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Pharmageddon: A Statutory Solution to Curb Ohio's Prescription Abuse Problem

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PHARMAGEDDON: A STATUTORY SOLUTION TO CURB OHIO’S PRESCRIPTION ABUSE PROBLEM

ED WOODWORTH*

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I. INTRODUCTION

Portsmouth, Ohio is a small steel town with a big city problem.¹ This city has been particularly hard hit by the prescription drug abuse epidemic.² Nationally, the prescription abuse epidemic has killed more people than the crack cocaine epidemic of the 1980's and the heroin epidemic of the 1970's *combined*.³ In 2010, "9.7 million doses of prescription painkillers were dispensed in Scioto County[, Ohio, or] 123 doses for each of the 79,000 men, women and children in the county."⁴ Portsmouth counts its dead by lining the front window of a vacant department store with pictures of those who died due to overdosing.⁵ The city is essentially raising third and fourth generation prescription drug addicts.⁶ In one particularly disheartening instance, a local family could name eleven houses on their street that sold drugs.⁷ The majority of people who abuse these medications either get their drugs from dealers on the street or from someone who has access to these drugs.⁸ The drug of choice—Oxycontin—is legal, and can be obtained from a local pharmacy with a prescription.⁹ Drug abuse there is so pervasive that, despite the high

¹ This Note frequently references Portsmouth, Ohio as a case study for the effects of ineffective legislation currently controlling in Ohio.

² Sabrina Tavernise, *Ohio County Losing Its Young to Painkillers' Grip*, N.Y. TIMES (Apr. 19, 2011), http://www.nytimes.com/2011/04/20/us/20drugs.html?_r=3&pagewanted=1; see also STATE MEDICAL BOARD OF OHIO, RESOLUTION REGARDING PRESCRIPTION DRUG ABUSE (2011), available at <http://www.med.ohio.gov/pdf/PrescriptionDrug%20Abuse.pdf> ("Between 1999 and 2008, there was a 360% increase in accidental over-dose deaths in Scioto County; 92% of these deaths are due to prescription medication.").

³ See Tavernise, *supra* note 2.

⁴ See STATE MEDICAL BOARD, *supra* note 2; see also OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION SERVICES, OHIO'S OPIATE EPIDEMIC: 2010 PRESCRIPTION OPIATE CONSUMPTION PER CAPITA (2011), available at <http://www.odadas.state.oh.us/public/OpenFile.aspx?DocumentID=12f9370d-e022-48ee-ba0a-b688d21167a5> (documenting opiate consumption per capita in each of Ohio's counties; Scioto, Ohio has one of the highest rates of opiate consumption).

⁵ See Tavernise, *supra* note 2.

⁶ See Tavernise, *supra* note 2.

⁷ See Tavernise, *supra* note 2; see also *Prescription Drug Abuse – Prescription Drug Addiction*, ATLANTA RECOVERY CENTER, <http://atlantarecoverycenter.com/drugs-of-abuse/prescription-drug-abuse/> (last visited Oct. 30, 2012) (explaining that Oxycontin is a highly addictive prescription drug and is fatal when taken in large doses).

⁸ See Tavernise, *supra* note 2.

⁹ See *Controlled Substances – Alphabetical Order*, OFFICE OF DIVERSION CONTROL, DRUG ENFORCEMENT ADMIN, U.S. DEP'T OF JUSTICE, http://www.deadiversion.usdoj.gov/schedules/orangebook/c_cs_alpha.pdf (last updated September 6, 2012) (listing Oxycodone, commonly known as Oxycontin, as a "Schedule II" substance). Schedule II substances can be prescribed by practitioners. *Section V – Valid Prescription Requirements*, OFFICE OF DIVERSION CONTROL, DRUG ENFORCEMENT ADMIN, U.S. DEP'T OF JUSTICE, <http://www.deadiversion.usdoj.gov/pubs/manuals/pract/section5.htm> (last visited Oct. 28, 2012).

unemployment rate,¹⁰ some businesses have difficulty finding job candidates who can pass a drug test.¹¹

While some parts of Ohio are affected more so than others by this prescription abuse epidemic,¹² current legislation allows a situation, like that of Portsmouth, to happen anywhere in Ohio. This is in large part due to Ohio's statutory scheme that focuses more on punishment than prevention, despite recent encouraging changes that have been made.¹³ Despite the changes already in place, the legislature should enact a consequential solution that prevents prescription abuse by removing these drugs from the streets.

Ohio has a system in place with the capability to curb prescription drug abuse, but it is far underutilized.¹⁴ The Ohio Automated Rx Reporting System ("OARRS") currently tracks all controlled prescription medications dispensed by an Ohio-licensed pharmacy.¹⁵ OARRS is "designed to allow physicians and pharmacists to cross-check prescriptions with each other and identify individuals who may be doctor shopping."¹⁶ When using OARRS, physicians can more effectively serve as the gatekeepers to dangerous prescription medications because they have access to more information to make the best decisions regarding prescription choices for patients.¹⁷ But, currently, reporting from the system is not required in all situations, and before the recent changes of 2011, only a minority of practitioners were

¹⁰ *Local Area Unemployment Statistics*, UNITED STATES DEPARTMENT OF LABOR, available at <http://data.bls.gov/timeseries/LASST39000003> (Data extracted on Oct. 28, 2012) (Ohio's unemployment rate for August, 2012 was 7.2%).

¹¹ See Tavernise, *supra* note 2.

¹² See OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION SERVICES, *supra* note 4 (displaying opiate consumption per capita in each of Ohio's counties). Although this map accounts for all opiate consumption, legitimate and illegitimate, it can be inferred that the incidence of illicit prescriptions would be more prevalent in areas with higher overall incidence rates of opiate consumption. See *id.*

¹³ See *infra* Part II.E (discussing the current state of Ohio law relating to prescription abuse, and the recent changes enacted by the Ohio Legislature to combat pill mills). See also *infra* Part II.B (discussing the shortcomings of Ohio's statutory system related to prescription drug abuse and prevention).

¹⁴ *Ohio Sheriffs' Group Seeks Better Drug Monitoring*, THE COLUMBUS DISPATCH (Jan. 20, 2010) <http://www.dispatch.com/content/stories/local/2010/01/20/drug-monitor.html> (reporting that before the recent changes in 2011, however, only 13% of Ohio's 42,000 doctors and dentists were registered to use this system).

¹⁵ See Ohio Rev. Code Ann. § 4729.75 (LexisNexis 2011) (granting the Ohio Board of Pharmacy authority to "establish and maintain a drug database . . . to monitor the misuse and diversion of controlled substances"). Distributors of drugs include not only retail pharmacies located within the state, but also mail order pharmacies located outside of the state. Ohio Rev. Code Ann. § 4729.77 (LexisNexis 2011) ("each . . . terminal distributor of dangerous drugs that dispenses drugs to patients in this state . . . shall submit to the board . . . prescription information" including patient information, prescriber identification, and prescription information such as drug, dosage, quantity, and days' supply).

¹⁶ *Doctor Shopping Chronic Pain Medication Addiction*, DRUGADDITION.COM, http://www.drug-addiction.com/doctor_shopping.htm (last visited Oct. 28, 2012).

¹⁷ See *id.*

registered to use it.¹⁸ In response to the growing prescription drug abuse epidemic, the Ohio legislature enacted House Bill 93 on May 20, 2011¹⁹ to eliminate “pill mills,”²⁰ or a physician’s office that sells prescriptions under the table to anyone with cash.²¹

Regardless of the positive effects with the enactment of H.B. 93, Ohio needs to take more action to prevent prescription abuse. Ohio was at the cusp of tackling the prescription abuse epidemic, but fell short of the results it was capable of attaining.²² Specifically, H.B. 93 falls short because it does not focus on prevention.²³ Instead, H.B. 93 only gives OARRS the capability to identify clinics that supply patients with unnecessary quantities of medication.²⁴ While this prevents some prescription abuse, it does not go far enough. For instance, most physicians may use Ohio’s Prescription Monitoring Program (PMP), also known as OARRS, but only few physicians are required to do so.²⁵ However, used to its full potential, OARRS can provide physicians with more information to identify drug-seeking behaviors of patients.²⁶

Also, H.B. 93 does not address other issues that facilitate drug abuse.²⁷ One reason why prescriptions are so easily abused is because there are so many of them in the house.²⁸ Another reason is that patients are not effectively held accountable

¹⁸ See *Ohio Sheriffs’ Group Seeks Better Drug Monitoring*, *supra* note 14.

¹⁹ See H.B. 93, 129th Gen. Assemb., Reg. Sess. (Oh. 2011), available at http://www.legislature.state.oh.us/bills.cfm?ID=129_HB_93.

²⁰ Russ Zimmer, *Ohio Law Nixes Pill Mills*, BUCYRUS TELEGRAPH F. (May 21, 2011), <http://www.bucyrustelegraphforum.com/article/20110522/NEWS01/305220007/Ohio-law-nixes-pill-mills>.

²¹ *What is a Pill Mill?*, THE OFFICIAL BLOG SITE OF THE BAY AREA COUNCIL ON DRUGS & ALCOHOL, <http://www.bacodablogs.com/2011/01/what-is-pill-mill.html> (last visited Oct. 28, 2012).

²² See OHIO STATE BOARD OF PHARMACY, OHIO’S DANGEROUS DRUG DATABASE PAST, PRESENT, AND FUTURE: HOUSE BILL 93 REPORT (2011) available at <https://www.ohiopmp.gov/Portal/Search.aspx?searchText=past%2c+present%2c+future>.

²³ See *infra* Part III.B.2 (discussing the reactive nature of Ohio’s current prescription legislation).

²⁴ See *Doctor Shopping Chronic Pain Medication Addiction*, *supra* note 16 (“[drug databases] allow physicians and pharmacists to cross-check prescriptions with each other and identify individuals who may be doctor shopping”).

²⁵ See *infra* Part II.F (discussing the current state of Ohio’s laws vis-à-vis prescription reporting).

²⁶ See OHIO STATE BOARD OF PHARMACY, *supra* note 22.

²⁷ See H.B. 93, *supra* note 19.

²⁸ See *infra* Part II.C. Part II.C discusses various sources of prescription drugs that are abused. Although this Note identifies three unique sources (pill mills, doctor shopping, and the home), these sources are interrelated because prescriptions obtained either from doctor shopping or from a pill mill invariably end up in homes, where other persons can access them.

for doctor shopping.²⁹ Thus, Ohio should mandate OARRS reporting and monitoring by all prescribers, promote OARRS interconnectivity with other states, mandate prescription return programs, and create stronger anti-doctor shopping statutes to effectively curb prescription abuse.

Prescription abuse in Ohio continues to be a serious and complex issue that should be addressed. Accordingly, Part II of this Note examines the background of prescription drug abuse generally. It identifies the dangers of prescription drug abuse, the cost drug abuse places on society, some reasons for prescription drug abuse, sources of prescription drugs, and discusses the current state and federal laws regarding prescription drug abuse and prescription reporting. Part III discusses the positive and negative aspects of H.B. 93 and Medical Rule 4731-11-11 and then offers proposals to more effectively prevent prescription drug abuse. Part IV discusses various criticisms of the current OARRS system and demonstrates why these concerns are either unfounded or do not outweigh the benefits of having such a system.

II. BACKGROUND

Prescription drug abuse is a complicated topic with many facets. To help understand the topic, it is necessary to discuss the dangers, costs, causes, and sources of prescription abuse, and to look at the relevant federal and Ohio statutes that pertain to prescription abuse. Thus, Part A identifies the dangers of abusing opioids, tranquilizers, and stimulants—three of the most commonly abused classes of prescriptions. Part B discusses the costs that prescription abuse places on society. Part C proffers various reasons for prescription drug abuse. Part D identifies pill mills, doctor shopping, and the home as major sources of prescription drugs. A brief description of the Controlled Substances Act, which regulates drugs at the federal level, can be found in Part E. Finally, Part F provides an overview of the statutory scheme surrounding prescription drug abuse in Ohio.

A. Dangers of Prescription Drug Abuse

The dangers of prescription drug abuse are well documented. Prescription drug abuse is “the intentional use of a medication without a prescription; in a way other than as prescribed; or for the experience or feeling it causes.”³⁰ The most commonly abused medications are pain relievers,³¹ tranquilizers,³² and stimulants.³³ As will be

²⁹ See *infra* Part III.B.1 (discussing in part the shortcomings of Ohio’s anti-doctor shopper statute).

³⁰ NATIONAL INSTITUTE ON DRUG ABUSE, PRESCRIPTION DRUG ABUSE (December, 2011), available at http://www.drugabuse.gov/sites/default/files/prescription_1.pdf.

³¹ “Opioids are commonly prescribed [as pain relievers] because of their effective analgesic, or pain-relieving, properties. Medications that fall within this class-referred to as prescription narcotics-include morphine (e.g., Kadian, Avinza), codeine, oxycodone (e.g., Oxycontin, Percodan, Percocet), and related drugs.” NATIONAL INSTITUTE ON DRUG ABUSE, PRESCRIPTION DRUGS ABUSE AND ADDICTION (2001), available at <http://www.chce.research.va.gov/docs/pdfs/RRPrescription.pdf>.

³² NATIONAL INSTITUTE ON DRUG ABUSE, *supra* note 30.

³³ NATIONAL INSTITUTE ON DRUG ABUSE, *supra* note 30.

discussed in more detail, the abuse of opioids, tranquilizers, and stimulants can have devastating effects on the human body.

1. Opioids

“The term *opiates* refers to naturally occurring alkaloids, such as morphine, codeine, and thebaine . . . that are derived from the opium poppy plant.”³⁴ Abusing opioids can be very harmful to the body.³⁵ Opioid chemicals bind to the opioid receptors in the central nervous system³⁶ and provide an analgesic effect because they decrease and alter the sensation of pain.³⁷ Opioid abuse may lead to drowsiness, and may dangerously decrease the rate of breathing.³⁸ Furthermore, “if combined with other medications that cause drowsiness or with alcohol, heart rate and respiration can slow down dangerously.”³⁹ In addition, a person’s prolonged use of opioids can dull the effects of the drug because the body becomes tolerant of the drugs’ effects.⁴⁰ Consequently, a person taking the drugs may increase their dosage.⁴¹ Finally, opioid addiction is most common in those who abuse these drugs recreationally, and the unpleasant withdrawal effects tend to reinforce the addiction.⁴² Ironically, the Ancient Sumerians referred to the opium plant as “hu gil” or “plant of joy,”⁴³ perhaps alluding to its propensity for abuse.⁴⁴

³⁴ Susan Y. Kim-Katz & Ilene B. Anderson, *Prescription Opiate/Opioid Drug Abuse: A New Epidemic*, THE AM. C. OF CHEST PHYSICIANS (Jan. 1, 2011), available at <http://www.chestnet.org/accp/pccsu/prescription-opiateopioid-drug-abuse-new-epidemic?page=0,3>. See also *Transforming Opium Poppies into Heroin*, PBS, <http://www.pbs.org/wgbh/pages/frontline/shows/heroin/transform/> (last visited Oct. 28, 2012).

³⁵ See Kim-Katz & Anderson, *supra* note 34.

³⁶ *How Do Opioids Work in the Brain?*, THE NATIONAL ALLIANCE OF ADVOCATES FOR BUPRENORPHINE TREATMENT, http://www.naabt.org/faq_answers.cfm?ID=6 (last visited Oct. 28, 2012).

