# PAs as Prescribers of Controlled Medications

***Introduction***

Physician assistants (PAs) are medical professionals educated and licensed to practice medicine as part of a patient-centered team. Since the early days of the profession, state and federal policymakers have acknowledged the extent of PA education and training by authorizing the prescribing of controlled medications.

***The Physician Assistant Profession***

The PA profession was conceived in the mid-1960s to increase the public's access to quality healthcare in response to a shortage of primary care doctors, similar to workforce issues currently plaguing many states. By design, PAs practice in teams with physicians and others and believe that team practice enhances patient care.

PA practice corresponds to physician practice, and varies according to the PA's training, experience, state law, and facility policy. In their work with physicians, PAs perform a comprehensive range of medical duties, from primary care to high-technology specialty procedures. PAs act as first assistants in major surgery and provide pre-and postoperative care, which includes prescribing discharge medications. In underserved or remote areas, or in the uniformed services, PAs serve as the sole providers of healthcare, consulting with physicians and other medical professionals as needed and as required by law.

***Physician Assistant Education***

Applicants to PA programs must complete a minimum of two years of college courses in basic science and behavioral science. This is analogous to pre-med studies required of medical students. There are more than 180 accredited PA programs in the United States.[1] Programs are affiliated with colleges and university schools of medicine or allied health. Ninety-one percent of PA programs offer a master's degree.[2] PA programs must obtain accreditation from the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).

The mean duration of PA education programs is 26 months.[3] PA students receive instruction from a variety of educators, including physicians, PAs and scientists. PA education is characterized by an intense yet practical curriculum, with both didactic and clinical modules. The first half of PA education provides a broad foundation in medical principles with a concentration on the clinical applicability of these principles. This didactic curriculum consists of coursework in the basic sciences, including anatomy, physiology, microbiology, clinical laboratory sciences, behavioral sciences and medical ethics. Students then receive hands-on clinical training through a series of rotations and clerkships in specified inpatient and outpatient settings. Rotations include, but are not limited to family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry. On average, students complete approximately 2,000 hours of supervised clinical practice prior to graduation, and the

[1] Accreditation Review Commission on Education for the Physician Assistant (ARC-PA, Web site, http://www.arc-pa.org/acc_programs/)

[2] *Twenty-Seventh Annual Report on Physician Assistant Educational Programs in the United States, 2010-2011.* Physician Assistant Education Association; 2013.

[3] *Twenty-Seventh Annual Report on Physician Assistant Educational Programs in the United States, 2010-2011.* Physician Assistant Education Association; 2013

total instruction in clinical medicine averages 577.6 hours.[4] The average length of clinical clerkships is 52 weeks.[5]

All PA programs have pharmacology courses; an average of 75 hours of formal classroom instruction in pharmacology is required by PA programs.[6] Pharmacology instruction is also integrated in clinical medicine units in the classroom and through clinical clerkships and rotations.

Only graduates of accredited programs are eligible to sit for the Physician Assistant National Certifying Examination (PANCE), administered by the independent National Commission on Certification of Physician Assistants (NCCPA). Passage of the NCCPA's PANCE exam is required for licensure as a physician assistant in all 50 states and the District of Columbia. Nearly half of all states require that a PA maintain NCCPA certification.

***PA Utilization: Role in Healthcare Delivery***

The clinical role of PAs includes primary and specialty care in medical and surgical practice. Historically, the profession provides these services in rural and urban areas which often lack sufficient access to healthcare. Although their training has a general medicine focus, two-thirds of all PAs practice in surgical or medical subspecialty areas.[7] Additionally, while the majority of PAs actively engage in clinical practice, some also incorporate their clinical knowledge into other professional roles such as clinical research, education and administration.

***PA Quality of Care and Cost Effectiveness***

Several studies over the last two decades have illustrated that the quality of care provided by PAs is at the level of that provided by physicians in comparable situations, with high levels of patient satisfaction.[8] A 2013 study using data from the Association of American Medical Colleges' Consumer Survey found that when patients were presented with scenarios wherein they could see a PA or a nurse practitioner sooner than a physician, most elected to see one of the other health care professionals.[9] In primary care practices a PA's presence permits patients to receive prompt attention, knowing that problems will be addressed effectively and that the expertise of the physician is available if needed. This also frees physicians to focus on patient problems that require the physician's expertise.

