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forthcoming in Journal of Medical Ethics

"First, Do No Harm": Physician Discretion, Racial Disparities, and Opioid Treatment Agreements

Abstract:

The increasing use of opioid treatment agreements (OTAs) has prompted debate within the medical community about ethical challenges with respect to their implementation. The focus of debate is usually on the efficacy of OTAs at reducing opioid misuse, how OTAs may undermine trust between physicians and patients, and the potential coercive nature of requiring patients to sign such agreements as a condition for receiving pain care. An important consideration missing from these conversations is the potential for racial bias in the current way that OTAs are incorporated into clinical practice and in the amount of physician discretion that current opioid guidelines support. While the use of OTAs has become mandatory in some states for certain classes of patients, physicians are still afforded great leeway in how these OTAs are implemented in clinical practice and how their terms should be enforced. This paper uses the guidelines provided for OTA implementation by the states of Indiana and Pennsylvania as case studies in order to argue that giving physicians certain kinds of discretion may exacerbate racial health disparities. This problem cannot simply be addressed by minimizing physician discretion in general, but rather by providing mechanisms to hold physicians accountable for how they treat patients on long-term opioid therapy to ensure that such treatment is equitable.

Introduction

The increasing use of opioid treatment agreements (OTAs) has prompted debate within the medical community about ethical challenges with respect to their implementation. OTAs are different from informed consent documents in that they not only list the risks associated with opioid medications and possible alternative treatment options, but also articulate the clinic policies and behavioral requirements to which patients must adhere in order to be prescribed these medications.[1] Debates on this topic commonly discuss concerns such as the efficacy of OTAs at reducing opioid misuse, how OTAs may undermine trust between physicians and patients, and the potential coercive nature of requiring

patients to sign such agreements as a condition for receiving pain care.[1-3] Another important but underexplored ethical consideration is the potential for racial bias in the current way that OTAs are incorporated into clinical practice and the way that these agreements allow for significant physician discretion regarding pain treatment. While the use of OTAs has become mandatory in some states for certain classes of patients, physicians are still afforded great leeway in how these OTAs are incorporated in clinical practice and how their terms end up being enforced. For example, if patients have aberrant drug tests, many OTAs (including the ones we will survey here) claim that physicians *may* discontinue prescribing opioids, not that they *will* do so.[4-7]

Physician discretion is a double-edged sword. On the one hand, physicians need some measure of flexibility to address the specific needs and situations of their patients. Nonetheless, physicians exhibit racial bias just as the general population does, which is one cause of racial health disparities.[8-10] As such, giving physicians discretion in how they respond to patients as individuals will likely result in disproportionately worse health outcomes for racially minoritized patients, and for Black patients in particular. Even if we accept that some measure of physician discretion is a necessary feature of therapeutic alliances surrounding long term opioid therapy (LTOT), we should not ignore the predictable racial disparities that will result from this discretion and we should create systems to monitor and address these predictable outcomes.

This paper hopes to start a conversation about the relationship between physician discretion as expressed in opioid treatment agreements and racial disparities in pain care. We use guidelines provided for OTA implementation by the states of Indiana and Pennsylvania as case studies in order to argue that giving physicians certain kinds of discretion may exacerbate racial health disparities. As we will argue, this problem cannot simply be addressed by minimizing physician discretion in general, but rather by providing mechanisms to hold physicians accountable for how they treat patients on LTOT to ensure that such treatment is equitable. It should be noted from the outset, then, that this paper ultimately does not defend or reject the use of OTAs in clinical practice. As others have articulated, there is little evidence that implementing OTAs improves patient health outcomes or guards against opioid misuse.[11] Accepting

some measure of physician discretion as necessary in the context of LTOT does not entail that patients should be required to sign a document that highlights the many ways physicians can wield this discretion in the course of treating their pain.

Moreover, it is unclear how OTAs should be incorporated into practice in an equitable way. If we leave it up to physicians to determine which patients must sign OTAs in order to begin LTOT based on judgments about risk, as we will argue, a predictable result of this practice will be that it exacerbates racial health disparities. But if OTAs are burdensome for patients and ineffective at improving health outcomes, then universal precaution approaches have their costs as well. A universal precaution approach to implementing OTAs can be criticized as inappropriately "leveling down" standards of medical treatment in an attempt to find an equitable response to the overdose crisis. If this is the case, then one possible resolution would be to get rid of the practice of using OTAs altogether, though current trends in regulation suggest this resolution is unlikely to come about in the near future.[12] We leave it up to defenders of OTA use to articulate their utility in clinical practice, and in the meantime offer preliminary suggestions about how to mitigate some of their ethical costs.