³⁷ Steve Richeimer & Susan Spinasant, *Drugs Used to Treat Pain: Opioids – Narcotics*, SPINEUNIVERSE.COM, <http://www.spineuniverse.com/treatments/medication/drugs-used-treat-pain-opioids-narcotics> (last updated on Feb. 1, 2010).

³⁸ NATIONAL INSTITUTE ON DRUG ABUSE, *supra* note 30; see also *Opioid Side Effects*, NEWS MEDICAL, <http://www.news-medical.net/health/Opioid-Side-Effects.aspx> (last visited Oct. 28, 2012) (“Although [respiratory depression] is the most serious adverse reaction associated with opioid use[, respiratory depression] usually is seen with the use of a single, intravenous dose in an opioid-naive patient.” Thus, the dangers of respiratory depression are most prevalent in those who take prescriptions on a recreational basis.).

³⁹ *What is Prescription Drug Abuse?*, NATIONAL INSTITUTE ON DRUG ABUSE (AUG. 7, 2012), <http://www.nida.nih.gov/researchreports/prescription/prescription2.html>.

⁴⁰ See generally Kathleen M. Foley, *Changing Concepts of Tolerance to Opioids: What the Cancer Patient Has Taught Us*, CURRENT AND EMERGING ISSUES IN CANCER PAIN: RESEARCH AND PRACTICE (1993), available at <http://painresearch.utah.edu/cancerpain/ch20.html> (evaluating the effects of drug tolerance in cancer patients).

⁴¹ *Risks of Opiate Abuse*, THE WAISMANN METHOD, <http://www.opiates.com/opiate-abuse.html> (last visited Oct. 28, 2012).

⁴² See *Opioid Side Effects*, *supra* note 38.

⁴³ Charles J. Fox III et al., *Opioids: Pharmacokinetics and Pharmacodynamics*, in 91 ESSENTIALS OF PAIN MANAGEMENT (Nalini Vadivelu et al. eds., 2011); see also Kim-Katz &

Opioids also have indirect effects on the health of patients with a history of prescription drug abuse.⁴⁵ For example, healthcare “providers tend to undertreat pain in this population due to biases, misconceptions, and systems issues.”⁴⁶ Thus, when patients with a substance abuse history are actually in pain and need medicine, physicians fear that the patient is “crying wolf” in an attempt to secure more medication.⁴⁷ This undertreatment results in “increased length of stay [at a hospital], frequent readmissions, and increased outpatient and emergency visits.”⁴⁸

Opioid abuse is so pervasive that it impacted nearly an entire generation of people living in southern Ohio.⁴⁹ The most popular drug abused in Scioto County, Ohio, is an opioid by the name of Oxycontin.⁵⁰ “Nearly 1 in 10 babies born last year in this Appalachian county tested positive for drugs.”⁵¹ The situation in Scioto County has been compared to the drug abuse epidemics of the 1970’s and 1980’s: “a generation of young people...were raised by their grandparents because their parents were addicts, and now they are addicts themselves.”⁵² The addiction to opioids creates such desperation that in some instances people will kill and commit other crimes to get access to Oxycontin.⁵³ For instance, a local elderly man had access to Oxycontin prescriptions, and a burglar broke into his house to search for them.⁵⁴

Anderson, *supra* note 34 (“The Sumerians first cultivated the opium poppy around 3400 BC and referred to it as Hul Gil, or the ‘joy plant.’”).

⁴⁴ See *Transforming Opium Poppies into Heroin*, *supra* note 34.

⁴⁵ Marian S. Grant et al., *Acute Pain Management in Hospitalized Patients with Current Opioid Abuse*, MEDSCAPE NEWS (June 6, 2007), http://www.medscape.com/viewarticle/557043_3.

⁴⁶ *Id.*; see also *Pain Management and Addiction*, TREATMENT-CENTERS.NET (July 25, 2012), <http://www.treatment-centers.net/pain-management-and-addiction.html>.

⁴⁷ *Pain Management and Addiction*, *supra* note 46.

⁴⁸ See Grant, *supra* note 45.

⁴⁹ See generally Tavernise, *supra* note 2 (describing Portsmouth’s plight with prescription abuse).

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.*; see also Grace Wyler, *Obama, GOP Govs., Want More Spending To Fight OxyContin Epidemic*, BUS. INSIDER, (Apr. 20, 2011), http://articles.businessinsider.com/2011-04-20/politics/30002690_1_prescription-drug-abuse-overdoses-oxycotin-first (“Prescription drug abuse has long been a scourge across Appalachia, claiming more lives than the ‘80s crack epidemic and the ‘70s heroin epidemic combined, [as reported by the Tavernise article, *supra* note 2].”).

⁵³ See Frank Lewis, *Two Found Fatally Shot in Lucasville*, PORTSMOUTH DAILY TIMES, (Jan. 11, 2010, 12:00 AM), http://www.portsmouthdailytimes.com/pages/full_story/push?articleTwo+Found+Fatally+Shot+In+Lucasville%20&id=5510425&instance=secondary_news_left_column; see also Julian Borger, *Hillbilly Heroin: The Painkiller Abuse Wrecking Lives in West Virginia*, THE GUARDIAN (June 24, 2001), <http://www.guardian.co.uk/world/2001/jun/25/usa.julianborger> (“The OxyContin epidemic has meanwhile generated an exponential rise in the crime rate, as addicts become ever more desperate to finance their craving.”).

⁵⁴ See Tavernise, *supra* note 2.

This burglar then killed the man and the woman he was living with, while the woman's young daughter watched.⁵⁵

2. Tranquilizers

Another drug that is readily available and can be dangerous when abused is tranquilizers.⁵⁶ Tranquilizers are commonly prescribed as anti-anxiety medications and sleep aids, and are part of the group of drugs known as depressants.⁵⁷ Tranquilizers include Xanax, Valium, and Ativan.⁵⁸ Tranquilizers operate by inducing a feeling of calm or well-being.⁵⁹ Also, combining an opioid with a depressant, such as a tranquilizer, can have dangerous health effects; for example, a user's heart rate and breathing may decrease to a dangerous level.⁶⁰ Combining tranquilizers with alcohol or opioids will similarly decrease the taker's heart rate to a dangerous level.⁶¹ But unlike opioids or tranquilizers, alcohol does not require a prescription and is commonly found in many households.

One of the most-publicized instances of overdose of tranquilizers was the recent case of Michael Jackson.⁶² A lethal cocktail of Propofol, Lorazepam, and Midazolam caused Michael Jackson's death.⁶³ On June 25, 2009, the artist who gave us such masterpieces as "Thriller," "Billy Jean," and "The Man in the Mirror" went into cardiac arrest in his mansion in Los Angeles, California.⁶⁴ Subsequent attempts

⁵⁵ *Id.*; see also Lewis, *supra* note 53.

⁵⁶ *Tranquilizers*, INSTITUTE FOR SUBSTANCE ABUSE TREATMENT EVALUATION, <http://www.institute.memphis.edu/tranquilizers.html> (last visited Oct. 28, 2012).

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ See *supra* Part II.A.1 (describing harmful side effects on the body when opioids are combined with tranquilizers).

⁶¹ See *supra* Part II.A.1.

⁶² See Katherine Harmon, *What is Propofol—and How Could It Have Killed Michael Jackson?*, SCI. AM., (Oct. 3, 2011), <http://www.scientificamerican.com/article.cfm?id=propofol-michael-jackson-doctor>.

⁶³ See *id.* (explaining that Propofol is a hypnotic that is used to induce general anesthesia); *Lorazepam*, NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION, <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000560/> (last revised Oct. 1, 2010) (Lorazepam is a benzodiazepine used to treat anxiety); *Midazolam*, NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION, <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000482/> (last revised Nov. 1, 2010) ("Midazolam is given to children before medical procedures or before anesthesia for surgery to cause drowsiness, relieve anxiety, and prevent any memory of the event."); Benjamin C. Wedro, *Michael Jackson's Death: Propofol (Diprivan) FAQ*, MEDICINE.NET, <http://www.medicinenet.com/script/main/art.asp?articlekey=113188> (last editorial review Nov. 8, 2011) (discussing that Michael Jackson's death was caused by Propofol, Lorazepam, and Midazolam taken together).

⁶⁴ Shulamit Shvartsman, *What Caused Michael Jackson's Sudden Death?*, LAWYERS.COM, <http://product-liability.lawyers.com/Product-Liability/What-Caused-Michael-Jacksons-Sudden-Death.html> (last visited Aug. 29, 2012); *Michael Jackson's Life Cut Shockingly Short*,

to resuscitate him by his personal physician, paramedics, and the personnel at a hospital emergency room were unsuccessful.⁶⁵ Over an hour after going into cardiac arrest, Michael Jackson was pronounced dead at Ronald Reagan University of California at Los Angeles Medical Center.⁶⁶ The medications that caused Michael Jackson's death were prescribed and administered to him by his personal physician.⁶⁷ Although tranquilizers have a common use—such as treating insomnia—they can be dangerous, and thus, their abuse needs to be controlled.⁶⁸

3. Stimulants

Similar to tranquilizers, stimulants have a common household use, and are also easily abused.⁶⁹ Common prescription stimulants include Adderall, Ritalin, and Concerta.⁷⁰ These drugs are typically used to treat Attention Deficit Hyperactivity Disorder (ADHD).⁷¹ But, ADHD drugs are a Schedule II narcotic, and thus, have a “limited medical purpose, with a high potential for abuse.”⁷² Because these drugs facilitate a better ability to concentrate, college students frequently abuse them in an effort to keep up with a heavy class load.⁷³ Students consider the effects of these drugs so beneficial that, according to a 2002 University of Wisconsin study, “20 percent of college students have used Adderall or Ritalin without a prescription.”⁷⁴ Students who use these drugs often say that the drugs helped them finish their work and remain focused.⁷⁵

Despite the perceived benefits of stimulant abuse, these drugs have severe medical consequences. Side effects include dry mouth, lack of hunger, insomnia,

MSNBC, <http://today.msnbc.msn.com/id/31552029/ns/today-entertainment/t/michael-jacksons-life-cut-shockingly-short/#.TrXN63JRQW0> (last visited Oct. 28, 2012).

⁶⁵ Shvartsman, *supra* note 64.

⁶⁶ *Michael Jackson's Life Cut Shockingly Short*, *supra* note 64.

⁶⁷ *See* Wedro, *supra* note 63.

⁶⁸ *See* *Tranquilizers*, *supra* note 56.

⁶⁹ *See* NATIONAL INSTITUTE ON DRUG ABUSE, *supra* note 30.

⁷⁰ *See generally* Peter R. Breggin, *Adderall Ritalin Concerta Side Effects in Adults and Child Medication*, NATIVEREMEDIES, <http://www.nativeremedies.com/articles/concerta-ritalin-adderal-side-effects.shtml> (last visited Oct 28, 2012) (describing use and effects of commonly prescribed ADHD stimulants).

⁷¹ *Id.*

⁷² *See generally* 21 U.S.C.S. § 812 (LexisNexis 2011) (describing the different schedules of drugs); *see also* *Controlled Substances – Alphabetical Order*, *supra* note 9 (depicting a list of various controlled substances, of which Amphetamine (Adderall) and Methylphenidate (Ritalin) are listed as Schedule II drugs).

⁷³ Kelsie Smith, *Dangers of Stimulant Abuse*, THE U. DAILY KANSAN, (Feb. 2, 2006), <http://kansan.com/archives/2006/02/02/dangers-of-stimulant-abuse/>.

⁷⁴ *Id.*

⁷⁵ *Id.*

nausea, and addiction.⁷⁶ Death can result in some cases when primary use of the drug causes “exploded blood vessels in the brain, heart attack, or dangerously elevated body temperature.”⁷⁷ Further, because these drugs cause insomnia, a patient may begin abusing depressants to help themselves sleep.⁷⁸ Consequently, uppers in the morning, and downers at night.⁷⁹ Interestingly, many students who take Adderall may not realize that the chemical name of this drug is “amphetamine.”⁸⁰ Further, “[o]ne of the easiest ways to make methamphetamine is from amphetamine.”⁸¹ Thus, an increase in the amount of Adderall available on the street may lead to increased quantities of methamphetamine on the street.⁸² Stimulants, similar to tranquilizers, have a common medical use, but they are still dangerous.⁸³ Thus, their use needs to be controlled to prevent abuse.

B. Costs of Prescription Abuse

In addition to the dangerous health effects of prescription abuse, drug abuse also has a high cost on society. Firstly, accidental drug overdose is the leading cause of accidental deaths for Ohioans since 2007.⁸⁴ Furthermore, these “[f]atal and non-fatal poisonings [with prescription drugs] cost Ohioans \$3.6 billion annually.”⁸⁵ Exacerbating the costs of prescription abuse, the “Ohio Substance Abuse Monitoring (OSAM) Network report[ed] a move from prescription painkillers to heroin among opiate abusers” and found that that “heroin is highly available in all regions of the state.”⁸⁶ Heroin abuse places additional costs on citizens. These costs are initially

⁷⁶ See *Side Effects of Prescription Stimulants*, STEADYHEALTH.COM, http://www.steadyhealth.com/articles/Side_effects_of_prescription_stimulants_a674.html (last visited Oct. 28, 2012); *What are Amphetamines?*, INFO DRUG REHAB, <http://www.info-drug-rehab.com/amphetamines.html> (last visited Oct. 28, 2012).

⁷⁷ See *What are Amphetamines?*, *supra* note 76.

⁷⁸ See *InfoFacts: Prescription and Over-the-Counter Medications*, NATIONAL INSTITUTE ON DRUG ABUSE, <http://www.drugabuse.gov/publications/drugfacts/prescription-over-counter-medications> (last revised May, 2012).

⁷⁹ “‘Downers’ in the evening and ‘uppers’ in the morning may be regarded as part of a popular entertainer’s professional equipment, as well as an occupational health hazard for the profession.” Thomas Szasz, *Who Killed Michael Jackson?*, THE FREEMAN (Mar., 2012), <http://www.thefreemanonline.org/columns/the-therapeutic-state/who-killed-michael-jackson/>.

⁸⁰ See Breggin, *supra* note 70.

⁸¹ *Methamphetamine Frequently Asked Questions*, THE VAULTS OF EROWID, http://www.erowid.org/chemicals/meth/meth_faq.shtml (last updated Jan., 2005).

⁸² See NATIONAL INSTITUTE ON DRUG ABUSE, *supra* note 30 (“Between 1991 and 2010, prescriptions for stimulants [such as Adderall] increased from 5 million to 45 million.” Thus, if there was a nine-fold increase in the amount of prescriptions written for stimulants in the last 20 years, it can be inferred that there is a nine-fold increase in the amount of stimulants that can be available to make methamphetamine, as compared to 20 years ago.).

⁸³ See generally *supra* Part II.A.2 (describing the dangers of tranquilizer abuse).

⁸⁴ STATE MEDICAL BOARD OF OHIO, *supra* note 2.

⁸⁵ *Id.*

⁸⁶ *Ohio’s Opiate Epidemic*, OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION SERVICES (July, 2011),

borne by law enforcement and the criminal justice system, which must combat illegal heroin abuse, and these costs then forwarded to the taxpayers.⁸⁷ Put bluntly, because Ohioans cannot afford to tolerate prescription drug abuse, Ohio needs to step up to the plate and better combat prescription abuse.

