Prescription Drug Monitoring: A Perspective

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Keywords: Prescription Drug Monitoring Programs, Database, Addiction Management, Informed Consent

INTRODUCTION

Ever received a prescription for Xanax? You can bet that there was a record of it made in a digital database. Prescription Drug Monitoring Programs (PDMPs) contain detailed information about which controlled medications physicians prescribe individuals, including where, when, how much, by whom, and more. The programs allow physicians to glimpse into the life of each patient that visits them — sometimes before a single word is exchanged between them. Every state has a PDMP, and many states share the data they collect through it.[1]

Lately, I have been concerned with the application of these databases in the context of addiction management. In the United States, overdose deaths in a twelve-month period leading to May 2020 involving fentanyl alone increased 38 percent over the same period the previous year.[2] Regrettably, I lost a partner to addiction. I have seen the difficulties those struggling with substance use go through — the shame, the guilt, and the roadblocks to positive change. But perhaps the most frustrating part has been the treatment they endure by others who brand them with a scarlet letter. Unfortunately, this can sometimes include healthcare professionals.

ANALYSIS

My central concern revolves around the lack of an informed consent requirement before entering prescription data into the PDMP when the reason given for the prescription is addiction management. Our community already stigmatizes those struggling with substance use disorder. The thought of having their prescriptions recorded rightly makes many of them feel uneasy. In the past, federal patient confidentiality guidelines prohibited recording narcotic prescription data in the PDMP in these contexts for this very reason.[3] However, in 2020, this restriction was revised, paving the way for healthcare practitioners to have access to medication history. Narcotics officers may also have access to the PDMP data and have raided dispensing practices. Their access varies by state and may require a warrant or court order.[4]

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Permitting access to sensitive prescription information can put patients in a position to be further alienated by their healthcare providers and it can impact access to healthcare. According to a recent study by the University of Michigan, having an active opioid prescription in your medical history is enough to deter 40 percent of primary care practices from accepting you as a patient.[5] Additionally, if medical professionals are hesitant to see patients who have legitimate opioid prescriptions, it stands to reason that patients who have prescriptions primarily known for addiction management will not fare much better. Studies suggest that those with prescription access cut off are twice as likely to turn to heroin.[6] Some die by overdose or suicide.[7]

To be fair, the current regulations do exhibit some regard for privacy. If patients receive medication through Federal "Part II" programs, their consent is required to record the prescription in the PDMP.[8] Unfortunately, many prescriptions are dispensed by private healthcare providers or sent to local pharmacies. When this is so, the consent requirement does not apply, making the privacy provision extensionally short-sighted.

I can understand why the healthcare and law enforcement communities would want easy access to prescription data. A central mission of the PDMP is to curb the diversion of controlled substances to nonprescription users and to help doctors better coordinate patient care. By curbing the diversion of opioid drugs specifically, it is thought that the rate of fatality related to opioid substances will also decline. If we monitor other opioid drugs like oxycodone so closely, we could monitor medications that manage addiction, such as Suboxone.

But the parallel between the two is not easily drawn. To be clear, addiction management medication like suboxone does not work on the opioid receptors to the same extent and in the same way that conventional opioids do.[9] Those that take suboxone for addiction frequently do not report feeling recreational effects. The medication has a ceiling effect where the receptors the substance targets become too saturated to allow for further effect, making abuse less likely. Lastly, the medication tends to outcompete rival opioids from occupying those receptors of the brain. Users often report that taking suboxone will inhibit them from feeling the effects of illicit opioids.

Characteristics like this make it harder to see why we should be as worried about the diversion of suboxone as diversion of other opioids like OxyContin. Even when suboxone *is* diverted, studies suggest that it is diverted to those with opioid addiction who wish to manage their withdrawals – exactly those whom we would want suboxone to be reaching – rather than those who are looking to abuse the medication.[10] In areas without major barriers to suboxone prescription, opioid death and addiction rates have fallen at a dramatic rate. In France, where there are no special waivers or provisions required for doctors to dispense suboxone, opioid overdose deaths have fallen by 79 percent since 1995.[11]

CONCLUSION

An informed consent requirement would allow those people trying to address their own drug misuse to maintain some privacy. As providing the data to practitioners has proven to disenfranchise some patients who have trouble finding care and could even expose them to law enforcement, it makes sense that some patients would not want to participate in PDMPs. The ability to opt out and the requirement of informed consent to opt in would give patients more control over their data. There are good reasons, then, to amend regulations at state and federal levels to exclude addiction related medication from the PDMP without explicit and informed consent from the patient.

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[3] ASAM. 2018. "Public Policy Statement on Prescription Drug Monitoring Programs (PDMPs)"

[4] Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). 2020. "Confidentiality of Substance Use Disorder Patient Records."
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[5] Lagisetty, et. al. 2019. "Access to Primary Care Clinics for Patients with Chronic Pain Receiving Opioids"

[6] Binswanger, et. al. 2020. "The Association between Opioid Discontinuation and Heroin Use: A Nested Case-Control Study"

[7] Oliva, et. al. 2020. "Associations between stopping prescriptions for opioids, length of opioid treatment, and overdose or suicide deaths in US veterans: observational evaluation."

[8] Federal guidelines: 42 CFR Part II. 2021. "PART 2 - CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS"

[9] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Service Administration Center for Substance Abuse Treatment. 2004. "TIP 40."

[10] Fiscella, et al. 2018. "Buprenorphine Deregulation and Mainstreaming Treatment for Opioid Use Disorder."

[11] Auriacombe, et al. 2004. "French field experience with buprenorphine."