Prescription Drug Monitoring Programs: Ethical Issues in the Emergency Department

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Prescription drug monitoring programs are statewide databases available to clinicians to track prescriptions of controlled medications. These programs may provide valuable information to assess the history and use of controlled substances and contribute to clinical decisionmaking in the emergency department (ED). The widespread availability of the programs raises important ethical issues about beneficence, nonmaleficence, respect for persons, justice, confidentiality, veracity, and physician autonomy. In this article, we review the ethical issues surrounding prescription drug monitoring programs and how those issues might be addressed to ensure the proper application of this tool in the ED. Clinical decisionmaking in regard to the appropriate use of opioids and other controlled substances is complex and should take into account all relevant clinical factors, including age, sex, clinical condition, medical history, medication history and potential drug-drug interactions, history of addiction or diversion, and disease state. [Ann Emerg Med. 2016;□:1-10.]

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INTRODUCTION

The increasing availability of prescription drug monitoring programs to prescribing clinicians raises important ethical considerations. In this article, we review the ethical issues surrounding the programs and how those issues might be addressed to ensure the proper application of this tool in the emergency department (ED). Through this analysis, we conclude that prescription drug monitoring programs are ethically appropriate, with certain caveats. Physician judgment is paramount to incorporate prescription drug monitoring program data, as well as other relevant clinical factors, when making clinical decisions about the appropriate use of opioids.

The use of opioids for both medical and nonmedical reasons has increased steadily in recent years. The United States is the highest consumer of opioids, accounting for approximately 80% of worldwide use. More than 4 million people aged 12 years or older report current nonmedical use of prescription pain relievers. Unintentional drug overdoses and related deaths increased from 4,030 in 1999 to 14,800 in 2008. Furthermore, more deaths occur from prescription drug use than from cocaine and heroin use combined. Multiple initiatives at the federal, state, and local levels have attempted to address this complex issue. The Centers for Disease Control and Prevention (CDC) has recently developed guidelines for prescribing opioids for chronic pain. Prescription drug monitoring programs are recommended in these guidelines as an important resource for physicians to use in decisionmaking when prescribing opioids, especially in the ED setting.

Regulation of pharmaceuticals with potential for abuse takes place at the international, federal, state, and local levels, including by the World Health Organization, the Federal Drug Administration, the Drug Enforcement Administration, state medical boards, state boards of pharmacy, local law enforcement, and local hospitals, pharmacies, and educational institutions. The goal of regulatory oversight of controlled substances is not to eliminate their supply but to ensure appropriate use for medical purposes while preventing diversion for nontherapeutic use. Through the years, prescription drug monitoring programs have embodied several forms, including multiple-copy prescription programs as early as the 1910s, to current prescription drug monitoring programs. Currently, 49 states (the exception being Missouri) and the District of Columbia have provisions for prescription drug monitoring programs.

There is considerable variation among states in regard to administration, funding, software, substances monitored, notices to consumers, data collection intervals, and reporting structures. State-based prescription drug monitoring programs typically collect data from prescribers and pharmacies, including the prescriber’s name and Drug
Enforcement Administration number, the prescription date, the name and dose of the medication, and the drug schedule code. Patient data, including name, address, date of birth, and sex, are obtained. The data are stored and processed, usually by a state government agency within a state’s department of health or bureau of opioid enforcement. Most states allow pharmacists and practitioners to access the prescription drug monitoring program but may require a subpoena for law enforcement officials to access the data. Some state prescription drug monitoring programs monitor schedule II, III, IV, and V medications, whereas others monitor only schedule II drugs. Data collection methods and the frequency of updates vary by state. Some programs use the data to identify potential abusers proactively, whereas others respond only to regulatory investigations. In addition, some states emphasize educational initiatives, whereas others do not.14

The effects of the implementation of prescription drug monitoring programs have been variable. A US General Accounting Office study from 2002 found that state prescription drug monitoring programs have reduced the time and effort required to investigate drug diversion cases and the supply of controlled substances.16 Data from the RADARS System Poison Center and Opioid Treatment surveillance databases demonstrate an association between prescription drug monitoring programs and decreasing trends in opioid abuse. In states without a prescription drug monitoring program, intentional exposures to opioids increased 1.9% per quarter from 2003 to mid-2009 but only 0.2% in those such programs.17 However, bordering states may experience an increase in the supply of prescriptions because of physician-shopping behavior.15,18,19 Some authors assert that prescription drug monitoring programs may result in a shift of the pattern of prescribing, but that the rate of abuse may not actually decrease.20 Despite the intention of agencies to curb the abuse of opioids, Paulozzi et al21 found that prescription drug monitoring programs are not significantly associated with lower rates of drug overdose or overdose mortality or with lower rates of consumption of opioid drugs and that the program’s effect on overall consumption of opioids appears to be minimal. These data reflect observation of correlation; causation cannot be inferred because of potential confounders.