C. Reasons for Prescription Drug Abuse

Despite the inherent danger and costs of abuse, there are many reasons why people abuse prescription drugs. Some people assume that a drug is safe because it is available through a prescription.⁸⁸ This is not necessarily true.⁸⁹ Some people abuse these drugs because they are readily available.⁹⁰ In fact, “[b]etween 1991 and 2010, prescriptions for stimulants increased from five million to forty-five million, a nine-fold increase, and opioid analgesics increased from about thirty million to one-hundred-eighty million, a six-fold increase.”⁹¹ Other people abuse prescription drugs for their performance-enhancing capabilities.⁹² Still others abuse these drugs to feel the effect of the drug, to get high, or to ameliorate stress.⁹³ For instance, injecting or snorting opioids elicits “a warm, floating feeling. Some say they feel pleasantly numb.”⁹⁴ Given the diverse reasons for prescription drug abuse, a solution that can address each of these reasons is needed.

D. Sources of Prescription Drugs Used for Abuse

Despite the inherent costs and dangers of prescription drug abuse, these drugs are readily available. Prescription drugs are readily available through pill mills, doctor shopping, and can even be found in the home.⁹⁵ As shown below, the ease through which controlled drugs can be accessed needs to be addressed.

1. Pill Mills

Pill mills are only one piece to the puzzle of prescription drug abuse. A pill mill is a “doctor, clinic or pharmacy that is prescribing or dispensing powerful

<http://www.odadas.state.oh.us/public/OpenFile.aspx?DocumentID=e934f58b-74cf-4e1c-b2a0-52eca5f6c271>, see also *infra* Part II.D.2 (further detailing the costs and dangers that prescription drug abuse and heroin abuse places on the individual as well as society).

⁸⁷ *Id.*

⁸⁸ See NATIONAL INSTITUTE ON DRUG ABUSE, *supra* note 30.

⁸⁹ See generally *supra* Part II.A (describing the dangers of prescription drug abuse).

⁹⁰ See NATIONAL INSTITUTE ON DRUG ABUSE, *supra* note 30.

⁹¹ See *id.* These increases demonstrate that the amount of drugs available to the general public has increased dramatically over the last two decades. *Id.*

⁹² See generally *supra* Part II.A.3 (describing the phenomenon of college students abusing stimulants, such as Adderall or Ritalin to cope with a difficult class load).

⁹³ See NATIONAL INSTITUTE ON DRUG ABUSE, *supra* note 30.

⁹⁴ Rachel Dissell, *Overdose Deaths Climb as Painkillers, Heroin Pour into Ohio Market*, THE PLAIN DEALER (Feb. 20, 2011, 6:00 AM), http://blog.cleveland.com/metro/2011/02/overdose_deaths_climb_as_paink.html.

⁹⁵ See NATIONAL INSTITUTE ON DRUG ABUSE, *supra* note 30.

[prescription] narcotics inappropriately or for non-medical reasons.”⁹⁶ Pill mills generally operate as cash-only pain management clinics.⁹⁷ Pill mills also tend to open and close down quickly to evade law enforcement.⁹⁸ They are characterized by long waits in line, and sometimes an absence of a single consultation with a physician.⁹⁹ Patients are frequently invited to “pick their poison” by indicating which medication they want, with no questions asked by the physician.¹⁰⁰ Physicians at these clinics rarely, if ever, explore alternative pain management techniques, and treat with pain pills only.¹⁰¹ The patient is then given a prescription for the drug of their choice.¹⁰² If the patient does not receive the drug immediately in the office, they are directed to a “preferred” pharmacy that will fill the prescription without issue.¹⁰³

The danger of pill mills goes far beyond harm to the health of an individual patient. For example, if a patient visits multiple pill mills,¹⁰⁴ they can amass a large quantity of drugs.¹⁰⁵ Patients can then consume drugs from this collection as they wish or sell them on the street, which presents a hazard to the community.¹⁰⁶ Another identified harm, beyond the harm to the individual patient, occurs when patients fill their prescription in another state. In such cases the state where the pill mill is located will have difficulty identifying prescription drug abuse.¹⁰⁷

⁹⁶ Pia Malbran, *What’s a Pill Mill?*, CBS NEWS (May 31, 2007 6:01 PM), http://www.cbsnews.com/8301-501263_162-2872835-501263.html.

⁹⁷ *What is a Pill Mill?*, *supra* note 21. Since pill mills operate as a cash-only business, insurance companies cannot monitor patient drug use. *Id.* Insurance companies will often monitor the drugs a patient receives, and refuse to pay for a drug if the patient recently had this medication filled, and still should have some medication left. Thus, it is difficult for the patient to amass a large supply of drugs. *See Fighting the Scourge of Pill Mills*, CBS NEWS (Oct. 16, 2011 9:35 AM), <http://www.cbsnews.com/stories/2011/10/16/sunday/main/20121033.shtml> (characterizing pill mills as a cash-only operation).

⁹⁸ *See* Malbran, *supra* note 96.

⁹⁹ *What is a Pill Mill?*, *supra* note 21.

¹⁰⁰ *Id.*; Malbran, *supra* note 96.

¹⁰¹ *What is a Pill Mill?*, *supra* note 21; Malbran, *supra* note 96.

¹⁰² *See* Malbran, *supra* note 96 (identifying one of the signs of a pill mill as the patient picking their own medication, no questions asked).

¹⁰³ *What is a Pill Mill?*, *supra* note 21; Malbran, *supra* note 96.

¹⁰⁴ *See infra* Part II.D.2 (discussing doctor shopping as a source for medications to abuse).

¹⁰⁵ In one instance, a patient in Georgia obtained a five-year supply of Oxycontin in one year by visiting dozens of pharmacies and almost sixty different doctors, and these drugs were paid for by taxpayers because the patient’s medications were covered by Medicare. *See* Robert Lowes, ‘Doctor-Shoppers’ Get Pain Meds at Medicare’s Expense, MEDSCAPE NEWS TODAY (October 26, 2011), <http://www.medscape.com/viewarticle/752340>.

¹⁰⁶ *See infra* Part II.D.ii (discussing the dangers inherent in drugs sold on the street).

¹⁰⁷ *See generally infra* Part III.C.2 (discussing the interconnectivity of the OARRS system and its ability to interface with the patient prescription databases of other states).

2. Doctor Shopping

Another source of collecting medications for abuse is the process known as “doctor shopping.”¹⁰⁸ Doctor shopping is the process of receiving treatment from multiple physicians concurrently.¹⁰⁹ These physicians often do not know that the patient is receiving treatment from other physicians.¹¹⁰ Doctor shoppers will often visit multiple physicians until they receive a prescription for their “preferred” drug.¹¹¹ Doctor shoppers will visit physicians that they do not know to further mask their true intent.¹¹² This process results in overmedicating patients; for example, a patient receiving Oxycontin from one physician may receive the same drug from another physician.¹¹³

The danger of doctor shopping is exacerbated by the existence of pill mills.¹¹⁴ The patient who “shopped” for the medication at multiple pill mills can either use the drugs from the resulting horde of medications, or sell them for a profit.¹¹⁵ Oxycontin can sell for approximately \$0.50 to \$1/mg on the street.¹¹⁶ Thus, a single 40mg pill of Oxycontin can sell for \$20 to \$40 illicitly. To make matters worse, the price of a 40mg pill of Oxycontin purchased legally from a pharmacy is \$4/pill.¹¹⁷ Therefore, given a prescription for 90 pills of Oxycontin (1 pill, three times a day), a patient will pay \$360 for the prescription, assuming the patient’s insurance is not involved.¹¹⁸ This same prescription can be sold on the street for \$1,800 to \$3,600.

¹⁰⁸ See Lowes, *supra* note 105.

¹⁰⁹ David L. Robinson, Note & Comment, *Bridging the Gaps: Improved Legislation to Prohibit the Abuse of Prescription Drugs in Virginia*, 9 *Appalachian J. L.* 281, 289 (2010).

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² See Madison Park, *How Physicians Try to Prevent ‘Doctor Shopping’*, CNN HEALTH (Apr. 7, 2010), http://articles.cnn.com/20100407/health/doctor.shopping.haim_1_prescription-drugs-xanax-doctor-shopping?_s=PM:HEALTH.

¹¹³ See *id.* Doctor shoppers will try various ways to obtain more medication. In addition to visiting multiple doctors, shoppers will “call during weekends [presumably when the doctor does not have his or her record on hand] or ask for prescription refills using excuses such as having dropped the pills in toilets or getting pills wet on a camping trip.” *Id.* See also Sara Jane Tribble, *Ohio Lawmakers Want to Mandate Prescription Monitoring by Doctors*, THE PLAIN DEALER, (Jan. 20, 2010), http://www.cleveland.com/healthfit/index.ssf/2010/01/lawmakers_want_to_mandate_pres.html (“If doctors were required to check the database, they would spot patients who were pill shopping, going to multiple pain clinics and emergency rooms to obtain prescriptions or samples.”).

¹¹⁴ Doctor shoppers can quickly amass a large quantity of drugs. This quantity would likely increase where the patient visits a pill mill that readily hands out medications with no qualms. See Lowes, *supra* note 105.

¹¹⁵ *Id.*

¹¹⁶ *OxyContin Diversion and Abuse*, THE NATIONAL DRUG INTELLIGENCE CENTER (Jan. 2001), <http://www.justice.gov/archive/ndic/pubs/651/abuse.htm>.

¹¹⁷ *Id.*

Combine this absurd profit margin with a high unemployment rate,¹¹⁹ and it is easy to see why patients could be tempted to “shop” for Oxycontin to supplement their income.¹²⁰

These high costs have other negative impacts. For example, those who can no longer afford the street price of Oxycontin may be pushed to use heroin,¹²¹ which is available in many parts of the country.¹²² Both heroin and Oxycontin are opioid derivatives¹²³ and therefore, they provide similar effects.¹²⁴ Currently, the cost of heroin is around \$172/gram, or \$0.17/mg.¹²⁵ Compare this price to the street price of Oxycontin at a minimum of \$20 for a 40mg pill,¹²⁶ and an abuser’s decision to switch from Oxycontin to heroin makes financial sense, if nothing else.¹²⁷

Heroin abuse is not a problem limited to the inner-city.¹²⁸ Deaths related to this drug are increasing in Ohio’s affluent suburbs, such as Independence, where four persons overdosed on heroin in less than eight weeks.¹²⁹ Switching from Oxycontin to heroin can be more dangerous; heroin may be laced with other chemicals because it is unregulated by the government.¹³⁰ In addition, an addict who abuses heroin places additional costs on law enforcement agencies, and ultimately the taxpayer.¹³¹ Ohio cannot afford to pay these costs. Thus, combating Oxycontin abuse, whether

¹¹⁸ If the patient’s insurance company is kept out of the loop with the medications a patient receives, then it will be easier for patients to get multiple prescriptions of the same medication. See *What is a Pill Mill?*, *supra* note 21.

¹¹⁹ *Local Area Unemployment Statistics*, *supra* note 10.

¹²⁰ See Borger, *supra* note 53 (“[Law enforcement officers are] trying to do [their] best to combat the dealers, who are often families on welfare trying to earn extra money.”).

¹²¹ *OxyContin Diversion and Abuse*, *supra* note 116.

¹²² *Ohio’s Opiate Epidemic: User Profiles*, *supra* note 86.

¹²³ *NIDA InfoFacts: Heroin*, NATIONAL INSTITUTE ON DRUG ABUSE, <http://www.nida.nih.gov/infofacts/heroin.html> (last updated Mar. 2010).

¹²⁴ See Dissell, *supra* note 94.

¹²⁵ OFFICE ON DRUGS AND CRIME, UNITED NATIONS, 2008 WORLD DRUG REPORT 257 (2008), available at http://www.unodc.org/documents/wdr/WDR_2008/WDR_2008_eng_web.pdf.

¹²⁶ Oxycontin on the street can sell for approximately \$0.50 to \$1/mg. Thus, a single 40mg pill of Oxycontin can sell for \$20 to \$40 on the street. See *OxyContin Diversion and Abuse*, *supra* note 116.

¹²⁷ See Dissell, *supra* note 94.

¹²⁸ See Dissell, *supra* note 94.

¹²⁹ Tracy Carloss, *Independence Bands Together to Fight Heroin After Four Overdoses in Eight Weeks*, WEWS NEWS CHANNEL 5 (Jun. 16, 2006), http://www.newsnet5.com/dpp/news/local_news/oh_cuyahoga/independence-bans-together-to-fight-heroin-after-4-overdoses-in-8-weeks.

¹³⁰ See Christian Nordqvist, *Fentanyl-laced Heroin Kills Hundreds Of Addicts in USA*, MED. NEWS TODAY (June 16, 2006), <http://www.medicalnewstoday.com/articles/45391.php>.

¹³¹ See generally *supra* Part II.B (describing the costs that prescription abuse places on society).

due to doctor shopping or other causes, will have the positive side effect of preventing heroin abuse.¹³²

3. The Home

To find another source of prescription medications, one need only look in the mirror, or rather, behind the mirror. As mentioned above, prescriptions for controlled substances have increased dramatically in the last twenty years.¹³³ This leads to an increased likelihood of unused prescriptions in the medicine cabinet.¹³⁴ These medications may be enticing to teenagers for “pharming,” who will in turn share the medications with friends who “pharmed” their own medicine cabinets.¹³⁵ These medications are placed in a bowl called “trailmix,” which everyone shares at an event called a “pharm party.”¹³⁶ The teens take pills from the “trailmix” randomly until they reach a sufficient high.¹³⁷ But, not all pill combinations will make the taker feel high. Accordingly, teens tend to consume more pills, thereby increasing the risk that they may unwittingly overdose on the “trailmix.”¹³⁸

Pharm parties and similar problems are not exclusive to teenagers. On March 2, 2012, a first-grade student from Cleveland, Ohio brought a bottle of anti-depressant medications to school and passed them out.¹³⁹ While there was no evidence that the child had bad intentions—as he may have thought that the medications were candy—eight students were still taken to the hospital.¹⁴⁰ Thankfully, none of the children developed life-threatening complications.¹⁴¹ But, this story should serve as

¹³² See Dissell, *supra* note 94.

¹³³ NATIONAL INSTITUTE ON DRUG ABUSE, *supra* note 30.

¹³⁴ Cf. Stan Donaldson, *Prescription Drug Collection Nets More than 8,700 Pounds in Cleveland Area*, THE PLAIN DEALER (Nov. 3, 2011 5:45 AM), http://blog.cleveland.com/metro/2011/11/prescription_drug_collection_n.html. While this article does not establish a causal relationship between number of prescriptions written and the amount of unused prescriptions in the home, the fact that over four tons of medications were collected at a local drug take-back program supports the inference that there is a large amount of unused medications in peoples' homes.

¹³⁵ Donna Leinwand, *Prescription Drugs Find Place in Teen Culture*, USA TODAY (June 13, 2006 7:40 PM), http://www.usatoday.com/news/health/2006-06-12-teens-pharm-drugs_x.htm. See also Kim-Katz & Anderson, *supra* note 34 (“Disturbingly, 41% of [teens] surveyed agreed that ‘using prescription drugs without a prescription is much safer to use than illegal drugs.’ This belief likely fuels the latest trend in drug abuse called ‘pharming,’ the practice of adolescents raiding medicine cabinets in search of finding drugs for abuse.”)

