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Letter to the Editor

Philosophical Barriers to Using Prescription Drug Monitoring Programs: Results from a Statewide Survey

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Dear Editor,

Prescription opioid abuse is a serious national public health concern and has gained the attention of policy makers, law enforcement officials, and clinicians. In 2016, an estimated 2.1 million people misused prescription opioids for the first time, and there were 17,087 opioid-related deaths in the United States [1]. Prescription drug monitoring programs (PDMPs) have been identified as an important tool for reducing prescription opioid abuse [2]. As of January 2019, 49 states and the District of Columbia have established PDMPs, and 19 states mandate that providers check PDMPs before prescribing opioids [3].

The evolution of policy changes related to California's PDMP (known as the Controlled Substance, Utilization, Review and Evaluation System [CURES]) began with mandatory registration of prescribers in July 2016 to the passage of Senate Bill 482 in September 2016, which requires prescribers to consult with CURES before prescribing controlled substances [4].

Previous research has linked logistical barriers including poor user interface, time constraints, and lack of knowledge to low utilization of PDMPs among primary care providers, but perceived philosophical barriers remain relatively unexamined [5].

To examine philosophical barriers to PDMP use as they exist among California physicians and pharmacists, we analyzed an open-ended question included in a statewide survey of physician and pharmacist attitudes and beliefs about CURES. The study population was a quasi-random sample of California physicians and pharmacists based on licensees' birth month. Surveys were completed between August 2016 and January 2017. Additional details of survey methodology and results have been published elsewhere [6]. Survey respondents were asked a single open-ended question: "Is there anything else you would like to tell us about CURES? (e.g., problems, recommendations)."

Responses were received from approximately half (49%, N = 867 of 1,757) of all survey respondents who were eligible to answer the open-ended question. Responses to the open-ended survey question were analyzed using content analysis followed by thematic analysis. For the content analysis, two investigators of different academic backgrounds, medicine and sociology, independently reviewed responses to identify content categories that emerged from the data. An analysis of the responses generated three major cross-cutting themes illustrating philosophical barriers to using CURES among physicians and pharmacists: 1) lacking relevance, 2) increasing social control, and 3) shifting professional responsibility.

Overall, the content of physician (N = 597) and pharmacist (N = 270) responses was similar, with some exceptions. Physicians expressed stronger opposition to mandating the use of PDMPs compared with pharmacists, and pharmacists were more likely to shift the responsibility of reporting and monitoring opioid use to physicians.

Relevance was the most common code related to philosophical barriers and the most frequently occurring. Both physicians (18.8%) and pharmacists (12.1%) questioned the relevance of PDMPs to their practice, citing professional discernment, prescribing and dispensing patterns, medical specialty practiced/type of pharmacy, and trust resulting from established patient relationships as more important factors for identifying opioid misuse that generally superseded the need to check the PDMP. Specifically, physicians and pharmacists commented that they only check the PDMP for new patients or in cases where suspicious behavior is demonstrated.

Several respondents noted that CURES was not relevant to pharmacists working outside of retail settings (e.g., hospitals, compounding pharmacies). Physicians and pharmacists who prescribed or dispensed few opioids or those working with populations they perceived to be at low risk for abuse expressed the belief that professional discernment should dictate if and when to use PDMPs. The following physician quote was typical of respondents who felt that CURES was not relevant: "I have not yet had a patient for whom I felt I needed to check CURES. Conversations with patient and family make me feel comfortable without the need to check CURES so far."

The second theme addresses concern regarding increasing social control. Legally requiring the use of CURES was often viewed among physicians and pharmacists as a means of social control, although more physicians expressed concerns about loss of autonomy and interference with patient care. One pharmacist stated, "I think it is at odds with the Patient's Pain Bill of Rights. Also, unfairly puts on us as pharmacists to police pain medication users. . .a dangerous precedent." Compared with pharmacists, physicians expressed stronger opposition to legally requiring the use of CURES, citing interference with patient care as a concern, illustrated by several physicians:

> CURES is good, but it should not be necessary to check CURES with each refill. The focus should be on the clinical encounter and helping patients to understand the dangers of these medications rather than spending time trying to "catch" those who are filling from multiple providers.

Shifting professional responsibility was identified as a third theme. Numerous physicians held pharmacists primarily responsible for using PDMPs because pharmacists dispense medications. At the same time, some pharmacists shifted responsibility to physicians, noting that physicians have the prescribing privileges and so have greater responsibility for preventing prescription drug misuse. Both groups of participants shifted the responsibility, justifying why the other should be tasked with checking PDMPs. Pharmacists explained their perceptions: "I think all prescribers of controlled substances should be required to check CURES. . .. The sole responsibility should not be with pharmacists."

Many physicians expressed very different perspectives, highlighting that pharmacists should be held responsible for monitoring prescription drug abuse. For example, one physician reported, "Pharmacy involvement should be greater in monitoring patients that reflect misuse."

Most respondents who answered the open-ended question expressed concern about legally requiring PDMP use while also acknowledging its value.

Barriers to using PDMPs appear to be more complex than previously recognized and consist of philosophical ideas regarding the health care system and one's professional role within the organization of health care. As of October 2018, California requires the use of its PDMP, which underscores the timeliness of addressing barriers and concerns regarding the use of PDMPs.

This study highlights relatively unexplored philosophical barriers facing physicians and pharmacists pertaining to PDMPs that can be applied to other states' prescription drug monitoring programs.

Intellectual buy-in from both physicians and pharmacists is essential to effectively implement and sustain PDMPs but is perhaps more difficult to address than logistical barriers, especially for states where PMDP use is not mandatory. Calling attention to the philosophical barriers is both timely and important as states make decisions regarding whether to legally require physicians and/or pharmacists to use PDMPs.

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