§1 Racial Bias in Medicine

There is substantial empirical evidence that physicians exhibit racial bias that negatively impacts patient care and contributes to health disparities. Some of this evidence concerns implicit bias, which can best be explained as a malleable, subconscious preference for one group over another.[10] Studies using the implicit-association test (IAT) have demonstrated that medical professionals succumb to the influence of implicit bias just as often as the general population does.[13-14] Since this type of bias is subconscious, a physician cannot rely on her own judgment to guard against its influences, and well-meaning physicians can make decisions tainted with implicit bias, to the detriment of their patients.

Studies have found that implicit bias on the part of physicians undermines the quality of care that Black patients receive.[13-15] For example, Green et al. found that physicians with higher levels of anti-Black implicit bias were less likely to recommend thrombolysis, the standard of care, when treating a hypothetical Black patient presenting with acute coronary syndrome.[13] Importantly, while their implicit

anti-Black bias was strongly associated with differential treatment, physicians' self-reported views about the hypothetical patient's cooperativeness did not predict racial differences in their treatment decisions.[13] This highlights how treatment outcomes can be influenced by implicit bias in ways that elude physicians' self-awareness. Physicians' implicit racial bias also leads to worse communication with patients, lower levels of patient satisfaction, and lower levels of patient confidence in physicians' treatment recommendations.[14-15]

There is also mounting evidence of racial bias in treatment specifically in the field of pain management. A complex set of institutional mechanisms leads to the undertreatment of pain in minority populations, including insufficient stock of pain medication in pharmacies situated in low-income neighborhoods, as well as collective physician behaviors such as inadequate prescribing.[16] Black patients are prescribed fewer opioids compared with white patients, and are instead more frequently prescribed non-opioid analgesics.[17-20] This trend appears in the Black pediatric population as well as in adult patients, and some studies record it in the elderly Black population.[17-22] Further, Black patients' opioid dosages are generally tapered more aggressively, which can lead to negative health consequences.[23-24]

Racial differences in opioid prescribing may be partially explained by racial and ethnic differences in preferences regarding types of pain medication. But they can also be correlated with [a] physicians' incorrect notion that Black patients have a higher pain tolerance, or with [b] physician's heightened suspicion of Black patients regarding the potential for opioid misuse.[25-26]

False beliefs about Black pain, specifically that Black people have fewer nerve endings and thicker skin and thus possess innate pain resistance, have a long history in American culture and in medicine. These views date back to 19th-century slaveowners and scientists who sought to justify enslavement and inhumane treatment of Black people, and remained prevalent into the 20th century as scientists rationalized unethical testing on Black patients such as the notorious Tuskegee experiment.[27-28] Importantly, whether or not a physician holds explicitly negative racial attitudes is not predictive of whether they hold false beliefs about Black physiology, and holding such beliefs is associated with underestimating Black patients' pain and providing a higher proportion of incorrect treatments.[27, 29] Thus,

physicians may take themselves to treat patients of all races equally, while in truth they are unable to see their biases for what they are, and their patient care suffers.

Finally, disproportionate suspicion of Black patients is evidenced by trends in clinical practice and elsewhere.[30-32] Black patients being treated with LTOT are more likely to be drug tested than white patients on LTOT.[31] In addition, of those patients who have aberrant drug tests, Black patients are more likely to have their LTOT discontinued, while white patients are more commonly allowed the leniency to continue opioid therapy despite the fact that white patients are in fact more likely to misuse prescription opioids.[31-32] Finally, Black people are more likely to face jail time for drug offenses than white people, and of those who are convicted on drug charges, Black people typically receive longer sentences.[33] These racial disparities related to incarceration lead to lasting negative health outcomes for Black patients and Black communities.[34]

Each of these disparities tells a larger story: physicians, whether they realize it or not, exhibit more distrust toward Black patients and are less likely to give them the benefit of the doubt when opioid misuse is indicated. These disparities strongly suggest that situations in which a professional must make a judgment call on an individual's character, such as when deciding whether to end LTOT or whether to report opioid misuse to police, are statistically more likely to have worse outcomes for Black people. Thus, practices that rely on physician discretion rather than providing clearer direction are likely to contribute to racial disparities.