¹³⁶ See Leinwand, *supra* note 135.

¹³⁷ Monica Kim Sham, Note, *Down on the Pharm: The Juvenile Prescription Drug Abuse Epidemic and the Necessity of Holding Parents Criminally Liable for Making Drugs Accessible in their Homes*, 27 J. CONTEMP. HEALTH L. & POL'Y 426, 436-37 (2011).

¹³⁸ *Id.*

¹³⁹ Kevin Freeman, *Parents Shocked Over Elementary Overdose*, FOX 8 CLEVELAND, (March 2, 2012, 10:35 PM), <http://fox8.com/2012/03/02/elementary-school-students-rushed-to-hospital-after-overdose/>.

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

a warning of the dangers of prescription medications, and the ease to which they can be accessed in the home. It would be difficult to fashion a law that would prevent a situation like this. For this reason, primary responsibility lies with the parents to educate their children so that they understand that prescription medications are not candy, and can be dangerous when taken.

As shown above, dangerous prescription medications are readily available to the public in many forms. Specifically, controlled prescription drugs can be procured through pill mills, doctor shopping or in the home.¹⁴² Once the drugs are obtained, it is easy and even profitable to sell them on the street.¹⁴³ Moreover, prescription drug abuse is dangerous to the health of an individual¹⁴⁴ and places high costs on society.¹⁴⁵ Although these drugs are dangerous and can be accessed easily, they still serve an important role in healthcare and it is necessary to find a solution capable of balancing competing illicit and legitimate medical interests.

E. Current State of Federal Law: Controlled Substances Act

In 1970, President Richard Nixon signed into law the Controlled Substances Act (“CSA”).¹⁴⁶ The CSA is a federal act that regulates the manufacture, possession, and distribution of certain medications.¹⁴⁷ Among other things, the law creates five classifications (commonly known as “schedules”) to group various controlled substances.¹⁴⁸ The drugs are placed in schedules based on their potential for abuse and whether they have any currently accepted medical use.¹⁴⁹ Schedule I contains drugs that have the highest potential for abuse and no accepted medical use; examples include marijuana and heroin.¹⁵⁰ Schedule II drugs have a high potential for abuse and severely limited medical purpose¹⁵¹—they include Adderall (amphetamine), Morphine, and Oxycontin (Oxycodone).¹⁵² Currently, physicians

¹⁴² See generally *supra* Part II (discussing access to controlled prescription drugs).

¹⁴³ See generally *supra* Part II.D.2 (discussing the financial incentives to sell prescription drugs on the street).

¹⁴⁴ See generally *supra* Part II.A (discussing the health effects of abusing medications).

¹⁴⁵ See generally *supra* Part II.B (discussing the costs prescription drug abuse places on society).

¹⁴⁶ See *Thirty Years of America’s Drug War*, PBS, <http://www.pbs.org/wgbh/pages/frontline/shows/drugs/cron/> (last visited Oct. 28, 2012) (While the source does not directly state that President Nixon signed the bill into law, it can be inferred that he did because the law was enacted in 1970, during Richard Nixon’s presidency.).

¹⁴⁷ See 21 U.S.C.S. § 801 (LexisNexis 2011) (discussing congressional findings regarding the possession, manufacture, and distribution of controlled substances).

¹⁴⁸ 21 U.S.C.S. § 802(6) (LexisNexis 2011).

¹⁴⁹ 21 U.S.C.S. § 812 (LexisNexis 2011).

¹⁵⁰ 21 U.S.C.S. § 812(c) (LexisNexis 2011).

¹⁵¹ 21 U.S.C.S. § 812 (LexisNexis 2011).

¹⁵² 21 U.S.C.S. § 812(c) (LexisNexis 2011); see *Drugs and Medications – Adderall Oral*, WEBMD, <http://www.webmd.com/drugs/drug-63163Adderall+Oral.aspx?drugid=63163&drugname=Adderall+Oral> (last visited Oct. 28, 2012) (the generic name for Adderall is amphetamine); see *Drugs and Medications – OxyContin Oral*, WEBMD, <http://www>

may only write prescriptions for drugs in Schedules II through V.¹⁵³ Because the medical profession is highly regulated by the government, the Ohio legislature has the ability to enact a solution that more effectively curbs prescription drug abuse, such as the Oxycontin epidemic in Southern Ohio.¹⁵⁴

F. Current State of Ohio Law vis-à-vis Prescription Reporting

In 2006, the Ohio Pharmacy Board created the Ohio Automated Rx Reporting System (“OARRS”) in part to identify drug-seeking behaviors of patients.¹⁵⁵ OARRS is an online patient database that aggregates patient data into reports that can be accessed by physicians, pharmacists, and law enforcement.¹⁵⁶ Similar patient databases are used in many states.¹⁵⁷ The reports from these databases provide healthcare professionals and law enforcement agencies with valuable information such as a patient’s prescription history and physicians’ prescribing trends.¹⁵⁸ The

.webmd.com/drugs/drug-2798OxyContin+Oral.aspx?drugid=2798&drugname=OxyContin+Oral&source=1 (last visited Oct. 28, 2012) (the generic name for OxyContin is Oxycodone).

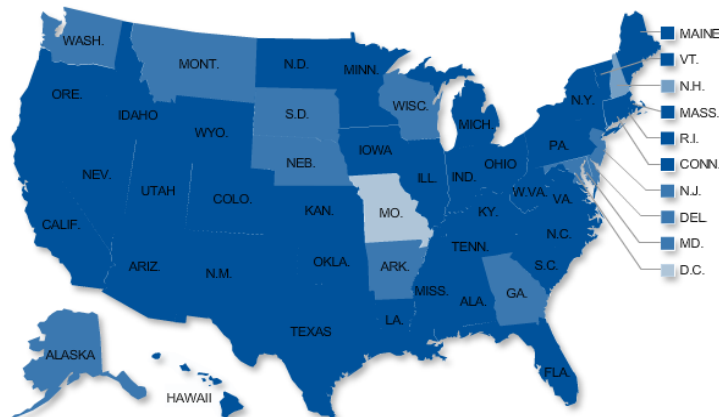
¹⁵³ See 21 U.S.C.S. § 812(b)(1) (LexisNexis 2011). Schedule I drugs “[have] a high potential for abuse. . . [have] no currently accepted medical use in treatment, . . . [or] there is a lack of accepted safety for use of the drug or other substance under medical supervision.” *Id.* Thus, Schedule I drugs cannot be prescribed by a doctor under federal law.

¹⁵⁴ See Tavernise, *supra* note 2.

¹⁵⁵ *What is OARRS?*, OHIO AUTOMATED RX REPORTING SYSTEM, <https://www.ohiopmp.gov/portal/Default.aspx> (last visited Oct. 28, 2012).

¹⁵⁶ *Id.*

¹⁵⁷ See generally Donna Leinwand Leger, *States Target Prescriptions by ‘Pill Mills,’* USA TODAY, <http://www.usatoday.com/news/nation/story/2011-10-13/pill-mill-drug-trafficking/50896242/1> (last updated Oct. 25, 2011 11:45 AM) (documenting prescription monitoring program databases by state). States colored in dark blue have a fully operational prescription database. *Id.* States colored in light blue have either proposed enabling legislation or enacted legislation providing for a prescription database, but no such database is active. *Id.* Missouri and Washington D.C., both colored white, have neither enacted nor proposed legislation to establish a prescription monitoring database. *Id.*



¹⁵⁸ *Id.*

Ohio legislature granted the Ohio Pharmacy Board the authority to establish OARRS in 2005.¹⁵⁹ The Ohio Pharmacy Board monitors the database to identify trends of overmedication, doctor shopping, and abuse.¹⁶⁰ These reports can also include information regarding Ohio patients who had prescriptions filled in other states.¹⁶¹ However, OARRS will only share prescription information with other states' prescription monitoring programs if they meet Ohio's statutory requirements and have signed a written agreement.¹⁶² As of the time this Note was written, OARRS can only interact with the prescription databases of nine other states.¹⁶³

Currently, "terminal distributors" of medications are required to submit information to OARRS regarding controlled medications that are dispensed to patients.¹⁶⁴ Terminal distributors are defined as persons engaged in the sale of "dangerous drugs," including pharmacies, hospitals, and nursing homes.¹⁶⁵ The information submitted to OARRS includes the name of the patient, the prescriber, the date of the prescription, medication name, quantity, strength, and dosage.¹⁶⁶ With this information, prescribers, pharmacists, and law enforcement may request

¹⁵⁹ OHIO REV. CODE ANN. § 4729.75 (LexisNexis 2011) ("The state board of pharmacy may establish and maintain a drug database. The board shall use the drug database to monitor the misuse and diversion of controlled substances.").

¹⁶⁰ *Id.*

¹⁶¹ See *Ohio Deploys NABP PMP InterConnect Statewide, Arizona Signs On to Participate*, NAT'L ASS'N OF BOARDS OF PHARMACY (Aug. 19, 2011), <http://www.nabp.net/news/ohio-deploys-nabp-pmp-interconnect-statewide-arizona-signs-on-to-participate/>.

¹⁶² OHIO REV. CODE ANN. § 4729.80(A)(11) (LexisNexis 2011) ("On receipt of a request from . . . another state's prescription monitoring program, the board may provide to the requestor information from [OARRS], but only if there is a written agreement under which the information is to be used and disseminated according to the laws of this state."); see also *Connecting to PMP InterConnect*, NAT'L ASS'N OF BOARDS OF PHARMACY, <http://www.nabp.net/programs/pmp-interconnect/nabp-pmp-interconnect/connecting-to-pmp-interconnect/> (last visited Oct. 28, 2012). These written agreements are known as a "memorandum of understanding." *Id.* The National Association of Boards of Pharmacy has a model memorandum drafted which lays out each state's rights, responsibilities, and privileges with respect to maintaining the interstate pharmacy database connection. See *id.*

¹⁶³ Ohio's OARRS can interact with the prescription monitoring programs of nine states: Arizona, Connecticut, Indiana, Kansas, Mississippi, North Dakota, South Carolina, Virginia, and West Virginia. Noticeably missing from this list are Michigan, Kentucky, and Pennsylvania—three states that share a border with Ohio. See *Ohio Deploys NABP PMP InterConnect Statewide, Arizona Signs On to Participate*, *supra* note 161.

¹⁶⁴ OHIO REV. CODE ANN. § 4729.77 (LexisNexis 2011) ("[E]ach pharmacy licensed as a terminal distributor of dangerous drugs . . . shall submit to the board the following prescription information: [prescription information such as patient name, doctor, drug dispensed, quantity, etc.]").

¹⁶⁵ OHIO REV. CODE ANN. § 4729.01(Q) (LexisNexis 2011).

¹⁶⁶ OHIO REV. CODE ANN. § 4729.77 (LexisNexis 2011).

reports regarding medication dispensed to patients in order to better serve the health of the patient and to protect the public at large.¹⁶⁷

In response to the growing prescription abuse epidemic, the Ohio General Assembly enacted House Bill 93 in 2011.¹⁶⁸ This Bill includes prescribers who dispense drugs (one of the hallmarks of a pill mill) in the definition of “terminal distributors.”¹⁶⁹ Thus, all prescribers who fall into the category of distributors (including dentists, physician’s assistants, and nurse practitioners) must now report drug dispenses to OARRS.¹⁷⁰ The goal was to make it easier for law enforcement agencies to identify pill mills without adversely affecting legitimate pain clinics that properly prescribe controlled medications.¹⁷¹ Specifically, agencies look for trends of physicians prescribing and dispensing high volumes of narcotic medications paid for by the patient without any assistance from insurance companies.¹⁷²

In addition to the changes promulgated by House Bill 93, the Ohio Medical Board enacted Rule 4731-11-11 in 2011 as part of an effort to go above and beyond affecting only pain clinics, but to also affect all physicians who prescribe controlled medications.¹⁷³ Rule 4731-11-11 requires physicians to review OARRS reports on patients if “the physician is aware of a patient suffering from addiction, drug abuse, or engaging in diversion of drugs.”¹⁷⁴ Furthermore, physicians must review an OARRS report on their patient at the beginning of treatment and once annually thereafter if the patient is being treated for more than twelve weeks.¹⁷⁵ These

¹⁶⁷ OHIO REV. CODE ANN. § 4729.80 (LexisNexis 2011). Pharmacists and prescribers may only request reports on patients that they are currently treating. *Id.* Law enforcement may only request reports in conjunction with an investigation of a drug offense. *Id.*

¹⁶⁸ See H.B. 93, 129th Gen. Assemb., Reg. Sess. (Oh. 2011), available at http://www.legislature.state.oh.us/bills.cfm?ID=129_HB_93; Gov. Kasich Signs House Bill 93, OHIO NEWS NETWORK (May 20, 2011), <http://www.onntv.com/content/stories/2011/05/21/story-pill-mills.html> (“Gov. John Kasich . . . signed House Bill 93 into law which will now help legislation that fights Ohio’s prescription drug abuse epidemic.”).

¹⁶⁹ See H.B. 93.

¹⁷⁰ *Id.*; see also OHIO ADMIN. CODE 4715-6-01 (LexisNexis 2011) (requiring dentists to report controlled medication dispenses to OARRS, and to review reports on patients in certain situations); see also OHIO ADMIN. CODE 4723-9-12 (LexisNexis 2011) (requiring nurse practitioners to report controlled medication dispenses to OARRS, and to review reports on patients in certain situations).

¹⁷¹ Zimmer, *supra* note 20.

¹⁷² See generally *supra* Part II.B.1 (describing the characterization of pill mills).

¹⁷³ House Bill 93 – New Law to Combat Prescription Drug Abuse, GRAND ROUNDS – YOUR REPORT FROM THE STATE MEDICAL BOARD OF OHIO (May 2011), available at http://www.med.ohio.gov/pdf/Newsletters/Spring11_Special_HB93.pdf.

¹⁷⁴ OHIO ADMIN. CODE 4731-11-11(B) (Lexis Nexis 2011).

¹⁷⁵ See OHIO ADMIN. CODE 4731-11-11(C) (Lexis Nexis 2011) (“A physician . . . shall, at a minimum, document receipt and assessment of an OARRS report . . . [o]nce the physician has reason to believe that the treatment will be required on a protracted basis; and [a]t least once annually, thereafter.”); See OHIO ADMIN. CODE 4731-11-11(A)(4) (Lexis Nexis 2011) (defining “protracted basis” as “a period in excess of twelve continuous weeks.”).

measures seek to provide physicians with as much information about their patient's medical history as possible before they prescribe a potentially dangerous drug.¹⁷⁶

While Rule 4731-11-11 is more stringent than House Bill 93, neither law goes far enough to prevent prescription drug abuse by patients. Ohio may have created OARRS to identify trends of prescription abuse, yet not all physicians are required to run reports from OARRS on controlled substances dispensed to the patient.¹⁷⁷ Thus, physicians, law enforcement agencies, and pharmacists are pulling reports from an incomplete database. Given the risks of prescription abuse, and the shortcomings of the current system, a solution that addresses each of these problems is needed.