Ultimately, clinical decisionmaking about the appropriate use of opioids is complex and should take into account all relevant clinical factors, including age, sex, clinical condition, medical history, medication history, potential for drug-drug interactions, history of addiction or diversion, and prognosis, especially for cancer or other terminal illnesses.

Foundational principles of bioethics, including respect for autonomy, justice, beneficence, and nonmaleficence and other important ethical concepts, are widely invoked to guide medical treatment and research in the United States. In their application, no single principle is universally more important than the others. Rather than strict rules, these principles and concepts can serve as a general framework to assess and resolve moral problems.22 In what follows, we will consider how ethical principles and concepts can guide the clinical application of prescription drug monitoring programs.

The principle of beneficence enjoins physicians to provide medical care for the benefit of their patients while minimizing potential harms.23 The American Medical Association Code of Medical Ethics states that “[a] physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.”24 In many cases, the appropriate treatment of pain is with an opioid agent, at times even for patients with a history of opioid abuse or addiction. Physicians who deny medically necessary analgesic treatment in those cases are not serving the best interests of their patients.

In its simplest form, the principle of nonmaleficence directs physicians to “do no harm.” Prescription of opioid analgesics, benzodiazepines, amphetamines, and other controlled substances can cause harm from misuse. At the far end of this spectrum is the possibility of death from accidental or intentional overdose. Such events can be mitigated by limiting prescriptions to what is needed for an acute episode and prescribing short-acting agents with lesser addictive potential. When it is clear or most likely that drugs will harm either patients or society, physicians should avoid prescribing them. A dilemma occurs when some data suggest that a patient might be seeking drugs for nontherapeutic purposes, whereas the patient presents with a plausible need for analgesia. Assessment of pain is subjective, based largely on patients’ self-report, and some patients provide inaccurate self-reports of pain for a variety of reasons. When doubt exists, many argue that it is preferable to administer analgesia to patients who report pain, even with the possibility that some will be seeking drugs for nontherapeutic purposes, rather than deny analgesia to a patient who is really experiencing pain.25,26 Thus, although the prescription drug monitoring program may be useful in determining who should or should not be prescribed controlled substances, ultimately treating physicians must make individualized clinical judgment to ensure compassionate, clinically appropriate, and ethical care of patients.

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The diversion of controlled substances from medical to nonmedical purposes has become a significant public health problem. ACEP supports the use of electronic prescription monitoring and believes these systems should:

- Protect patient privacy.
- Not discourage a patient with a genuine medical condition from seeking care.
- Support access to legitimate medical use of controlled substances.
- Ensure accuracy and completion of the data.
- Be voluntary.
- Provide liability protection for the practitioner.
- Minimize burdensome requirements on the physician.
- Use a robust monitoring system with intrastate linkages, easily accessible and navigable by practitioners 7 days a week, 24 hours a day.
- Be limited to appropriate individuals and agencies, including physicians, pharmacists, and law enforcement.
- Not be used to evaluate physicians’ practice.
- Allow physicians to monitor their own prescribing patterns and to identify potential unauthorized use.
- ACEP opposes mandatory reporting of potential abuse to law enforcement because such reporting fundamentally conflicts with the appropriate role of physicians in the patient-physician relationship.

Figure 1. ACEP policy statement on electronic prescription monitoring.27 Reproduced with permission.

The American College of Emergency Physicians’ (ACEP’s) policy statement on electronic prescription monitoring (Figure 1) provides important guidance about the appropriate use of prescription drug monitoring programs.27 This policy statement rightly notes that the use of prescription drug monitoring programs should not lead to punitive measures against patients, such as reporting to authorities for criminal prosecution, which might result in patients’ delaying or being reluctant to seek medical care.