§2 Physician Discretion in OTAs

In the last section, we presented evidence that physicians exhibit racial bias, and that this bias combined with structural racism has a negative impact on pain management for Black patients. This section explores the distinctive potential for racial bias that comes with the use of OTAs in clinical practice. To do this, we will compare the sample OTAs and guidance for their implementation developed by the states of Indiana and Pennsylvania. Because these documents are offered as guidance and are meant to be adapted to individual practices, we should expect some variation across practices in how they are implemented. However, guidance from state health organizations has real impacts on health care

system protocols, insurance, and legislation, so this guidance is informative about the characteristics of OTAs statewide. We will look at three different domains in which physician discretion may be codified in each of these documents: [1] in the choice to discontinue opioid medication or terminate care, [2] in the choice to drug test patients, and [3] in the choice to communicate with others about the patient's medications, including communicating with law enforcement (See Table 1). Given what we know about racial bias, each of these occasions for physician discretion is also an opportunity for harmful treatment of Black patients.

§ 2.1 The sample OTAs

In 2013, the Indiana Prescription Drug Abuse Prevention Task Force (IPDAPTF) created a manual for physicians entitled *First Do No Harm*, which includes a sample OTA and additional guidelines for LTOT.[4] This manual has not been revised in light of more recent federal guidance, and no other sample treatment agreements have been issued by the state of Indiana since the manual was first published. While language supporting physician discretion is particularly clear in Indiana's sample OTA, we will point out ways in which the discretionary powers codified in that document can be found in other sample OTAs. In these other samples, the discretionary powers are made less explicit. In this way, the *First Do No Harm* manual is a helpful case study because it highlights various forms of physician discretion in OTAs, some of which are more problematic than others.

In 2020, the Pennsylvania Department of Health (DOH) issued new regulations to give guidance on Pennsylvania's new opioid patient treatment agreement law, Act 112 of 2019, which mandates that patients sign OTAs before being prescribed LTOT.[5] These regulations include a sample OTA, which we argue does a much better job at introducing physician accountability alongside physician discretion. This sample OTA draws on previous bioethical discussions about the ethical burdens associated with using OTAs,[35] and attempts to ameliorate those burdens. Notably, we will argue that even this preferable sample may still allow for too much physician discretion, which is likely to exacerbate existing racial health disparities related to opioid prescribing.

§ 2.2 Discretion over discontinuation of medication and termination of care

There are two ways in which the Indiana sample OTA enshrines discretionary powers on the part of the physician when it comes to decisions related to discontinuation of opioid medication or patient dismissal: the physician can make decisions on the basis of medical judgement and on the basis of the patient's behavior. Consider first how the Indiana OTA describes physician discretion in response to patient behavior. Before enumerating the norms and expectations related to LTOT, the Indiana OTA begins with the following clause: "Violation of any part of this agreement may result in this medication being discontinued, as well as termination of your relationship with your provider."[4] While this clause may sound particularly extreme, it is a common part of sample OTAs in general. The American Academy of Pain Medicine's *Agreement on Controlled Substances Therapy for Chronic Pain Treatment*, for instance, closes with similar language: "You understand and agree that failure to adhere to these policies will be considered noncompliance and may result in cessation of opioid prescribing by your physician and possible dismissal from this clinic."[6]

There are a number of ethical problems with this sort of framing that others have compellingly noted: such language makes the documents read like legal contracts instituted to protect healthcare providers from liability rather than promote the patient's interests, it is overly punitive in tone and undermines trust in the therapeutic relationship, and finally, without any explicit non-abandonment clause, it fails to convey to patients that they have certain protections regarding access to continued medical care.[1-3, 36-37] We share these concerns, and we want to draw attention to one significant way in which the physician discretion codified in OTAs can further exacerbate these already ethically problematic clauses.