III. ARGUMENT

Ohio has made great strides to combat prescription drug abuse.¹⁷⁸ In spite of legislative efforts, new laws such as House Bill 93 and Medical Rule 4731-11-11 have shortcomings because they react to the problem of pill mills, instead of combating prescription abuse generally.¹⁷⁹ In addition to these recent changes, the Ohio legislature should mandate reporting for all controlled medication, make OARRS interface with the prescription databases of other states, better promote prescription return programs, and strengthen its laws regarding doctor shopping. By taking these additional measures, Ohio will more effectively prevent the problem of prescription drug abuse.

A. Core Competencies of House Bill 93 and Medical Rule 4731-11-11

House Bill 93 and Medical Rule 4731-11-11 are a step in the right direction to curb prescription abuse for two reasons. First, House Bill 93 makes it very difficult to operate pill mills, while simultaneously making it easier for healthcare providers to access OARRS.¹⁸⁰ Second, Medical Rule 4731-11-11 mandates OARRS reporting in some situations, which provides physicians with more information on medications their patients are already taking.¹⁸¹

1. House Bill 93 Makes It Difficult to Operate Pill Mills in Ohio

House Bill 93 has been effective in closing Ohio's pill mills.¹⁸² In fact, many of the pill mills in Portsmouth shut down before House Bill 93 took effect.¹⁸³ These pill

¹⁷⁶ See *House Bill 93 – New Law to Combat Prescription Drug Abuse*, *supra* note 173.

¹⁷⁷ See generally *supra* Part II.F (describing who must report to OARRS and what information must be reported).

¹⁷⁸ See generally *supra* Part II.F (describing laws adopted by Ohio to combat prescription drug abuse).

¹⁷⁹ See *House Bill 93 – New Law to Combat Prescription Drug Abuse*, *supra* note 173.

¹⁸⁰ See *House Bill 93 – New Law to Combat Prescription Drug Abuse*, *supra* note 173.

¹⁸¹ See OHIO ADMIN. CODE 4731-11-11(B) (Lexis Nexis 2011).

¹⁸² Noah Adams, *A County Takes Down Prescription Pill Mills*, NPR (June 19, 2011), <http://www.npr.org/2011/06/19/137284148/a-county-triumphs-over-prescription-pill-mills> (noting that at the time the article was written, all pill mills in Portsmouth had shut down); see also Alan Johnson, *Prayers Answered: Scioto County's Last 'Pill Mill' Shut*, COLUMBUS DISPATCH, <http://www.dispatch.com/content/stories/local/2011/12/21/prayers-answered-sciotos-last-pillmillshut.html> (Dec. 21, 2011 5:52 AM) (noting that the last pill mill in Scioto county shut down at the end of 2011).

mills shut down in part because they did not want to comply with H.B. 93 and Rule 4731-11-11.¹⁸⁴ Under H.B. 93, prescribers who actually dispense controlled medications, rather than merely prescribing medications, must report to OARRS the controlled medications they dispense.¹⁸⁵ This allows Ohio's Pharmacy Board to identify pill mills operating under the guise of pain management clinics.¹⁸⁶ Additionally, Medical Rule 4731-11-11 requires all pain management clinics to be licensed to continue operation.¹⁸⁷ This licensing requirement allows law enforcement agencies to monitor pain management clinics without adversely affecting the clinics that properly prescribe controlled substances and explore alternative treatment options.¹⁸⁸ Finally, under H.B. 93, only physicians may be licensed to run these clinics.¹⁸⁹ This keeps laypersons—who may have ambitions that contradict a physician's Hippocratic Oath—out of the practice of medicine.

2. The Recent Changes Also Enable Easier Access to OARRS

House Bill 93 increases healthcare providers' access to information. All support staff within a physician's office can now apply for an account to run OARRS reports on patients.¹⁹⁰ Previously, only prescribers were able to apply for these accounts.¹⁹¹ This change allows physicians to delegate the task of running reports to support staff.¹⁹²

¹⁸³ Adams, *supra* note 182.

¹⁸⁴ *Id.*

¹⁸⁵ OHIO REV. CODE ANN. § 4729.79(A) (LexisNexis 2011). (“If [Ohio] . . . maintains a drug database . . . , each licensed health professional . . . who personally furnishes a controlled substance or other dangerous drug . . . to a patient in this state shall submit to the board the following information: [information about the prescription, including patient name, doctor name, drug name, dosage, etc.]”); *see also* H.B. 93, 129th Gen. Assemb., Reg. Sess. (Oh. 2011), *available at* http://www.legislature.state.oh.us/bills.cfm?ID=129_HB_93 (summarizing the changes brought by House Bill 93).

¹⁸⁶ *See generally* OHIO REV. CODE ANN. § 4729.79(A) (LexisNexis 2011) (providing that persons who furnish a drug to a patient must report this act to a database controlled by the Ohio Pharmacy Board).

¹⁸⁷ *House Bill 93 – New Law to Combat Prescription Drug Abuse, supra* note 173. A pain management clinic is defined as a place where “[t]he primary component of practice is treatment of pain or chronic pain; [and t]he majority of patients of the prescribers at the facility are provided treatment for pain or chronic pain that includes the use of controlled substances, tramadol, carisoprodol, or other drugs specified in rules adopted under this section.” OHIO REV. CODE ANN. § 4731.054(A)(5)(a)(i-ii) (LexisNexis 2011).

¹⁸⁸ H.B. 93, 129th Gen. Assemb., Reg. Sess. (Oh. 2011), *available at* http://www.legislature.state.oh.us/bills.cfm?ID=129_HB_93.

¹⁸⁹ *House Bill 93 – New Law to Combat Prescription Drug Abuse, supra* note 173.

¹⁹⁰ *See* OHIO REV. CODE ANN. § 4729.80(a)(5) (LexisNexis 2011) (providing agents of the prescriber the ability to request reports from OARRS).

¹⁹¹ *See generally* H.B. 93. Prior to House Bill 93, section 4729.80(a)(5) gave only prescribers and pharmacists the ability to access the database. *Id.*

¹⁹² *See* OHIO REV. CODE ANN. § 4729.80(a)(5) (LexisNexis 2011).

Medical Rule 4731-11-11 also works in tandem with House Bill 93 by requiring pain management physicians to run reports on patients at the inception of treatment and once annually thereafter.¹⁹³ The rule obligates physicians to monitor their patients and ensure that they are not “shopping” elsewhere to get medication.¹⁹⁴ Also, this rule establishes a duty to run a report if a physician suspects a patient of abusing medication.¹⁹⁵ Rule 4731-11-11 places more duties on a physician to ensure patients do not abuse medication.¹⁹⁶

B. Shortcomings of H.B. 93 and Rule 4731-11-11

The enactment of House Bill 93 and Rule 4731-11-11 are moves in the right direction to combat prescription abuse in Ohio. There are problems with these recent changes, however. First, there are technical issues with these laws. Second, they react to the problem of pill mills¹⁹⁷ but do not adequately address the core of the prescription abuse problem.

1. Technical Issues with Ohio’s Current Law

Despite the efficacy of H.B. 93 in eliminating pill mills,¹⁹⁸ in general the law does not curb prescription drug abuse.¹⁹⁹ Doctor-shopping patients can still visit a pain clinic, and “explore” alternative treatments, only to find that it “was not effective” and potentially receive the prescription for the drug of their choice.²⁰⁰ Thus, a patient who never has a real medical need for a medication is free to abuse it, or sell it on the street.²⁰¹

Currently, Ohio does not have an adequate “doctor shopping statute.”²⁰² Although Ohio criminalizes procuring medication through deceit (i.e. doctor shopping) under section 2925.22, case law has only found “deceit” where a patient

¹⁹³ See OHIO ADMIN. CODE 4731-11-11(C) (Lexis Nexis 2011).

¹⁹⁴ *Id.*

¹⁹⁵ See OHIO ADMIN. CODE 4731-11-11(B) (Lexis Nexis 2011) (setting forth a list of “red flags” that should trigger suspicions of abuse, such as early refills, requesting brand name drugs instead of generic, patient appearing to appointment intoxicated, etc.).

¹⁹⁶ OHIO ADMIN. CODE 4731-11-11(B) (Lexis Nexis 2011); H.B. 93, 129th Gen. Assemb., Reg. Sess. (Oh. 2011), *available at* http://www.legislature.state.oh.us/bills.cfm?ID=129_HB_93.

¹⁹⁷ See Zimmer, *supra* note 20.

¹⁹⁸ See Adams, *supra* note 182 (explaining that at the time of the writing of the article, all pill mills in Portsmouth had shut down).

¹⁹⁹ H.B. 93.

²⁰⁰ See H.B. 93. Noticeably absent from the bill is any provision relating to doctor shopping. *See id.*

²⁰¹ See generally *supra* Part II.C.2 (describing the street prices of prescription drugs and the temptation of selling them on the street).

²⁰² OHIO REV. CODE ANN. § 2925.22(A) (LexisNexis 2011) (“[n]o person, by deception, shall procure . . . a dangerous drug . . .”).

forged a prescription or visited multiple physicians to procure medication.²⁰³ Based on case law, section 2925.22 would be ineffective to prevent “deceit” where a drug-seeking patient went to a pain clinic, explored alternate pain management techniques, but still dishonestly complained of pain.²⁰⁴ Moreover, even if the law successfully prosecuted doctor shoppers, it could only do so after the patients have illicitly procured dangerous medications.

However, Ohio cannot easily tighten the grip of section 2925.22. If the legislature strengthened this law, or put the “burden of proof of pain” on the patient, patients with real health conditions treatable only by medication could unintentionally be caught in the web.²⁰⁵ Patients who have a hard time managing health problems may be justified in using painkillers.²⁰⁶ Further, it would still be very difficult to find deceit in the case of an interstate doctor shopper, as OARRS can only interact with the prescription databases from nine other states.²⁰⁷ The solution to curbing prescription abuse is not to increase the scope of section 2925.22.

Similarly, Rule 4311-11-11 has structural problems. Currently, physicians must run reports on their patients at the inception of treatment if they believe treatment will be necessary for twelve weeks or longer, and once annually thereafter.²⁰⁸ Physicians must also review OARRS reports on their patient when they suspect prescription abuse.²⁰⁹ One year is a long time to wait to run these reports if abuse is not suspected. Requiring a physician to run these reports more often may prevent an abuse problem, or catch the problem in its early stages.

House Bill 93 and Rule 4731-11-11 create a loophole in the law when they work together.²¹⁰ First, House Bill 93 does not require the physician to report information in OARRS if a physician does not dispense medication to a patient.²¹¹ Additionally,

²⁰³ Cf. *State v. O'Connell*, 2011-Ohio-652, 655 (Ohio Ct. App. 2011); *State v. Hartney*, 2010-Ohio-4331, 4332-33 (Ohio Ct. App. 2010); *State v. Newland*, 2009-Ohio-1340, 1341-43 (Ohio Ct. App. 2009). In these cases, deceit could be proven where the defendant visited multiple doctors to obtain prescriptions of pain medications, and these doctors did not know about the existence of the other doctors. No case can be found on point where deceit was alleged when a patient had only one doctor.

²⁰⁴ OHIO REV. CODE ANN. § 2925.22(A) (LexisNexis 2011).

²⁰⁵ See *Lowes*, *supra* note 105. Although discussing prescription abuse in the context of Medicare fraud, the same tension exists here. The author notes in the article that if Medicare regulations were tightened to prevent medication abuse, patients with legitimate and complicated problems who see four or five specialists to treat their condition could be caught in the web. *Id.*

²⁰⁶ *Id.*

²⁰⁷ See *Ohio Deploys NABP PMP InterConnect Statewide, Arizona Signs On to Participate*, *supra* note 161 (explaining that OARRS can interact with the prescription monitoring programs in Arizona, Connecticut, Indiana, Kansas, Mississippi, North Dakota, South Carolina, Virginia, and West Virginia).

²⁰⁸ See OHIO ADMIN. CODE 4731-11-11(C) (Lexis Nexis 2011).

²⁰⁹ OHIO ADMIN. CODE 4731-11-11(B) (Lexis Nexis 2011).

²¹⁰ See H.B. 93, 129th Gen. Assemb., Reg. Sess. (Oh. 2011), *available at* http://www.legislature.state.oh.us/bills.cfm?ID=129_HB_93; OHIO ADMIN. CODE 4731-11-11(C) (Lexis Nexis 2011).

²¹¹ OHIO REV. CODE ANN. § 4729.79 (LexisNexis 2011).

Rule 4731-11-11 only requires physicians to review an OARRS report at the inception of a twelve-week or longer treatment.²¹² Therefore, if a patient visits multiple physicians on a short-term basis to receive controlled medications, the patient's drug-seeking behaviors may go undetected. A patient's drug-seeking behavior may only be uncovered when a patient fills a prescription at an Ohio pharmacy, because once a prescription is filled, it will be reported to OARRS.²¹³ However, OARRS cannot report on this information, and, therefore, OARRS users are running reports on an incomplete database if a patient fills a prescription in Kentucky, or any of the 39 other states incompatible with OARRS.²¹⁴ Thus, a patient's healthcare provider, as well as Ohio's law enforcement agencies, may be oblivious to all medications a patient receives. This is especially troubling when Scioto County, Ohio—a county with a high rate of opiate consumption—²¹⁵ borders with Kentucky, which has similar prescription abuse problems.²¹⁶ Thus, the Ohio legislature should fill this statutory hole, or promote pharmacy database communications between Ohio and other states in order to effectively combat prescription abuse.

2. Reactive

Ohio's recent changes are also reactive to the epidemic of pill mills. While House Bill 93 removes one source of prescriptions in Ohio, there is more that could have been done. Neither House Bill 93 nor Medical Rule 4731-11-11 identify patients who receive a modest supply of drugs from only one physician and either abuse the medicine or sell it on the street.²¹⁷ Conversely, these laws are partially successful in curbing doctor shopping because they require prescribers to report

²¹² See OHIO ADMIN. CODE 4731-11-11(C) (LexisNexis 2011).

²¹³ OHIO REV. CODE ANN. § 4729.77 (LexisNexis 2011) (setting forth requirement that pharmacies report prescription information to OARRS).

²¹⁴ See *Ohio Deploys NABP PMP InterConnect Statewide, Arizona Signs On to Participate*, *supra* note 161 (indicating that OARRS can interact with the prescription monitoring programs in Arizona, Connecticut, Indiana, Kansas, Mississippi, North Dakota, South Carolina, Virginia, and West Virginia). *But see* Leger, *supra* note 157 (mentioning that OARRS *can* interact with Kentucky's KASPER). Given this discrepancy, and the memorandum of understanding between Kentucky and Ohio, it appears the Kentucky and Ohio have agreed in theory to share prescription information, but have not yet performed the necessary technical work to connect the databases.

²¹⁵ See generally *Ohio's Opiate Epidemic: User Profiles*, *supra* note 86 (table displaying prescription opiate consumption per capita in each of Ohio's counties).

²¹⁶ See generally *Politicians, Physicians Should Lead Fight Against Ky. Pill Mills*, KENTUCKY.COM (Nov. 15, 2011), <http://www.kentucky.com/2011/11/15/1960000/politicians-physicians-should.html> (describing generally the problems Kentucky faces with pill mills); cf. Tavernise, *supra* note 2 (describing generally the havoc wrought in Southern Ohio by pill mills).

