement" or "policy" than a "contract." He did feel as though patients should be asked to sign a copy to acknowledge they received it. If policy dictates that all patients receive it, I don't see the need to keep a signed copy, but that was his thought.

2. I have been considering the pros and cons of having a pain contract. I would be interested in seeing a copy of the contract you currently use. I have noticed that a lot of the pain management specialists are mostly interested in doing lumbar injections and really don't want to write prescriptions for chronic narcotics and have often referred those patients back to us to deal with their chronic pain. Anyone else has this experience/problem?

3. I try not to give narcotics to those who shouldn’t have them, based upon past history and red flags. Those who chronically need them, sign a pain contract. If they break the rules, they get no more narcotics. We agree on a specified dose and monthly amount and that is all they get no matter what happens. During visits, we don’t spend much time discussing pain. I try to direct the conversation toward functional goals.

4. My clinic policy states that narcotics shall be prescribed for no longer than 2 weeks; we do not treat chronic pain. If patients require a longer course of narcotics, they are referred to a pain management specialist. There have been no confrontations thus far, as this policy is made clear at the initial visit. This policy also extends to several of the benzodiazepines.

5. In the Family Medicine Center there exists a process to ensure that people on chronic narcotic therapy are part of a treatment plan that includes utilizing Pain Management specialists and other specialties, including psychiatry depending on the source of pain and the presence of co-morbidities. Every effort is made to minimize the dosage and frequency of narcotics. Any patient on narcotics for longer than 3 months is also required to sign a narcotics contract. Frequently drug screens are performed to ensure that the patient is taking the prescription medication and not abusing recreational drugs. The plan is explained to the patient in detail. There are occasional confrontations, but by and large the interactions involving narcotics have been peaceful. We are reluctant to fire patients, because we are often the court of last resort.

6. I have them sign a contract with me. If the contract is broken, they are fired. It is very simple.

7. I have a very strict policy regarding refills, appointments, etc. I try to blame the harshness on the state and federal government so the patient can have someone else to be grumpy with. “Yeah, darn those feds for putting these rules into place… (wink wink)”. It works.