The principle of respect for autonomy guides physicians to honor patient wishes about their medical treatment. This principle gives patients broad rights to refuse unwanted treatment but does not give them unrestricted claims to receive treatment on demand. Clinical decisions about opioid prescribing should include a careful evaluation of the nature of the condition and, in some cases, the previous response of the patient to a particular therapy. Patients who request one therapy over another should not automatically be assumed to be seeking drugs for nontherapeutic purposes. However, in cases of addiction or dependence, respect for autonomy may be appropriately overridden by nonmaleficence, that is, avoiding harm to the patient by contributing to an opioid addiction or dependence.

Emergency physicians practice medicine in the larger environment of health care and thus under a set of societal duties, which may include protecting both individual patient welfare and public health and safety in preventing impaired driving and impulsive or violent behavior. Society has an interest in reducing criminal and harmful behavior such as drug dealing and its associated crimes, which may be linked to unnecessary prescribing of controlled substances. There is also a societal interest in reducing unnecessary visits to EDs and other sites, which waste valuable resources and divert time and attention from patients with true medical needs. Prescription drug monitoring programs may help limit such usage and ensure that patients most in need will be able to gain access to care in a timely manner. If patients are identified who are at risk for opioid addiction or diversion, providers should fulfill their societal duty by facilitating counseling and outpatient treatment resources. In some cases, outpatient naloxone may be considered as rescue therapy for accidental overdose in known addicts and users. Caution should be used to avoid a false sense of security among patients. If used, naloxone should be considered a temporary treatment and should be accompanied by an appropriate drug treatment plan.

Confidentiality is a prima facie duty of physicians, but it can be overridden when there is a more compelling competing duty.28,29 Prescription drug monitoring programs can be useful in making this determination. Such programs usually have safeguards in regard to who can view the information they contain, as well as penalties for improper sharing of it. Clinicians must respect the confidentiality of patients included in the prescription drug monitoring program and avoid sharing of information unless clinically necessary to provide care.

Concerns that prescription drug monitoring programs may violate rules of the Health Insurance Portability and Accountability Act by collecting patients’ prescription histories without consent are misplaced. The act provides exceptions for “an oversight agency” to supersede confidentiality protection if it is designed to “address
controlled substances.” Prescription drug monitoring programs can access only specific, limited information, and government agencies and prescribers can access the data only if necessary. Requiring patient informed consent for inclusion in a prescription drug monitoring program is not necessary and would in fact undermine the value of these programs. Patients may claim that their right to privacy has been compromised because they were uninformed of prescription drug monitoring programs and subjected to participation involuntarily. Individual rights to confidentiality of medical information have never been viewed as absolute, however. Legally, consumers of controlled medications have been subjected to government scrutiny as far back as 1910. The stakeholders in the regulation of opioids are well described elsewhere. The power of federal and state authorities to regulate prescribing of controlled substances in the interest of public health supersedes the patient’s right to privacy or to receive prescriptions for certain drugs. Requiring patient informed consent for inclusion in a prescription drug monitoring program is not necessary and would in fact undermine the value of these programs for protecting both individual patient welfare and public health and safety. Use of prescription drug monitoring programs without a patient’s consent is therefore ethically justifiable in that efforts to curb prescription drug diversion and abuse outweigh privacy concerns, particularly because the resultant effect is often in best interests of a particular patient and society as a whole, and unlikely to cause any harm.31

Maintaining patient confidentiality in the ED setting within the constraints of the law is important to maintaining patient trust and the patient-physician relationship. Physicians should take care to avoid inadvertent or incidental disclosures of prescription drug monitoring program data.

Truth telling is absolutely necessary for a successful patient-physician relationship and is a duty accorded to both parties in ethical codes. Prescription drug monitoring program data may reveal dishonesty and serve as a reason to deny a request for controlled substances. Physicians must also be honest about their suspicions or what they have discovered in medical records or the prescription drug monitoring program. Such discussions must be respectful and nonjudgmental.

In the ethical analysis of prescription drug monitoring program use, it is important to consider justice and fairness. In the most basic and formal understanding of justice, “[e]quals must be treated equally, and unequals must be treated unequally.” However, variability in accessibility, type of data, accuracy, and timeliness may preclude provider ability to treat patients with similar needs for controlled substances similarly. In an investigation conducted by Weiner et al,15 clinicians’ impressions of drug-seeking behavior did not coincide with study-defined measures of drug-seeking behavior in 29% of cases, leading to changes in prescription patterns after prescription drug monitoring program use in 9.5% of cases, with a net effect of prescribing of more opioids. Baehren et al34 also found that among the 74 cases (41%) in which prescription drug monitoring program use changed clinical management, 29 cases (39%) resulted in more opioid medications prescribed than planned. These findings suggest that standard use of a prescription drug monitoring program may identify individuals whose providers mistakenly suspect them to be abusers of prescription drugs, possibly resulting in inadequately controlled pain. Use of the program by clinicians may in fact eliminate bias by providing accurate, real-time information about the controlled substance prescriptions a patient has filled. The goal therefore should be universal, nationwide access used in a manner that allows fair application that protects patients from bias and simultaneously intends to limit diversion and abuse.