²¹⁷ See H.B. 93, 129th Gen. Assemb., Reg. Sess. (Oh. 2011), available at http://www.legislature.state.oh.us/bills.cfm?ID=129_HB_93; OHIO ADMIN. CODE 4731-11-11(C) (LexisNexis 2011).

controlled medications dispensed to OARRS in all situations, but require reports to be run only in some situations.²¹⁸

Rule 4731-11-11 is more effective in combating doctor shopping opposed to H.B. 93. However, the rule still falls far short to tackle the problem head-on. For example, Rule 4731-11-11 requires physicians to view OARRS reports on their patients when they suspect their patients of abusing medications or suspect that the patient will be treated with a controlled substance for more than twelve weeks.²¹⁹ These rules are easily circumvented. First, the requirement that physicians view reports on their patients where abuse is suspected is based partially on the physician's subjective belief.²²⁰ The physician could easily circumvent the rule simply by saying, "I did not think my patient was abusing medications."²²¹ Second, an ill-intentioned physician may agree to only treat a patient with controlled medications for less than twelve weeks.²²²

Ohio's current statutory scheme also does not effectively prevent the cycle of abuse. While H.B. 93 removes pill mills as a source of prescriptions for patients, it does not attack the root problem, namely, stopping patients from abusing medications. Further, physicians may prescribe a controlled medication, such as Oxycontin, to their patient in good faith, when in reality that patient was simply shopping for medication. If this physician failed to investigate a patient's medical history and this patient was doctor shopping, the physician could be liable for failing to investigate the patient's medical history.²²³ This illustrates that "[t]he problem with the current legislation is that [Ohio's] criminal sanctions represent reactive

²¹⁸ "[E]ach licensed health professional . . . who personally furnishes a controlled substance or other dangerous drug . . . to a patient in this state shall submit to the board the following information . . ." OHIO REV. CODE ANN. § 4729.79(A) (LexisNexis 2011); OHIO ADMIN. CODE 4731-11-11(B) (LexisNexis 2011) (delineating the situations that require prescribers to view OARRS reports on their patients).

²¹⁹ See OHIO ADMIN. CODE 4731-11-11(B) (LexisNexis 2011) ("If a physician believes or has reason to believe that a patient may be abusing or diverting drugs, the physician shall use sound clinical judgment in determining whether or not the reported drug should be prescribed or personally furnished to the patient under the circumstances."); OHIO ADMIN. CODE 4731-11-11(C) (LexisNexis 2011) ("A physician prescribing . . . reported drugs to treat a patient on a protracted basis shall, at a minimum, document receipt and assessment of an OARRS report . . . [a]t least once annually . . ."). Further, a "protracted basis" is defined as "a period in excess of twelve continuous weeks." OHIO ADMIN. CODE 4731-11-11(A)(4) (LexisNexis 2011).

²²⁰ "If a physician believes or has reason to believe that a patient may be abusing or diverting drugs . . . the physician shall access OARRS." OHIO ADMIN. CODE 4731-11-11(B)(1) (LexisNexis 2011).

²²¹ At the time this Note was written, Rule 4731-11-11 had just taken effect and therefore had not yet been interpreted by Ohio case law.

²²² OHIO ADMIN. CODE 4731-11-11(C) (Lexis Nexis 2011) (requiring that doctors must review patient reports if treating for twelve weeks). Thus, if a doctor treats a patient for only eleven weeks, there is no duty to run an OARRS report on a patient.

²²³ OHIO ADMIN. CODE 4731-11-11(B)(1) (Lexis Nexis 2011). A physician must review an OARRS report if he "believes or has reason to believe that a patient may be abusing or diverting drugs." *Id.* Because the regulation is so new, there is no case law yet elaborating or providing examples of when the physician "had reason to believe" her patient was abusing or diverting prescription medications.

remedies because penalties can only be imposed after a finding of unlawful distribution . . .”²²⁴ While sanctions for breaking the law may convince prescribers and patients to follow it, “a reactive remedy cannot retroactively repair any damage which the unlawfully prescribing physician may have caused in the way of physical and psychological dependence in addicted victims.”²²⁵ Thus, Ohio needs a solution that prevents prescription drug abuse before the damage to the patient is done.

House Bill 93 does not prevent injury to patients. As noted above, it requires prescribers who furnish drugs to patients to report this activity to OARRS.²²⁶ While the Ohio Pharmacy Board will monitor this database for trends of overmedication, doctor shopping and abuse, prescribers do not need to monitor the database in many situations.²²⁷ Prescribers, who are in the best position to identify signs of patient drug abuse, are not required in all situations to review an OARRS report on their patient, which will delineate all controlled medications received by the patient in the last two years.²²⁸ And before a trend is identified by law enforcement an ill-intentioned patient could have either amassed a large quantity of drugs to sell on the street, or harmed themselves by taking these drugs.²²⁹ Regardless, the damage is already done before the pharmacy board can take action. Thus, Ohio should instead adopt a solution that can stop the problem of medication abuse before another situation similar to the “Portsmouth” problem happens elsewhere in Ohio.

C. Proposed Solution

As shown above, prescription drug abuse is a complex problem in Ohio that has life altering consequences, is extremely costly, and is a problem not adequately addressed by Ohio’s current legislation.²³⁰ Further, Ohio’s law addressing prescription drug abuse is confusing regarding who has to review reports on their patients and when.²³¹ Thus, more needs to be done to help prevent abuse. The first step would be to require mandatory OARRS monitoring for all controlled

²²⁴ David L. Robinson, *Bridging the Gaps: Improved Legislation to Prohibit the Abuse of Prescription Drugs in Virginia*, 9 APPALACHIAN J. L. 281, 282 (2010). Although this law review article discusses Virginia’s challenges with prescription abuse, Ohio has similar challenges.

²²⁵ *Id.*

²²⁶ OHIO REV. CODE ANN. § 4729.79 (LexisNexis 2011).

²²⁷ OHIO REV. CODE ANN. § 4729.75 (LexisNexis 2011); OHIO ADMIN. CODE 4731-11-11(B) (LexisNexis 2011).

²²⁸ OHIO REV. CODE ANN. §§ 4729.77–.79 (LexisNexis 2011).

²²⁹ See generally *supra* Part II.C.2 (describing the danger and temptation of selling prescriptions on the street). See also Lowes, *supra* note 105 (discussing case studies of patients amassing large quantities of drugs).

²³⁰ See *supra* Part III.B.1–2.

²³¹ Cf. OHIO ADMIN. CODE 4731-11-11(C) (LexisNexis 2011) (requiring doctors to review patient reports if treating for more than twelve weeks); OHIO ADMIN. CODE 4731-11-11(B) (LexisNexis 2011) (requiring doctors to review OARRS patient reports if they suspect abuse); OHIO REV. CODE ANN. § 4729.79 (LexisNexis 2011) (requiring prescribers to submit reports to OARRS if they physically dispense medications to a patient, with no requirement to run a report).

medications. This includes running reports on patients before medication is prescribed, and reporting to OARRS the controlled medications that were dispensed. The second step would require OARRS to interact with the prescription monitoring programs of other states. The third step is to better promote the current pharmacy take back programs. The final step would be to create a stronger anti-doctor shopping statute. While these suggestions are not a panacea to end Ohio's prescription abuse epidemic, they more effectively remove the fuel to the fire of prescription abuse, instead of simply treating the symptoms of abuse.

1. Mandatory OARRS Monitoring

Given the nature of Ohio's drug abuse problem, the Ohio legislature should require all physicians to run OARRS reports on their patients before writing prescriptions for controlled medication, and report to OARRS controlled medications prescribed to patients. As previously mentioned, H.B. 93 allows hospital support staff to sign up for OARRS,²³² which would decrease the administrative burden on physicians.²³³ The Ohio State Board of Pharmacy already offers access to OARRS to practitioners and pharmacists at no cost.²³⁴ The information from these *free* reports would allow physicians to quickly and efficiently identify the drug-seeking behaviors of their patients.²³⁵ Physicians would then have the necessary tools to make prescribing decisions in the best interests of their patient's health.

In order to establish these requirements, Ohio first needs to amend O.R.C. Sections 4729.79 and 4729.80(A)(5). Section 4729.79 currently reads:

(A) If the state board of pharmacy establishes and maintains a drug database . . . , each licensed health professional authorized to prescribe drugs, other than a veterinarian, who personally furnishes a controlled substance or other dangerous drug the board includes in the database pursuant to rules adopted under section 4729.84 of the Revised Code to a patient in this state shall submit to the board the following information:

- (1) Prescriber identification;
- (2) Patient identification;
- (3) Date drug was furnished by the prescriber;
- (4) Indication of whether the drug furnished is new or a refill;
- (5) Name, strength, and national drug code of drug furnished;
- (6) Quantity of drug furnished;
- (7) Number of days' supply of drug furnished;

²³² See OHIO REV. CODE ANN. § 4729.80(A)(5) (LexisNexis 2011) (providing agents of the prescriber the ability to request reports from OARRS).

²³³ See generally *supra* Part III.A (discussing the positive changes that House Bill 93 and Medical Rule 4731-11-11 bring).

²³⁴ William T. Winsley & Donna E. Droz, *Ohio's Dangerous Drug Database Past, Present, and Future: House Bill 93 Report*, OHIO STATE BOARD OF PHARMACY AUTOMATED (November 21, 2011), <https://www.ohiopmp.gov/portal/docs.aspx> (follow "Legislative Report for HB 93" hyperlink).

²³⁵ See Tribble, *supra* note 113 ("If doctors were required to check the database, they would spot patients who were pill shopping, going to multiple pain clinics and emergency rooms to obtain prescriptions or samples.").

(8) Source of payment for the drug furnished.²³⁶

The Ohio legislature should amend Section 4729.79(A) to read (changes in italics):

(A) If the state board of pharmacy establishes and maintains a drug database . . . , each licensed health professional authorized to prescribe drugs, other than a veterinarian, who personally furnishes *or prescribes* a controlled substance or other dangerous drug the board includes in the database pursuant to rules adopted under section 4729.84 of the Revised Code to a patient in this state shall submit to the board the following information:

- (1) Prescriber identification;
- (2) Patient identification;
- (3) Date drug was furnished *or prescribed* by the prescriber;
- (4) Indication of whether the drug furnished *or prescribed* is new or a refill;
- (5) Name, strength, and national drug code of drug furnished, *and name and strength of drug prescribed*;
- (6) Quantity of drug furnished *or prescribed*;
- (7) Number of days' supply of drug furnished *or prescribed*;
- (8) Source of payment for the drug furnished.

Essentially, Section 4729.79(A) would be amended to include “or prescribe” anywhere the word “furnished” appears. This would provide that all controlled drugs prescribed are reported to OARRS. Thus, if a patient fills their prescription out of state, OARRS will still have information that a patient may have received the drug. While reporting controlled medications prescribed to OARRS may seem daunting at first, many physicians’ offices already store records electronically, and have even begun to send prescriptions via email.²³⁷ Some states similarly require prescribers to send their prescriptions electronically to pharmacies, which has the added benefit of ensuring accuracy and tracking whether a prescription was filled.²³⁸ If Ohio enacted a similar requirement, prescribers would need to submit the same information to the pharmacy board.

However, requiring that prescribers report medications prescribed is not enough. The Ohio legislature needs to also require that all physicians monitor reports on their patients before prescribing or dispensing a controlled medication. As a result, physicians will be able to see what controlled medications their patient is taking, as well as prescriptions they may have received from an Ohio physician, but were filled

²³⁶ OHIO REV. CODE ANN. § 4729.79 (LexisNexis 2011).

²³⁷ See Associated Press, *New York Lawmakers OK Electronic Drug Prescriptions Bill*, SYRACUSE.COM (June 11, 2012, 7:20 PM), http://www.syracuse.com/news/index.ssf/2012/06/new_york_lawmakers_ok_electron.html (“[D]octors already are moving toward writing prescriptions electronically. . .”).

²³⁸ See *id.* (discussing New York’s requirement that physicians must electronically submit prescriptions to pharmacies within three years).

in another state.²³⁹ To make this a requirement, the Ohio Legislature needs to amend Section 4729.80(A)(5). This section currently reads:

(A) If the state board of pharmacy establishes and maintains a drug database . . . the board is authorized or required to provide information from the database . . . :

(5) On receipt of a request from a prescriber or the prescriber's agent registered with the board, the board may provide to the prescriber information from the database relating to a current patient of the prescriber, if the prescriber certifies in a form specified by the board that it is for the purpose of providing medical treatment to the patient who is the subject of the request.²⁴⁰

The Ohio legislature should amend Section 4729.80(A)(5) to read (changes in italics):

(A) If the state board of pharmacy establishes and maintains a drug database . . . the board is authorized or required to provide information from the database . . . :

(5) On receipt of a request from a prescriber or the prescriber's agent registered with the board, the board *must* provide to the prescriber information from the database relating to a current patient of the prescriber, if the prescriber certifies in a form specified by the board that it is for the purpose of providing medical treatment to the patient who is the subject of the request. *Such request shall be made by the prescriber or the prescriber's agent registered with the board if the doctor is currently treating the patient with a controlled drug as defined by the Controlled Substances Act (21 U.S.C.S. § 812) or a dangerous drug.*

Under the proposed Section 4729.80(A)(5), prescribers who treat their patients with controlled medications would now be required to monitor OARRS reports on their patients. The changes to this section include replacing “may” with “must.” Specifically, the pharmacy board was previously not required to provide OARRS reports to requesting physicians.²⁴¹ Still, some practitioners are concerned that monitoring OARRS reports on patients can be time-consuming.²⁴² But, the Ohio State Board of Pharmacy has reported that 99.5% of all report requests in 2011 were processed in less than three seconds, which directly contradicts this criticism.²⁴³ Under this proposal, medical support staff can reliably request OARRS reports on all

²³⁹ See *infra* Part III.C.2 (discussing the challenges of ascertaining medications a patient received in another state, and a solution to that challenge).

²⁴⁰ OHIO REV. CODE ANN. § 4729.80(A)(5) (LexisNexis 2011).

²⁴¹ See *id.* (“On receipt of a request from a prescriber or the prescriber’s agent registered with the board, the board *may* provide to the prescriber . . .” (emphasis added)).

²⁴² Cf. Zimmer, *supra* note 20 (“[D]octors have issues with the cumulative time commitment of system checks. Others have criticized it for the lag time between when a prescription is filled and when that activity actually appears in the database.”); Tribble, *supra* note 113 (arguing that OARRS reporting “would hit doctors at a time when they are seeing more patients and implementing their own electronic medical records.”).

²⁴³ See Winsley & Droz, *supra* note 234.

patients the physician will consult with at the beginning of the day. Thus, the physician will have OARRS information on all of their patients before patients arrive.