Not only does the Indiana sample OTA open with the possibility of dismissal or medication discontinuation; it also gives no guidance for the patient as to the sort of infraction that they could expect would prompt either of these responses, or why some behavior would lead physicians to one response over the other. Thus, the physician is *de facto* encouraged to choose on a case-by-case basis which patients suspected of opioid misuse should have their LTOT discontinued or their relationship with the

physician terminated. Based on the evidence presented above concerning racial bias in pain care, this sort of deference to the physician's professional opinion expressed in the *First Do No Harm* guidelines is likely to result in less continuity in pain management for Black patients as compared with white patients. More generally, rushed tapering and discontinuation of care has disproportionately affected poor patients, women, and patients of color.[23-24] Abrupt tapering and destabilizing of dosages can lead patients to seek out illicit drugs and is correlated with a three-fold increase in overdose deaths.[38-40]

Consider, in addition, how the Indiana OTA codifies physician discretion regarding patient dismissal or medication discontinuation on the basis of medical judgement. The sample Indiana OTA states that "[i]f it appears to [the] healthcare provider that there is no improvement in [the patient's] daily function or quality of life from the controlled substance, [the] medicine may be discontinued."[4] We should highlight that, in this document, the physician's medical judgement may justify a change in the patient's medication but not a patient's dismissal from the practice. This is an important curtailment of physician discretion present in Indiana's OTA that offers patients protection against dismissal due to their medical prognosis. One side effect of the opioid crisis is that patients with chronic pain have increasingly had difficulty finding physicians willing to treat them.[41] Once patients with chronic pain have found a physician, it could be a source of comfort for them if their OTA suggests that they will not be dismissed from the practice just because the physician sees no clinical improvement. Moreover, this clause seems precisely like the sort of domain in which physician discretion is key: physicians should use their clinical judgment to determine whether opioid medications are working to ensure that patients do not become dependent on a non-beneficial drug.

While some physician discretion about clinical value of medication is appropriate here, it is useful to contrast the way the physician discretion is explained in the Indiana sample OTA and in the Pennsylvania sample OTA. The Pennsylvania sample OTA has a similar clause regarding discontinuation of opioids. Among the physician responsibilities this sample OTA describes are the following:

> "I will listen to my patient's stories about living with pain. I will keep their personal goals in mind when recommending treatment."

> "I will keep learning about how to treat pain and recognize when opioid medications are causing more harm than benefit."[5]

There is a subtle difference in the way that physicians' medical judgment should enter into treatment decisions as per these two documents. In the Indiana OTA, the physician determines from their own perspective whether LTOT is working and whether it provides an improved quality of life for the patient. In contrast, when it comes to the role of physician medical judgment in the Pennsylvania OTA, the physician must determine whether the treatment is meeting the patient's stated goals and, on the basis of this standard, whether LTOT is causing more harm than benefit.

The Pennsylvania OTA thus keeps physician discretion in check in two ways. First, in the Pennsylvania OTA, the reasons for discontinuation must be derived from the physician's judgment of harm rather than more broadly from their judgment of lack of improvement. Moreover, according the Pennsylvania OTA, the judgement of harm should be grounded in the patient's stated goals and not merely in the physician's own views on the patient's quality of life. Thus, while both the Indiana and Pennsylvania OTAs provide some physician leeway in determining whether or not to discontinue LTOT, the Pennsylvania OTA circumscribes the physician's discretionary power in this domain and expects physician decisions to be justified in terms of the personal goals of the patient.

The Pennsylvania sample OTA further curtails physician discretion regarding medication discontinuation and patient dismissal as compared to the Indiana OTA. While the Pennsylvania document also includes provisions about expecting patients to follow clinic policies in order to continue LTOT, nowhere in the document does the physician reserve the right to dismiss patients for failing to do so.[5]

§ 2.3 Discretion Over Reporting

Both sample OTAs have clauses articulating physician reporting responsibilities. However, the Indiana sample OTA couches this responsibility in terms of physician discretion, whereas the Pennsylvania sample OTA describes these responsibilities as mandated by the state.[4-5] The Indiana OTA requires patients to authorize physicians to seek out information about their past medical behaviors or to provide information to third parties if physicians deem it necessary. The sample OTA states: "I agree to

allow my healthcare provider to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions if he or she feels it is necessary."[4] This is notable for a number of reasons. In general, physician-patient confidentiality is one of the founding tenets of modern medicine. When OTAs require patients to allow physicians to contact family members and law enforcement whenever "he or she feels it is necessary," they expect patients to give up one of their most significant rights in order to access treatment. This is likely to strain the physician-patient relationship and inhibit sincere communication.

Moreover, as with the LTOT discontinuation statement, the Indiana sample OTA does not provide information about which sorts of patient behaviors warrant breaches of confidentiality. Given what we know more generally about the workings of bias in medicine, this feature of the Indiana OTA allows for the disproportionate involvement of law enforcement in the lives of Black patients. Given that Black people are more likely to be incarcerated and receive longer sentences for the same crimes as compared with white people, giving physicians discretion in this area would have an outsized impact on the lives of Black patients on LTOT.