Numerous studies have shown that employing PAs is not only good for the patient and the physician, but is also cost-effective. A 2004 study of data in 26 primary care practices of approximately 2 million visit records found PAs or NPs attended to one in three adult medicine visits and one in five pediatric medicine visits, and the associated costs of those visits were lower among practices with greater use of PAs or NPs.[10] A 2007 Archives of Surgery report highlighted a teaching hospital which used computer models to predict future staffing needs and estimated in the next five years they will need to hire 10 PAs at the cost

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[4] Simon, A., M. Link, and A. Miko. *Nineteenth Annual Report on Physician Assistant Educational Programs in the United States, 2002-2003.* Association of Physician Assistant Programs, August, 2003.

[5] *Twenty-Seventh Annual Report on Physician Assistant Educational Programs in the United States, 2010-2011.* Physician Assistant Education Association; 2013

[6] Simon, A., M. Link, and A. Miko.*Nineteenth Annual Report on Physician Assistant Educational Programs in the United States, 2002-2003.* Association of Physician Assistant Programs, August, 2003.

[7] American Academy of Physician Assistants Annual Survey, 2013.

[8]Hooker RS, Potts R, Ray W. Patient satisfaction: comparing physician assistants, nurse practitioners and physicians. *Permanente Journal* 1997; 1: 38-42. *See also*: Graffeo CA, Hill JT. Patient satisfaction with physician assistants (PAs) in an ED fast track. *Am J Emerg Med* 2000; 18: 661-665; Miller W, Riehl E, Napier M, Barber K, Dabideen H. Use of physician assistants as surgery/trauma house staff at an American College of Surgeons-verified level II trauma center. *J Trauma* 1998; 44: 372-376;6; Oliver DR, Conboy JE, Donahue WH, Daniels MA, McKelvey PA. Patients' satisfaction with physician assistant services. *Physician Assist* 1986; 10(7): 51-54, 57-60.

[9] Dill, Michael; Pankow, Stacie; Erickson, Clesee; Shipman, Scott. Survey Shows Consumers Open To A Greater Role For Physician Assistants And Nurse Practitioners *Health Affairs*, 2013, 32, No. 6: 1135–1142

[10] Roblin, Douglas;Howard, David; Becker, Edmund; Adams, E. Kathleen; Roberts, Melissa. Use of Midlevel Practitioners to Achieve Labor Cost Savings in Primary Care Practice of an MCO. 2004, *Health Services Research* June; 39(3): 607–626.

of $1,134,000-- $441,000 less costly than hiring hospitalists.[11] In surgical practices, the presence of PAs enables surgeons to delegate the performance of preoperative histories and physical examinations, the ordering and compiling of necessary tests and part of the postoperative care. The familiarity and experience of the physician-PA surgical team results in efficiency in the operating room that can reduce operative and anesthesia times.

***Full Prescriptive Authority: A Key Element of PA Practice***

The wide and varied use of controlled medications is an integral part of providing comprehensive medical care. In primary care, controlled medications are used for treating coughs, anxiety and pain associated with minor trauma. In surgical practices and specialty practices, controlled medications are used in the treatment of postoperative pain, for immediate treatment of trauma patients whose injuries require stabilization for transport, in emergency departments and by healthcare teams that care for patients with terminal illnesses. PAs practicing in psychiatry frequently prescribe medications to treat anxiety and other mental health disorders.

According to the Drug Enforcement Administration (DEA), "controlled substances have legitimate clinical usefulness and the prescriber should not hesitate to consider prescribing them when they are indicated for the comfort and well-being of patients." Thus, PAs, as part of a patient-centered team, should have prescriptive authority for all schedules of controlled medications. The DEA has a registration category specifically for PAs (listed as "midlevel practitioners") who are authorized to prescribe controlled medications by state law or regulation. PAs delegated to prescribe controlled substances must register with the DEA to obtain a registration number.