The proposed amendment to Section 4729.80(A)(5) also includes language from House Bill 93. Specifically, it notes that either the physician, or the physician's support staff can make reports.²⁴⁴ In addition, this proposed change incorporates terms of art from the definitions of Section 4729(F). Specifically, "Dangerous Drug" is defined as:

- (F) "Dangerous drug" means any of the following:
- (1) Any drug to which either of the following applies:
 - (a) Under the "Federal Food, Drug, and Cosmetic Act," 52 Stat. 1040 (1938), 21 U.S.C.A. 301, as amended, the drug is required to bear a label containing the legend "Caution: Federal law prohibits dispensing without prescription" or "Caution: Federal law restricts this drug to use by or on the order of a licensed veterinarian" or any similar restrictive statement, or the drug may be dispensed only upon a prescription;
 - (b) Under Chapter 3715. or 3719. of the Revised Code, the drug may be dispensed only upon a prescription.
 - (2) Any drug that contains a schedule V controlled substance and that is exempt from Chapter 3719. of the Revised Code or to which that chapter does not apply;
 - (3) Any drug intended for administration by injection into the human body other than through a natural orifice of the human body.²⁴⁵

Under the proposed change, the use of the term "controlled drug" captures any drug that the FDA has classified as "dangerous."²⁴⁶

The mandatory monitoring requirement could also be codified within the Ohio Administrative Code. In order to establish these requirements, Ohio can amend Medical Rule 4731-11-11,²⁴⁷ Dental Rule 4715-6-01,²⁴⁸ and Nursing Rule 4723-9-12.²⁴⁹ These rules propagated by the Ohio Medical, Dental, and Nursing Boards delineate situations in which prescribers should review OARRS reports on their patients before prescribing controlled medications.²⁵⁰ Instead, the rule should require

²⁴⁴ See OHIO REV. CODE ANN. § 4729.80(A)(5) (LexisNexis 2011) (providing agents of the prescriber the ability to request reports from OARRS); see *supra* Part III (describing positive changes of H.B. 93, one of which being access to OARRS by medical support staff).

²⁴⁵ OHIO REV. CODE ANN. § 4729.01(F) (LexisNexis 2011).

²⁴⁶ 21 U.S.C.S. § 812(c) (LexisNexis 2011) (listing all drugs the FDA has listed as "controlled").

²⁴⁷ OHIO ADMIN. CODE 4731-11-11 (LexisNexis 2011).

²⁴⁸ OHIO ADMIN. CODE 4715-6-01 (LexisNexis 2011).

²⁴⁹ OHIO ADMIN. CODE 4723-9-12 (LexisNexis 2011).

²⁵⁰ See *e.g.* OHIO ADMIN. CODE 4731-11-11(B)(1) (LexisNexis 2011) (requiring physicians to review an OARRS report on patients in certain situations before prescribing a controlled drug); OHIO ADMIN. CODE 4715-6-01(B)(1) (LexisNexis 2011) (requiring dentists to review an OARRS report on patients in certain situations before prescribing a controlled drug); OHIO ADMIN. CODE 4723-9-12(B)(1) (LexisNexis 2011) (requiring nurse practitioners to review an OARRS report on patients in certain situations before prescribing a controlled drug).

prescribers to review OARRS reports on their patients in *all* situations before prescribing a controlled drug.

Mandatory controlled prescription monitoring is not a novel idea. New York's legislative branch recently passed a similar requirement, known as The Internet System for Tracking Over-Prescribing Act ("I-STOP").²⁵¹ I-STOP has not yet been signed into law in New York, although it did pass both the state Senate and House of Representatives, and Governor Cuomo supported the effort to pass I-STOP.²⁵² While the initiative is obviously too new to discern the ramifications of I-STOP, it will likely curb prescription abuse because physicians will now review a patient's controlled medication history, before prescribing new controlled drugs. Thus, under New York's proposed law, if a patient previously received a month's supply of a controlled drug from a prescriber, a new prescriber will have access to, and will be required to review, that information before prescribing the patient the same or a new controlled drug.²⁵³ Because mandatory OARRS monitoring only provides information to physicians, it cannot prevent abuse where physicians willfully ignore this information.

While amending Section 4729.80(A)(5) and sections of the Ohio Administrative Code is a step in the right direction, it is naïve in that the solution anticipates all physicians will only prescribe medically necessary controlled medications to their patients. Thus, mandatory reporting is ineffective in situations where a physician and patient work together to feed a patient's addiction. A well-known example is the previously mentioned death of Michael Jackson.²⁵⁴ The medications that caused Jackson's death were prescribed and administered by his personal physician,²⁵⁵ who was found guilty of involuntary manslaughter.²⁵⁶

²⁵¹ *New York Passed Legislation Requiring E-Prescribing Software*, DAW SYSTEMS, INC. (June 29, 2012), <http://dawsystems.com/news/e-prescribing-legal-news/new-york-passed-legislation-requiring-e-prescribing-software/> ("This is the first state in the country to mandate that doctors observe patient's medical history and previous prescriptions before assigning schedule II, III or IV controlled substances.").

²⁵² See Dan Herbeck, *Welcoming Legal Remedy to Prescription Drug Nightmare*, BUFFALO NEWS (Jul. 12, 2012, 12:05 AM), <http://www.accessmylibrary.com/article-1G1-296348490/welcoming-legal-remedy-prescription.html>; see also *Internet System For Tracking Over-Prescribing Act S-7637-2011(D)(2)*, NYSENATE.GOV, <http://open.nysenate.gov/legislation/bill/S7637-2011> (last visited Dec. 4, 2012); *New York Passed Legislation Requiring E-Prescribing Software*, *supra* note 251 (noting that state legislators passed I-STOP in June, 2012).

²⁵³ See *Internet System For Tracking Over-Prescribing Act S-7637-2011(D)(2)*, *supra* note 252.

²⁵⁴ See *supra* Part II.A.2 (discussing Michael Jackson's death that was caused by tranquilizers).

²⁵⁵ See Wedro, *supra* note 63.

²⁵⁶ See Karen Grigsby Bates, *Jury Finds Dr. Murray Guilty in Pop Star's Death*, NPR (Nov. 8, 2011), <http://www.npr.org/2011/11/08/142123505/jury-finds-dr-murray-guilty-in-pop-stars-death>; see also Alan Duke, *Conrad Murray Sentenced to Four Years Behind Bars*, CNN (Nov. 30, 2011, 5:46 AM), <http://www.cnn.com/2011/11/29/justice/california-conrad-murray-sentencing/index.html> (reporting that Dr. Murray, the doctor who prescribed the drugs that killed Michael Jackson, was sentenced to prison for four years).

Still, despite some of the limitations of mandatory OARRS reporting, such reporting has additional benefits outside the scope of preventing prescription abuse. For example, a specialist could have access to a patient's controlled medication history for the last two years.²⁵⁷ This would allow this physician to make decisions in the best interest of the patient by prescribing medications based on potential drug interactions. In a similar vein, physicians in emergency rooms will have complete prescription information on a patient that they are treating.²⁵⁸ Having such information would lead to better healthcare for all patients. Despite the benefits of mandatory OARRS reporting, practitioners still would only have access to patient prescription information from Ohio.

2. Interstate OARRS Connectivity

Under today's system, mandatory OARRS reporting will not likely prevent prescription abuse where patients receive drugs in another state. Currently, OARRS can only interact with the prescription databases in nine other states.²⁵⁹ Thus, physicians can only see the medications a patient receives in those states.²⁶⁰

To make mandatory prescription reporting truly effective, OARRS should communicate with the prescription databases of all states.²⁶¹ Currently, there is no single database that handles a prescription-monitoring program ("PMP").²⁶² Thus, it would seemingly be challenging and expensive to make the database of one state communicate with the database of another state.²⁶³ Currently, OARRS can interface with the PMPs of Arizona, Connecticut, Indiana, Kansas, Mississippi, North Dakota, South Carolina, Virginia, and West Virginia.²⁶⁴ Noticeably missing from this list is Kentucky, Pennsylvania, and Michigan, which share a border with Ohio. Patients living in a southern Ohio city, such as Portsmouth, could have prescriptions filled in Kentucky and OARRS would not be able to report this information. Even though Ohio eliminated pill mills with the enactment of H.B. 93, patients can still go to an out of state pill mill to obtain controlled medications such as Oxycontin. Ohioans can depend on out of state pill mills because Ohio's law enforcement agencies, and

²⁵⁷ See *supra*, Part III.B.1–2.

²⁵⁸ See *supra*, Part III.B.1–2.

²⁵⁹ See *Ohio Deploys NABP PMP InterConnect Statewide, Arizona Signs On to Participate*, *supra* note 161.

²⁶⁰ See *Ohio Deploys NABP PMP InterConnect Statewide, Arizona Signs On to Participate*, *supra* note 161.

²⁶¹ See *supra* Part III.B.1 (discussing the limitations of a prescription database that cannot interact with the prescription databases of other states).

²⁶² See *Ohio Deploys NABP PMP InterConnect Statewide, Arizona Signs On to Participate*, *supra* note 161. While not directly stated, this can be inferred because OARRS is able to interact with the databases from only nine other states. If there was a single database that managed this process, OARRS would likely interact with more than just nine other states.

²⁶³ See *Ohio Deploys NABP PMP InterConnect Statewide, Arizona Signs On to Participate*, *supra* note 161.

²⁶⁴ See *infra* Part III.C.2 (proposing that OARRS should interact with the PMPs of other states).

more importantly, the Ohio patient's physician, would be oblivious to the medications a patient receives out of state.

Because of the limitations of the current system, the Ohio legislature should appropriate resources to Ohio's Board of Pharmacy, which manages OARRS.²⁶⁵ Currently, OARRS is funded entirely by federal grants.²⁶⁶ With these additional state resources, the Pharmacy Board could fully utilize OARRS by interacting with the PMPs of other states, such as Kentucky's KASPER.²⁶⁷ Interacting Kentucky's PMP system with Ohio OARRS system is especially important not only because Kentucky has similar prescription abuse problems as Ohio, but also because Kentucky shares a border with Ohio.²⁶⁸ Interstate connectivity of prescription databases would prevent doctor shoppers living near state borders from filling prescriptions in multiple states, unbeknownst to authorities. Promoting interstate reporting would also add teeth to Ohio's 2925.22, which can only prevent "deceit" in Ohio and nine other states with whom OARRS connects with.²⁶⁹ While interstate OARRS reporting would be beneficial, it is not a cure-all for Ohio's "interstate doctor shopping" problem, unless each state similarly required physicians to use their respective databases to report controlled medications prescribed to patients.²⁷⁰ Thus, amending Section 4729.80(A)(5), as proposed in the previous section, would only be as effective as other states' stances on prescription drug abuse.²⁷¹

²⁶⁵ OHIO REV. CODE ANN. § 4729.75 (LexisNexis 2011) ("The state board of pharmacy may establish and maintain a drug database. The board shall use the drug database to monitor the misuse and diversion of controlled substances. . .").

²⁶⁶ See Winsley & Droz, *supra* note 234.

²⁶⁷ KASPER (*Kentucky All Schedule Prescription Electronic Reporting*), KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES, <http://chfs.ky.gov/os/oig/KASPER.htm> (last updated Sept. 21, 2012); see also Leger, *supra* note 157. While Ohio and Kentucky have a memorandum of understanding, the prescription monitoring programs of these states do not yet communicate with each other. *Id.*

²⁶⁸ See generally *Politicians, Physicians Should Lead Fight Against Ky. Pill Mills*, *supra* note 216 (describing the problems Kentucky faces with pill mills); cf. Tavernise, *supra* note 2 (describing the havoc wrought in Southern Ohio by pill mills).

²⁶⁹ See *supra* Part III.B.1 (describing the shortcomings of Ohio's "doctor shopper" statute).

²⁷⁰ E.g., KY REV. STAT. ANN. § 218A.202(3) (LexisNexis 2011) (showing that similar to Ohio, Kentucky requires *only* dispensers and not prescribers to report prescription data to KASPER; but OARRS cannot share information with KASPAR because there is no memorandum of understanding); 28 PA. CODE § 25.131 (Lexis Nexis 2011) (showing that Pennsylvania only requires pharmacies to report on Schedule II substances like Oxycontin, but not Schedule III to V substances); IN. CODE ANN. § 35-48-7-8.1 (LexisNexis 2011) (showing that similar to Ohio, Indiana requires *only* dispensers and not prescribers to report prescription data to INSPECT); MICH. ADMIN. CODE R. 338.3162d (LexisNexis 2011) (showing that similar to Ohio, Michigan requires *only* dispensers and not prescribers to report prescription data to its prescription monitoring program; but OARRS cannot share information with Michigan's database because there is no memorandum of understanding); see also *Ohio Deploys NABP PMP InterConnect Statewide, Arizona Signs On to Participate*, *supra* note 161 (listing the different states that OARRS can interact with, included in the list is Indiana).

²⁷¹ See *supra* Part III.C.1 (proposing that Ohio legislature amend Section 4729.80(A)(5) to require all physicians to report controlled medications prescribed to patients to OARRS); see generally, *Interstate Sharing of Prescription Monitoring Database Information*, NATIONAL

3. Unused Prescription Collections

A third solution to help curb prescription drug abuse would be to “take back” unused prescription medications.²⁷² The DEA currently has a program to collect unused medications.²⁷³ The premise of this program is that the DEA will host collection centers for people to bring their unused prescriptions to get these drugs off of the street.²⁷⁴ The DEA will then destroy the medications in a safe way.²⁷⁵ Ohio has established a similar drug “take back” program under House Bill 93.²⁷⁶ The effectiveness of this newly established program in removing excess prescription drugs from the street remains to be seen. Recent drug “take back” programs have had promising results as did one in Cleveland, Ohio where over four tons of medications were collected.²⁷⁷ Where community resources are limited, commentators have proposed retail pharmacy-based programs, where patients would be more likely to return medications.²⁷⁸ The pharmacy would then turn these drugs into the DEA for destruction.

Removing prescription drugs from the street would reduce the instances of prescription drug abuse originating in the home.²⁷⁹ While this will not stop the abuse problem entirely, because not all persons will turn in their unused medications, decreasing the amount of drugs on the street will certainly help to curb abuse.

4. Anti-Doctor Shopper Statute

The Ohio legislature should also effectively punish the act of doctor shopping. Ohio currently does not effectively criminalize the act of obtaining prescriptions through fraud.²⁸⁰ While most of this Note advocates prevention-oriented legislation, backward looking statutes can also effectively prevent drug abuse if used properly.

ALLIANCE FOR MODEL STATE DRUG LAWS (Oct. 17, 2011), *available at* <http://www.namsdl.org/documents/InterstateSharingofPMPInformation10.14.2011.pdf> (surveying the enabling prescription monitoring program laws of various states).

²⁷² See *supra* Part III.

²⁷³ *National Take Back Initiative*, OFFICE OF DIVERSION CONTROL, DRUG ENFORCEMENT AGENCY, http://www.deadiversion.usdoj.gov/drug_disposal/takeback/index.html (last visited Dec. 4, 2012).

²⁷⁴ See *id.*; Donaldson, *supra* note 134.

²⁷⁵ See Donaldson, *supra* note 134.

²⁷⁶ See OHIO REV. CODE ANN. § 4729.69(A) (LexisNexis 2011) (“The state board of pharmacy, in collaboration with the director of alcohol and drug addiction services and attorney general, shall establish and administer a drug take-back program under which drugs are collected from the community for the purpose of destruction or disposal of the drugs.”).

²⁷⁷ See Donaldson, *supra* note 134.

²⁷⁸ See Robert J. Greenwood, *Commentary on “Drug Take-Back Programs Are Safe, Clean”*, NCPANET.ORG, <http://www.ncpanet.org/index.php/ncpa-commentary/913-commentary-on-qdrug-take-back-programs-are-safe-cleanq> (last visited Dec. 4, 2012); *Issues*, THE DRUG TAKE-BACK NETWORK, <http://www.takebacknetwork.com/issues.html> (last visited Dec. 4, 2012).