In contrast, the Pennsylvania sample OTA alerts the patient that the physician is required to participate in the Pennsylvania Prescription Drug Monitoring Program. Here, the physician is not exercising their own discretion about whether or not to report suspected aberrancy. Moreover, the Pennsylvania sample OTA includes the patient's "right to review and correct information on [their] report."[5] This is one example in the Pennsylvania OTA where patients are provided mechanisms for holding physicians accountable for their role as LTOT providers. There are no such accountability mechanisms on offer in the Indiana sample OTA.

§ 2.4 Discretion Over Drug Testing

Finally, one domain in which both the Indiana and Pennsylvania sample OTAs offer physicians discretion is in the practice of drug testing and monitoring patients on LTOT for potential opioid misuse and diversion. This sort of discretion creates opportunities for implicit bias to undermine patient care and exacerbate health disparities. The Pennsylvania sample OTA requires patients to agree to complete a

"targeted urine drug test" in situations in which "the provider determines testing is necessary."[5] The Pennsylvania law that the guidance is based on defines a targeted test as "a urine drug test ordered at the discretion of a prescriber, based on observation of the prescriber and related circumstances that enhance clinical decision making."[42] Similarly, the Indiana sample OTA does not recommend that all patients on LTOT be required to complete regular drug testing. Rather, the manual advises physicians to engage in risk stratification, which includes "evaluation of aberrant behaviors (actions that demonstrate irresponsibility).[4] One might see this as a good thing, as patients judged to be at low-risk could be spared the inconvenience and cost of drug testing. However, non-universal drug testing means that physicians are left with the discretion to determine which patients they think are at high risk for opioid misuse and diversion. This feature, common to both sample OTAs, would likely result in more Black patients being drug tested than white patients.[31]

One may worry that universal drug tests are a way of "leveling down" the standard of care for patients on LTOT in the name of racial equity. Not only can drug tests be time consuming and costly, they are also stigmatizing. It could be argued that physicians should not expose all patients to this sort of treatment, but only those for whom such tests are warranted. We recognize the stigma and the limits of these drug tests.[3] It is beyond the scope of this paper to adjudicate whether drug testing is an appropriate component of administering LTOT. The point we wish to make here is that as long as drug testing continues to be a standard part of LTOT, sample OTAs undermine patient care in racialized ways when they communicate that such testing is carried out at physicians' discretion.

First, if drug testing contributes to better health outcomes for pain management, white patients may not receive monitoring that is clinically appropriate due to physician bias, and may not be getting medical support that they need to manage possible opioid dependence or addiction. Second, regardless of the effectiveness of drug testing, without the adoption of a universal precaution approach, patients reasonably presume they are being tested based on their physician's judgment about their risk of opioid misuse or diversion. This presumption can inhibit trust; while this is a problem for the therapeutic alliance between physicians and patients across the board, it may pose unique and challenging barriers for Black

patients to receive the care they need. One study found that Black patients of physicians with higher implicit bias not only reported lower levels of satisfaction and confidence in their physicians' treatment decisions, but also anticipated greater difficulty in completing the recommended treatment.[15]

While it is not stated in the Indiana sample OTA itself, the *First Do No Harm* manual does give some recommendations for when to administer a drug test, such as after repeated requests for early refills or when a patient has a history of substance misuse. However, it also states that "any other factor" is grounds for drug testing and that the physician can still drug test if the patient does not exhibit the behaviors listed.[43] To some extent, it is appropriate to clarify that the reasons for drug testing described in the manual are not exhaustive. It can be difficult to determine which patients have opioid use disorder, since patients may not exhibit any of the common signs. Moreover, there is little evidence that screening tools succeed at risk stratification.[44] However, relying on physician judgment is not an improvement. Physicians often have difficulty distinguishing high-risk from low-risk patients; studies suggest that they instead rely on their implicit biases to decide who to test.[25, 31]

Physicians should exercise epistemic humility regarding the clinical implications of urine drug tests and risk stratification screenings. That is, physicians should recognize and be open about the limitations of their own clinical expertise and the tools that are available to them to guard against opioid-related morbidity and mortality.[45] As long as public health experts advocate for the use of drug tests as an important tool for mitigating the overdose crisis, these tests should be carried out in a way that does not further exacerbate health disparities.[44, 46] Because they recommend targeted rather than universal testing, both Indiana's and Pennsylvania's current guidance for LTOT provide opportunities for racial bias to influence the practice of pain management.