Although prescription drug monitoring programs have the potential to aid emergency physicians in identifying individuals for whom alternatives to opioid-based pain management may be appropriate, there are foreseeable case scenarios in which the use of the programs may raise ethical dilemmas in the ED. The following case examples with discussions highlight when those tensions may arise and how they might be resolved.

A 48-year-old male patient presents with dental pain on a Friday night. He states that he will not be able to see his dentist until Monday, is willing to accept a dental block for temporary relief, but is afraid that his pain will not be adequately controlled after he leaves the ED. A review of the prescription drug monitoring program indicates that the patient has previously received opioid prescriptions for multiple acute pain events in a variety of settings—back pain from his primary care physician, dental pain in other EDs—but nothing within the last few months. When this information is conveyed to the patient, he acknowledges his previous prescriptions but denies dependence or abuse. He states instead that when he has acute pain, he requires stronger agents.

As previously discussed, a critical issue for emergency physicians in the mandated use of prescription drug monitoring programs is how that information is translated into clinical practice. The assumption is that data from prescription drug monitoring programs will reduce the prescription of opioids that are unnecessary. However, this assumption has an underlying premise that patients requiring opioid agents are either extraordinarily injured or presenting to the ED to maintain anonymity in
perform serial examinations during days or even hours. In the case of painful conditions for which the differential diagnosis is broad, the introduction of a prescription drug monitoring program may confound clinical decisionmaking and potentially bias the judgment of the treating physician. From an ethical viewpoint, this creates tension between the obligation of physicians to provide appropriate and beneficial care (alleviation of pain or appropriate diagnosis) and avoidance of harm (enabling abuse or dependency). In addition, there is the possibility of cognitive anchoring and bias leading to misdiagnosis, as in this case. Given the nature of emergency care, there is a need for emergency physicians to be cognizant of the difficulties of having “too much information” that may mislead or bias the evaluation of patients.

As the medical director of the ED, you receive a request from hospital administration to review opioid prescriptions from your center. Querying the prescription drug monitoring program for your state, you discover that one of your colleagues appears to be an outlier in his prescription patterns by prescribing far more opioid medications than others in the group. When you ask your colleague about this, he states that he makes his decisions on prescribing opioids based on his clinical judgment of the acute needs of the patient. He also believes that prescription drug monitoring program data do not take into account the situations encountered in the ED.

The CDC recently published guidelines on the prescription of opioids for chronic pain.⁹ The crux of these guidelines suggests that the current epidemic of opioid addiction and abuse can be alleviated by the use of alternative nonopioid and nonmedication modalities, careful monitoring and counseling of patients, and reference to prescription drug monitoring programs for appropriate patients. Unfortunately, these solutions have limited application to ED practice, especially in the face of the treatment of patients presenting with an acute exacerbation of a chronic pain-causing condition (eg, back pain, chronic pancreatitis) that might already be managed with opioids. Emergency physicians do not have consensus guidelines or objective standards by which to evaluate the need for opioid pain management in these circumstances. Prescription drug monitoring programs provide data to inform, but not conclusively determine, decisionmaking by emergency physicians on opioid prescriptions. In this context, deference to individual emergency physician professional training and expertise would seem appropriate in evaluating the particular circumstances of whether a patient should receive an opioid prescription.

However, emergency physicians do not practice in a vacuum. As principles 9 and 10 of the ACEP Code of Ethics state, emergency physicians have an obligation to be appropriate stewards of resources and support efforts...
to improve the public’s health. In the context of opioid prescriptions, this would suggest there is a role for licensing and governmental authorities faced with a public health challenge such as the current epidemic to at a minimum inform and, in extreme cases, guide physician practice. We agree that prescription drug monitoring programs are an important tool to educate practitioners and, indirectly, patients about whether opioid prescriptions are appropriate. However, the use of program data alone to judge physician practice or competence is premature because the level of detail gathered does not take into context the limitations in patient assessment in the ED, the ability of patients in need of pain management to obtain follow-up in a timely fashion, and the reality that even individuals with evidence of opioid abuse and dependency can require acute opioid-based pain management.