²⁷⁹ See *generally supra* Part II.D.3 (identifying dangers of prescriptions found in the home).

²⁸⁰ See *supra* Part III.B.1 (discussing Ohio’s § 2925.22 and its ineffectiveness).

Specifically, an anti-doctor shopper statute used in conjunction with mandating physician OARRS reporting for controlled medications can be a useful tool to prevent prescription abuse.²⁸¹ In this way, Ohio can prevent prescription abuse that is initiated by a patient.

Florida currently criminalizes the act of obtaining prescriptions through fraud.²⁸² The Florida statute differs from Ohio's Section 2925.22 in that it specifically prevents patients from doctor shopping.²⁸³ Florida's Section 893.13(7)(a)(8) mandates that a patient cannot withhold that they "received a controlled substance or a prescription for a controlled substance of like therapeutic use from another practitioner within the previous 30 days."²⁸⁴ Further, "withholding" has been interpreted to mean "hold back," as such a patient must volunteer to a prescriber that they recently received a controlled medication from a different prescriber, regardless of whether the prescriber specifically asks for this information.²⁸⁵ Although Florida's doctor shopping statute criminalizes this activity, it would be difficult to enforce in Ohio under the current statutory system.²⁸⁶ Without a mandatory reporting requirement, physicians would only know that their patients are shopping if the physicians happened to run a report on their patients. Accordingly, if Ohio were to enact legislation similar to Florida's Section 893.13(7)(a)(8), it would only be truly effective if the burden was on the prescribers and patients. Effective legislation would require a prescriber's burden to run reports up front and a patient's burden to affirmatively disclose all medications they were taking before receiving a prescription for controlled medications.

D. Debunking the Criticism of OARRS by Practitioners and Patients

Despite the potential wealth of information OARRS contains, healthcare professionals cite many reasons as to why they choose not use these reports. Some critics point to the burden of running OARRS reports on patients.²⁸⁷ Others are

²⁸¹ See generally *supra* Part III.C.1 (proposing that Ohio mandate OARRS reporting for controlled medications).

²⁸² FLA. STAT. ANN. § 893.13(7)(a)(8)–(9) (LexisNexis 2011).

²⁸³ *Knipp v. State*, 67 So. 3d 376, 379 (Fla. Dist. Ct. App. 4th Dist. 2011) (interpreting that a patient's failure to affirmatively disclose prior requests to receive a controlled medication is a violation of section 893.13(7)(a)(8)). *But cf.* OHIO REV. CODE ANN. § 2925.22(A) (LexisNexis 2011) ("[n]o person, by deception, shall procure . . . a dangerous drug . . ."); *State v. O'Connell*, 2011-Ohio-652, ¶3 (Ohio Ct. App. 2011); *State v. Hartney*, 2010-Ohio-4331, ¶¶2-3 (Ohio Ct. App. 2010); *State v. Newland*, 2009-Ohio-1340, ¶¶2-4 (Ohio Ct. App. 2009) (finding deception shown where patient affirmatively lied about medications she was taking.).

²⁸⁴ FLA. STAT. ANN. § 893.13(7)(a)(8) (LexisNexis 2011).

²⁸⁵ *Knipp*, 67 So. 3d at 379 ("Whether an individual has actually withheld information in violation of the statute depends on whether s/he requested a controlled substance and failed to disclose the fact that s/he received a drug of like therapeutic use within the previous thirty days. In other words, the statute requires that an individual affirmatively requesting a substance provide information to the practitioner.").

²⁸⁶ See *supra* Part III.B.1 (discussing inadequacy of statute in regards to doctor shopping).

²⁸⁷ *Cf. Zimmer*, *supra* note 20 ("doctors have issues with the cumulative time commitment of system checks. Others have criticized [the system] for the lag time between when a

concerned with the privacy issues of maintaining a patient database filled with information relating to a patient's healthcare.²⁸⁸ As shown below, these criticisms are either untenable or do not outweigh the benefit of having such a system in place.

Some criticize the slow response time it takes to run a report, and thus the argument follows that physicians have less time to effectively treat patients.²⁸⁹ But, in 2006 (the inception of OARRS), the average time needed to run a report on a patient was 30 seconds.²⁹⁰ By 2011, the time had decreased to just 3 seconds per request.²⁹¹ In fact, the State Board of Pharmacy has noted in their report to the Ohio legislature, after the enactment of H.B. 93, that when OARRS users complain of the difficulty in accessing OARRS most of their complaints stem from user errors, such as: difficulty connecting to the internet, difficulty logging on to the website, and other technical issues, such as the speed of the user's computer or the network speed.²⁹² In order to address some of these shortcomings, the Ohio Board of Pharmacy has begun working with two large pharmacy systems to see if OARRS can be integrated into both the workflow and software of the user's system.²⁹³

Some physicians are concerned with the administrative burden of referencing an online patient database before prescribing a medication to a patient.²⁹⁴ This criticism is moot, however, because House Bill 93 grants medical support professionals the ability to access OARRS.²⁹⁵ Further, the Ohio Board of Pharmacy has reported that now 99.5% of requested reports process in less than three seconds.²⁹⁶ Others maintain that such an online database is unnecessary because physicians are in the best position to evaluate their patients and determine what medications, if any, are in

prescription is filled and when that activity actually appears in the database."); Tribble, *supra* note 113 (arguing reporting "would hit doctors at a time when they are seeing more patients and implementing their own electronic medical records. Doctors receive training on what to look for and how to evaluate potential patients who are doctor shopping for dangerous pain medications. . .").

²⁸⁸ See Sharon Woods Harris, *Drug Databases Raises Privacy Concerns*, PEKIN TIMES (Mar. 14, 2009 10:00 AM), <http://www.pekintimes.com/news/x679797701/Drug-database-raises-privacy-concerns>; see also Bill Sizemore, *Hacking of Prescription Database May Lead to Headaches*, THE VIRGINIAN PILOT (May 8, 2009), available at <http://web.archive.org/web/20100213023552/http://www.pekintimes.com/news/x679797701/Drug-database-raises-privacy-concerns>.

²⁸⁹ Zimmer, *supra* note 20.

²⁹⁰ OHIO STATE BOARD OF PHARMACY, *supra* note 22.

²⁹¹ OHIO STATE BOARD OF PHARMACY, *supra* note 22.

²⁹² OHIO STATE BOARD OF PHARMACY, *supra* note 22.

²⁹³ OHIO STATE BOARD OF PHARMACY, *supra* note 22.

²⁹⁴ Tribble, *supra* note 113.

²⁹⁵ See OHIO REV. CODE ANN. § 4729.80(A)(5) (LexisNexis 2011) (providing agents of the prescriber the ability to request reports from OARRS); see *supra* Part III.A (describing positive changes of H.B. 93, one of which is to provide OARRS access to medical support staff).

²⁹⁶ See Winsley & Droz, *supra* note 234.

their patient's best interest.²⁹⁷ OARRS does not retroactively prescribe medication for a patient, but instead only gives additional information to physicians to make better, more informed choices.²⁹⁸

Some critics of the online database are also concerned with storing personal medical information on a central database and the accompanying vulnerability of patients' privacy.²⁹⁹ These critics point to various issues, including a patient's right to disclose personal medical information and the external threat of hackers.³⁰⁰ As to the first issue, some patients wish to compartmentalize their personal medical information.³⁰¹ For example, patients may not be comfortable with a specialist accessing their complete prescription medical history over a two-year period, which may include problems unrelated to the patient's treatment.³⁰² This concern to keep information private, however, does not justify the risks. On a micro level, physicians need all relevant information about their patients' medical history, including a list of the medications they are taking, to provide the best care compatible with the patient's prior treatments and medications. On a macro level, ending PMPs because some patients may not want physicians to know what medications they are taking intensifies the problems with our current system in which physicians are unable to determine the breathe of medications their patients are taking.

Critics also cite computer hackers as another privacy concern.³⁰³ These critics point to the Virginia pharmacy database security breach as a worst-case scenario.³⁰⁴ In Virginia, a hacker accessed the state's online patient database and copied eight million entries on personal medical information.³⁰⁵ The hacker then deleted the Virginia database, and subsequently encrypted the copy that he kept for himself,

²⁹⁷ Tribble, *supra* note 113 (“Doctors receive training on what to look for and how to evaluate potential patients who are doctor shopping for dangerous pain medications.”).

²⁹⁸ STATE MEDICAL BOARD OF OHIO, IMPROVING PATIENT CARE THROUGH ENHANCED USE OF OARRS 1, *available at* <https://www.ohiopmp.gov/Portal/images/MedBoardArticle.pdf> (“OARRS prescription history reports are an important component of delivering and coordinating patient-centered care . . . Prescription history reports . . . assist providers in better management of a patient’s prescription regimen . . .”).

²⁹⁹ *See* Harris, *supra* note 288; Sizemore, *supra* note 288.

³⁰⁰ *See* Harris, *supra* note 288; *see also* Sizemore, *supra* note 288 (a group of legislators asked the Florida governor to veto a new prescription database, citing the Virginia incident).

³⁰¹ *See generally* Harris, *supra* note 288. Although this Article discusses privacy in the context of law enforcement access to a prescription database, patients may be similarly apprehensive to allow other healthcare professionals to access the database.

³⁰² *See* Harris, *supra* note 288.

³⁰³ *See* Sizemore, *supra* note 288.

³⁰⁴ *See* Sizemore, *supra* note 288.

³⁰⁵ Ira Winkler, *The Virginia PMP Hack: ‘Burn After Reading’*, INTERNET EVOLUTION, (May 13, 2009), http://www.internetevolution.com/author.asp?section_id=515&doc_id=176649; Bryan Boughton, et al, *FBI Probes Hacker’s \$10 Million Ransom Demand for Stolen Virginia Medical Records*, FOXNEWS.COM (May 7, 2009), <http://www.foxnews.com/story/0,2933,519187,00.html>.

preventing the state from obtaining the information.³⁰⁶ The hacker finally posted a ransom note, demanding \$10 million for the password to decrypt the database.³⁰⁷

While the situation in Virginia was unfortunate, it was also preventable. First, the prescription database was not encrypted.³⁰⁸ If this file had been encrypted, risks would have been mitigated because most hackers could not have easily opened the file the hacker in Virginia downloaded.³⁰⁹ Also, storing copies of the database offsite would mitigate the damage caused by hackers attacking the website.³¹⁰ As soon as the database is taken offline, it can be restored through a comprehensive disaster-recovery plan.³¹¹ Fortunately, Virginia maintained database copies, and it was brought back online within a few days.³¹² Such precautionary measures demonstrate that prescription databases, such as OARRS, can be safe tools when the proper security measures are put in place.

As demonstrated above, there are many tenable concerns with implementing a centralized database to store patient prescription information.³¹³ While the risks are note-worthy, such risks do not justify continuing to permit prescribers to exercise discretion in deciding whether to run reports. Further, some criticisms are no longer an issue after the enactment of H.B. 93 and the solution this Note proposes.³¹⁴

³⁰⁶ See Winkler, *supra* note 305.

³⁰⁷ See Winkler, *supra* note 305; Brian Krebs, *Hackers Break Into Virginia Health Professions Database, Demand Ransom*, THE WASHINGTON POST (May 4, 2009, 6:39 PM), http://voices.washingtonpost.com/securityfix/2009/05/hackers_break_into_virginia_he.html.

³⁰⁸ See Winkler, *supra* note 305.

³⁰⁹ See generally, Twylite, User Comment to *How Long it Would Take to Brute-Force Crack an AES Encrypted TrueCrypt File? Is it Possible?*, http://www.reddit.com/r/programming/comments/9pu3k/how_long_would_it_take_to_bruteforce_crack_an_aes/ (last visited Dec. 4, 2012) (reasoning that assuming a 12-character password, a hacker needs to perform approximately 255 operations to open an encrypted drive. A government supercomputer that cost \$250,000 took 56 hours to do this in 1998. Moore's Law hypothesizes that a modern super computer costing \$1 million could crack a 12-character password in 7 minutes.).

³¹⁰ See Winkler, *supra* note 305.

³¹¹ Effective disaster recovery plans are outside the scope of this Note, but most organizations should have an effective plan if they do not have one already. See also Dom Nicastro, *State Prescription Monitoring System Protects Against Hackers*, THE WASHINGTON POST (May 15, 2009), <http://www.healthleadersmedia.com/content/LED-233155/State-Prescription-Monitoring-System-Protects-Against-Hackers.html##> (discussing the security measures the Illinois Prescription Monitoring Program took in light of the security breach in Virginia. These measures included hiring a private security firm to manage its servers and hiring a different security firm to try to hack its database.).

³¹² Winkler, *supra* note 305.

³¹³ See *supra* Part III.D (regarding less treatment time and security breach risks associated with utilizing a database).

³¹⁴ See OHIO REV. CODE ANN. § 4729.80(A)(5) (LexisNexis 2011) (providing agents of the prescriber the ability to request reports from OARRS); see *supra* Part III.A (describing positive changes of H.B. 93, one of which is to provide OARRS access to medical support staff). See also Winsley & Droz, *supra* note 234 (reporting that OARRS reports are now provided to requesters in less than three seconds 99.5% of the time).

Finally, privacy issues regarding hackers can be mitigated with proper security measures, as shown in Virginia case.³¹⁵ Accordingly, Ohio needs to embrace OARRS as a tool to combat prescription abuse, instead of vilifying it as a source of liability.

IV. CONCLUSION

Prescription medications undoubtedly have an essential role in healthcare. As demonstrated by the recent prescription abuse epidemics in Portsmouth, Ohio and heroin deaths in Ohio's suburbs, these medications are still dangerous, can lead to the abuse of more serious drugs, and should be treated with the respect they deserve.³¹⁶ Thus, Ohio should mandate the use of OARRS reporting by all physicians, increase the capacity of OARRS to interact with prescription databases from other states, better promote drug "take back" programs, and enact stronger anti-doctor shopper statutes.³¹⁷ While these ideas are not a panacea to curbing all prescription drug abuse, it will force the gatekeepers of controlled medications to think twice before they dispense medications. Implementing these initiatives will provide physicians the information necessary to make educated decisions about the best medications to prescribe their patients. Additionally, these changes will remove dangerous prescriptions from the streets, which inevitably lead to the slippery slope of more serious illicit drug abuse.³¹⁸ These solutions will restrict the home and physician's offices as major sources of prescription drugs, and thus help contain the problems of prescription drug abuse.

³¹⁵ See *supra* Part III.D (describing Virginia incident, which highlighted the importance of encrypted data and back-up data stored off-site).

³¹⁶ See Tavernise, *supra* note 2 (describing Portsmouth's plight with prescription pain-killers); See Carloss, *supra* note 129 (describing recent heroin epidemic in Independence, Ohio); See generally *supra* Part II (describing the dangers of prescription medications and the slippery slope to more serious prescription abuse).

³¹⁷ See generally *supra* Part III.C (asserting that Ohio should make changes to its current statutory system, including mandating the use of OARRS reporting by all physicians, increasing the capacity of OARRS to interact with prescription databases from other states, better promoting drug take back programs, and enacting stronger anti-doctor shopper statutes).

³¹⁸ See generally *supra* Part II.D.2 (describing the slippery slope of prescription drug abuse into more serious illegal drugs); *supra* Part III.C.3 (asserting that Ohio should better promote drug take back programs to remove excess pills from the street).