

# Examining the ethical duality of using prescription drug monitoring programs in the fight against opioids

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Saint Louis University's Liz Chiarello, Ph.D., associate professor of sociology, recently [published](#) an article in the *American Sociological Review*. The article explores pharmacists' use of prescription drug monitoring programs (PDMPs) and the ethical and practical application of PDMPs in health care.

Chiarello examined six states with various levels of resources dedicated to fighting the opioid crisis and studied how pharmacists in those states use PDMPs when filling prescriptions.

"I started this project because I saw health care and law enforcement trying to work together to combat the opioid crisis," Chiarello said. "The prescription drug monitoring program was a lynchpin since it was a technology shared across fields. I wanted to understand how two fields, health care and [criminal justice](#), dealt with the same social problem and how they worked together and at cross purposes in the process."

PDMPs were introduced to give pharmacists a quicker and easier way to determine if patients were at risk of misusing their prescriptions. In practice, PDMP use fundamentally changed the way pharmacists interact with patients in four distinct ways: routines, relationships, roles, and routes.

Pharmacy work is nearly always fast-paced and demanding. Before PDMPs, pharmacists had to rely on their own instincts and gather additional information to determine if a patient was misusing substances, processes that took time away from other tasks. With PDMPs, pharmacists can quickly access an algorithmic risk score which streamlines the process. Pharmacists can also use these PDMP reports to justify refusing to dispense opioids.

PDMPs also changed the way pharmacists interact with their patients, doctors, and law enforcement. Before PDMPs, pharmacists were covert

in defying the wishes of patients or doctors and had few interactions with law enforcement. Now, can pharmacists collaborate with law enforcement and challenge physicians' prescriptions.

Roles have changed as well, as pharmacists have embraced policing roles that conflict with their roles as treatment providers. Before PDMPs, pharmacists generally saw themselves as "medical gatekeepers" responsible for caring for patients. Today, pharmacists increasingly embrace "legal gatekeeping" roles that focus on rooting out patients who are breaking the law.

Finally, when it comes to PDMPs, pharmacies and pharmacists have changed what happens when patients do not receive their medication. In the past, patients were simply denied their prescription. Today, with the heavy use of PDMPs, pharmacists may directly lead law enforcement to those who are misusing pills. Patients denied medications may seek pain relief outside of the medical system, which exposes them to a toxic and dangerous drug supply.

All of these point to why Chiarello refers to PDMPs as "Trojan Horse Technologies." PDMPs were originally designed for law enforcement and given as a "gift" to health care via federal grants that funded the creation of statewide PDMPs. They were touted as a way to increase efficiency and accuracy within pharmacies while better protecting patients from harm. According to Chiarello, though, PDMPs are not health care tools but rather enforcement tools implemented in health care spaces.

"Even though PDMPs resemble other health care technologies like the electronic medical record, they are fundamentally different because they are oriented around surveillance and enforcement," Chiarello said.

"These logics remain even as PDMPs make their way into health care fields. Like the Greeks embedded in the Trojan horse destroyed the

Trojan civilization, enforcement logics embedded in PDMPs threaten to undermine the very core of health care."

"Not only are PDMPs shifting health care providers' practices and commitments, but PDMPs make private health care data available to enforcement agents who use it to pursue legal cases against health care providers and patients. PDMPs, therefore, are a two-tiered surveillance technology that enables law enforcement to monitor patients and providers and enables health care providers to monitor patients."

Chiarello added that if the core principle of PDMPs were patient care, then the information would be protected in health care records rather than made readily available to law enforcement.

"If what we cared about was tracking people's prescription drugs, and we wanted to do it in the health care system, we would put it in the electronic health record," Chiarello said.

"The reason it's in the PDMP, and the reason the Department of Justice paid a lot of money to create PDMPs, is because it's an end run around HIPAA. It's a backdoor through which law enforcement can access private medical records. PDMPs give law enforcement a trove of data that they couldn't otherwise access. They've essentially deputized health care providers to do enforcement work."

PDMPs have been in use by pharmacies since the 1940s but did not become prevalent until the 2000s. They use a variety of factors to determine whether or not a patient could potentially be using scripts to misuse prescription drugs.

Red flags can manifest in a number of ways, including paying cash for pills instead of going through insurance, having prescriptions from a number of different doctors, or having a high dosage. Naturally, not all

patient circumstances are the same, and using solely these factors can disproportionately affect certain populations.

"There are quite a lot of red flags that could come up in PDMPs, and most are set by the DEA," Chiarello said. "But these red flags do not necessarily indicate wrongdoing. It's poor and uninsured people who are going to pay cash. If you're seeing different doctors, but you're going to the same practice, PDMPs don't show that. People become tolerant of opioids over time and need higher doses to have an effect, so people who have been on them for a while are likely to be on high volumes."

"The algorithm takes all of that information and puts it into a single number, almost like a social credit score. It incorporates all of this information and can determine whether or not you 'deserve' access to medication. And the algorithm is a black box. No one except for the company that runs the PDMP knows exactly which factors go into the risk score"

Chiarello said there are a number of ways pharmacies can assist in the fight against the opioid crisis.

"The main problem is that policymakers have been so focused on bringing down prescribing rates that they have not focused enough on stopping overdose, which is really the biggest problem," Chiarello said. "Pharmacies should stock evidence-based medications like buprenorphine and naloxone that are critical for preventing overdose and getting people on the road to recovery."

"This is a social problem versus a legal problem," Chiarello continued. "Diabetes is medicalized. We have an answer for it; we have a diagnosis. But we still treat addiction and pain as moral issues and, in some cases, criminal issues. However, the evidence base on [substance use disorder](#) shows that medications are the most effective approach."

"The problem is most doctors do not prescribe medications for substance use disorder. The other problem on the pharmacy end is that pharmacies don't carry them either. Making sure the medications that are the gold standard for treating substance use disorder are available in pharmacies is far more effective than policing your patient and sending them out of your pharmacy with nothing."

Ultimately, throughout her research, Chiarello found pharmacists generally appreciated PDMPs, because the technology made their work more efficient and helped them avoid facing legal consequences for over-dispensing opioids. However, there was a significant cognitive dissonance between doing what is best for the patients and what is best for the [pharmacist](#), an area Chiarello will explore further as the ethical and practical uses of PDMPs become more apparent as the opioid crisis rages on.

"PDMPs are imperfect technologies," Chiarello said. "Looking at what the consequences of using PDMPs are, I believe we need an ethical adjustment and rethink what this tool is and what it can do. It could be used as a health care tool if it were used in the context of a health care system devoted to providing care. Currently, it is used in the context of enforcement, where patients are being pushed out of care and left with nowhere to go."

"Hopefully, health care providers and administrators will correct the course and reaffirm their commitment to helping patients. After all, isn't that what health care is all about?"

**More information:** Elizabeth Chiarello, Trojan Horse Technologies: Smuggling Criminal-Legal Logics into Healthcare Practice, *American Sociological Review* (2023). [DOI: 10.1177/00031224231209445](https://doi.org/10.1177/00031224231209445)

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