§3 Moving forward

The sample OTAs from Indiana and Pennsylvania are just two examples of how regulatory bodies in general have given physicians different levels of discretion in how they monitor their patients on LTOT. One reason that physician discretion sounds appealing is that it allows physicians to treat different patients differently based on their unique lives, comorbidities, preferences, and other factors. Universal

recommendations can be impractical across populations and regions, and on the individual level, one might argue that physicians know their patients better than a regulatory body does and thus are better equipped to address their personal needs. However, racial bias among physicians may prevent them from understanding their patients sufficiently to personalize their care in an equitable and non-harmful way. So, while physician discretion seems beneficial in theory, it could be exacerbating health disparities. More research is needed on how OTAs are used in practice and what sorts of patient behaviors influence clinical decision-making about LTOT. However, given the evidence at present, the cautionary stance would be to presume that physician discretion leads to worse pain treatment for Black patients.

While physician discretion can be a problem, minimizing discretion in every domain is not the solution. As we have argued, some of the occasions for physician discretion, such as the decision to pursue targeted drug testing, should be eliminated or minimized; this is because of the expressive harm done to patients who come to believe physicians are viewing them with suspicion. However, we recognize that in other domains, physician discretion is an important part of clinical care and has a role to play in pain management. For instance, physicians' clinical judgement can help patients make decisions about whether LTOT is effective according to the patient's own goals of care.

Finding the balance between universal precaution approaches that minimize bias on the one hand and paying attention to patients' individual circumstances on the other is challenging, particularly at the policy level, and we do not offer final solutions here. We suggest instead that creating mechanisms to hold physicians accountable for their decision-making is one important step toward ensuring that pain treatment is practiced equitably. Having an open conversation about the terms of an OTA could increase transparency around the ways in which physicians and patients can hold each other accountable in the context of LTOT.[47] For instance, crafting agreements that, like the Pennsylvania sample OTA, require physicians to solicit the goals of care from the patient creates an opportunity for physicians to exhibit epistemic humility, where the decision about whether to start or continue LTOT can be "an iterative and collaborative activity."[48] Finally, holding physicians accountable for how they use their discretionary powers will require better monitoring and data collection regarding the aggregate outcomes of physician

behavior. Health systems and clinics need to keep good records of which patients have signed OTAs and how the terms of those agreements are being enforced. Healthcare providers should regularly audit records of patient dismissals and tapering patterns to determine whether there are racialized differences in pain management over time. If differences are found, policy changes may be needed to minimize physician discretion in particular domains to make pain management more equitable.

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Table 1: Comparing Two Sample OTAs

Domain of physician discretion	*Does the Indiana OTA codify physician discretion?*	*Does the Pennsylvania OTA codify physician discretion?*
Whether to perform random drug testing	Yes: "I agree and understand that my physician has the right to perform random urine drug testing."	Yes: "We have discussed the importance of targeted urine drug testing. The Patient agrees to complete a targeted urine drug test in a situation in which the provider determines testing is necessary."
Whether to discontinue medication for medically indicated reasons	Yes: "If it appears to my healthcare provider that there is no improvement in my daily function or quality of life from the controlled substance, my medicine may be discontinued."	Yes: "Physician responsibility: I will listen to my patient's stories about living with pain. I will keep their personal goals in mind when recommending treatment."
Whether [a] to discontinue medication or [b] to dismiss patient from practice as the result of patient violation of clinic policies	[a] Yes and [b] Yes: "Violation of any part of this agreement may result in this medication being discontinued, as well as termination of your relationship with your provider."	[a] Yes and [b] No: "I understand the following prescribing policies of my healthcare provider and the conditions under which my healthcare provider may change my treatment plan or may stop prescribing opioid medication:"
Whether to contact third parties about patient's opioid use	Yes: "I agree to allow my healthcare provider to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions if the he or she feels it is necessary."	No: "I understand that information regarding prescriptions for controlled substances are collected by the Pennsylvania Prescription Drug Monitoring Program, and that I have the right to review and correct information on my report and may do so by visiting www.doh.pa.gov/pdmp and clicking 'Patient.'"
Whether to replace lost or stolen medication	Yes: "If my medications are lost, misplaced or stolen, my physician may choose not to replace my medications."	N/A