A good first step would be to ensure that emergency physicians, as part of their licensure, receive information about how their prescription patterns compare with those of similar practitioners. Simultaneously, it is imperative that professional societies and governmental authorities generate expert guidance on alternatives to opioid prescriptions from the ED and advocate system-related changes that allow timely outpatient follow-up for individuals requiring such prescriptions and more broad access to a pain management specialist. Until then, attempts to legislate limitations on opioid prescriptions from the ED are addressing only the consequences of a fragmented health care delivery system, not the root causes, leading to inappropriate infringement on ED practice and potential undertreatment of patients with legitimate pain management needs.

Compulsory use of prescription drug monitoring programs is controversial. In the ED environment, mandatory use of a database may be impractical and may not be necessary in every clinical circumstance. The decision to prescribe an opioid medication is complex and may take into account factors such as clinical condition, acuity of illness, patient age, degree of pain, and availability of outpatient follow-up resources. Oversimplification of this multifaceted decisionmaking process may result in adverse consequences.

For clinicians who prescribe controlled substances frequently, state laws that require registration in the system are reasonable to fulfill ethical obligations. Although current ACEP policy states that burdensome requirements should be minimized, we do not think the “burden” justifies physicians’ opting out of participation. Because the use of prescription drug monitoring programs is ethically favorable, emergency providers should use these data to provide the best possible care to their patients.

Although we advocate the widespread availability of prescription drug monitoring programs and their appropriate usage, we do not support mandatory use of such programs for all patients in the ED setting. We oppose penalizing prescribers who, acting in their patients’ best interests, may choose not to use the program. Although querying prescription drug monitoring programs is often useful, universal requirements to reference a program may not be necessary or warranted in all cases. For example, an acute injury such as a fracture may be appropriately treated with opioid agents, even for a patient with a history of opioid use or abuse. When a prescription drug monitoring program query is not performed, documentation of medical decisionmaking may be important. Overly restrictive regulations should be regarded with caution and may result in undertreatment of pain.

Effective pain management is essential to the practice of emergency medicine and results in improved comfort, improved patient satisfaction, and reduced anxiety. Even in the environment of increased emphasis on adequate pain assessment and management, numerous studies have demonstrated inadequate pain management among ED patients. Inadequate treatment of pain may lead to “pseudoaddiction,” in which patients whose pain is poorly controlled escalate their demands for analgesics through behavioral changes to convince others of the pain’s severity, leading to mistrust between the patient and the health care team. It may be challenging to order sufficient pain medication while avoiding risks of addiction, drug-seeking behavior, and drug diversion. Careful consideration should be given to the best analgesic plan for the patient and his or her unique clinical condition, including pain threshold, ability to function, and overall prognosis. In many cases, nonopioid analgesia is appropriate and may include agents such as acetaminophen, nonsteroidal anti-inflammatory agents, ketamine, and nitrous oxide, or nonpharmacologic approaches such as physical therapy, immobilization, massage, or acupuncture. However, opioids are often the appropriate agent and should be prescribed when clinically indicated in the lowest effective dose for a brief period. Patients should be told that the expectation of complete relief of pain may not be feasible and that such an expectation may increase the risk for inappropriate use or addiction.

Although short-term opioid use is unlikely to lead to addiction, there are some cases of opioid addiction originating from ED use. Patient education should
include information about medication adverse effects, including potential for addiction.42

When chronic pain is treated, coordination of care with primary care providers is important. A multidisciplinary care plan may be helpful in developing a consistent, opioid-sparing approach to chronic pain management. The long-term use of opioids is associated with numerous adverse effects, including nausea, constipation, somnolence, depression, impaired cognition, substance abuse, and risk of overdose death.43-50 Yet a limited prescription of a short-acting opioid may be appropriate as a bridge to a definitive outpatient care plan.

In addition to painful emergency conditions, emergency physicians encounter a subset of patients who engage in deceptive practices to obtain opioid and other controlled substances. These patients may be dependent on these medications or may also divert them for street sale.51-54 When such behavior is recognized, emergency physicians should take the appropriate steps to intervene. This should include an open and honest discussion with the patient about the appropriate use of pharmacotherapy, potential addiction, and the best possible outpatient treatment, including a coordinated care plan with the patient, primary care physician, and potentially the pain management service. Some patients would benefit from counseling and drug treatment. Because of time constraints in the ED setting, referral to a drug treatment program may be appropriate. Some areas have inadequate resources for opioid addiction for patients who desire treatment. Emergency physicians should advocate adequate treatment resources in the area in which they practice.

Individual patient care plans ideally should be appropriately documented and used for best pain management. Some EDs have attempted to identify patients at risk of drug diversion and addiction by keeping patient logs or notebooks.55,56 We do not recommend this practice because of the possibility of undue anchoring bias against patients who may have a legitimate need for pain control.

One goal of prescription drug monitoring programs is to provide information to clinicians to help them reduce inappropriate prescribing of controlled substances in an attempt to prevent or not enable drug addiction and dependency. However, patients with drug dependency may at times appropriately need to be prescribed opioid medications for an acute illness or injury. Given the ethical and professional obligations of emergency physicians to address pain and the limitations in modalities available in the acute care setting to effectively meet this requirement, there is an ethical tension between increased knowledge of controlled drug use, abuse, and dependency from prescription drug monitoring programs and the professional responsibility to address the legitimate analgesic or anxiolytic needs of ED patients.57

In accordance with these ethical issues, we provide a summary of what we believe is the ethically appropriate use of prescription drug monitoring programs (Figure 2).

**Use PDMP records for all patients for whom the information is relevant.**

**Consult PDMP records for all patients treated with controlled substances where required by law.**

**Be open and honest with patients about the information obtained in a PDMP.**

**If addiction or diversion is suspected, refer patients to the appropriate resources to seek treatment for these conditions.**

**Protect patient confidentiality within the constraints of the law.**

**Prescribe opioids when appropriate, taking into account all relevant clinical factors, including age, sex, clinical condition, medical history, medication history, potential drug interactions, history of addiction or diversion, and prognosis.**

**Support clinical research to establish evidence about best practices for opioid prescribing.**

**PDMP**, Prescription drug monitoring program.

**Figure 2. Ethical use of prescription drug monitoring programs in the ED.**

There are several potential improvements to existing models for prescription drug monitoring programs. These include making enrollment available to all prescribers of controlled substances, including licensed resident and midlevel providers; integrating a prescription drug monitoring program with a primary care setting.
monitoring program into the electronic health record that proactively filters and pushes information to the prescribing physician; standardization of prescription drug monitoring program content to include prescriptions dispensed after cash payment; real-time updates of the prescription drug monitoring program as medications are dispensed by pharmacies; and interstate exchange of information.\textsuperscript{62-64} Recently, an expert consensus panel published recommendations for improving the operational effectiveness of prescription drug monitoring programs.\textsuperscript{57}

The legal ramifications of the use of prescription drug monitoring programs are largely unknown. There is no current standard of care or legal protection for the use of the programs. Evidence about best practices will be important in establishing a standard of care for opioid prescribing. On balance, bioethical principles suggest that providers should use prescription drug monitoring programs when clinically indicated as one data point among many to assist in clinical decisionmaking.

In addition, there is a need for high-quality studies that inform local, state, and federal efforts. To date, prescription drug monitoring program study quality has been limited, with flaws that include lack of baseline data and comparison groups, small sample sizes, self-reported outcomes, use of surveys, and lack of long-term follow-up.\textsuperscript{65} Contributing to the problem of low research quality is the fact that prescription opioid use is superimposed on increasing rates of heroin-related morbidity and mortality.\textsuperscript{34}

Prescription drug monitoring programs are just one tool designed to address the complex epidemic of opioid abuse, diversion, and overdose. Clinician education on the treatment of chronic pain and substance abuse, and greater availability of drug treatment programs are equally important efforts to reduce opioid-related abuse, diversion, and morbidity and mortality.\textsuperscript{58} To fulfill our ethical obligation to maximize patient benefit while minimizing harms, a similar multidisciplinary approach that has the support of state and federal funding and policy nationwide will be required.

Prescription drug monitoring programs are an ethically appropriate tool for the safe and effective prescribing of opioid agents. The programs provide valuable information to assess the history and use of controlled substances and can be valuable in clinical decisionmaking in the ED. They are one of multiple important sources of information to assist in the provision of ethical, compassionate, and unbiased emergency medical care.

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APPENDIX 1

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