PAs derive prescriptive authority from state authority and their physicians. Even if a state authorizes prescribing for PAs, no individual PA may prescribe without agreement with a supervising physician. All states with the exception of Kentucky authorize PAs to prescribe controlled medications. More than three quarters of all states and the District of Columbia have passed laws or regulations allowing Schedule II prescriptive authority for PAs.[12] The first state to do so was Arizona, which authorized PAs to prescribe Schedule II medications in 1978.[13] No state that has enacted provisions to allow PAs to prescribe controlled medications has ever rescinded the law.

Laws that restrict the ability of physicians to delegate comprehensive prescriptive authority to PAs have the potential to cause interruptions in the delivery of care. If a patient seen by a PA requires a drug that state laws prohibit PAs from prescribing, then both patients and clinicians are forced to take extra steps to ensure that standard medical care is provided and the patient receives the medication. This is also problematic in rural and underserved areas, where a PA may be the only health care professional available. In order to provide effective and timely care, PA prescriptive authority should be determined at the practice level by the physician and the PA.

The Federation of State Medical Boards (FSMB) is a national organization representing state medical boards which license both physicians and PAs (with the exception of eight states where PAs are regulated under an independent board). FSMB has compiled data on PA disciplinary actions by state since the early 1980s.[14]

Over time, states that have allowed PAs to prescribe Schedule II controlled substances have seen no increase in the number of disciplinary actions against PAs.[15] While the FSMB data does not make a distinction between disciplinary actions directly related to prescribing versus other infractions, the lack of

[11] Mitchell CC, Ashley SW, Zinner MJ, Moore FD Jr.. Predicting future staffing needs at teaching hospitals: use of an analytical program with multiple variables." *Archives of Surgery*, 2007 Apr;142(4):329-34.
[12] Legislative History of the Joint Board on the Regulation of Physician Assistants, 1972-2001. Approved and memorialized by the Joint Board on the Regulation of Physician Assistants, August 29, 2001.
[13] Appendix 1, AAPA summary, "Year Schedule II Authority Granted, by State." October 2012.
[14] Federation of State Medical Boards, March 8, 2013
[15] Appendix 2, graphical analysis of statistical data, AAPA, October 2012.

any upward trend demonstrates that PAs are no more likely to violate the law when authorized to prescribe Schedule II medication.

The National Practitioner Data Bank (NPDB) was established through Title IV of Public Law 99-660, the Healthcare Quality Improvement Act of 1986, as amended. This registry records all medical malpractice cases that come to trial in the United States. Over the last sixteen years, the rate of settled litigation for PAs was less than one-fourth that of physicians in comparable roles.[16] This trend continues—PAs have been responsible for only 1,021 malpractice payments since the opening of the NPDB.[17] To date, the liability of PAs in the United States is considerably less than physicians in comparable roles, as measured by medical insurance premiums and malpractice cases. PAs have less than one percent of all medical malpractice payment reports.[18]

Anecdotally, regulators do not view PAs as high-risk prescribers of Schedule II controlled substances. While there is a great amount of national attention focused on the opioid abuse epidemic, the problem is multi-faceted—simply banning qualified health professionals from prescribing Schedule II medications will not alleviate addiction to and abuse of opioid medication. Policymakers agree that the solution to this problem requires enhanced patient and provider education on the addictive properties of certain controlled substances, increased public awareness on the overall financial and cultural cost of opioid addiction, and enforcement of existing laws to prosecute all involved in drug diversion, including health professionals who abuse their prescribing authority.[19]

**Conclusion**

Projected increases in the number of insured individuals who will be seeking access to care and many of the factors that are creating physician workforce issues in the U.S. can be partially offset by the use of PAs, whose education and training allows them to meet patient needs. Additional positive attributes of the profession are the ability of PAs to work in diverse places of employment and a myriad of medical specialties. PAs can also extend and deliver high quality healthcare to patients in a variety of settings which may not otherwise have adequate access to care.

PAs have been part of the healthcare workforce for almost 50 years. Adopting best practice language into state laws and regulations enables PAs and physicians to extend care to patients more effectively. States that have not yet joined the majority of states and the District of Columbia in authorizing PAs to prescribe controlled medications, particularly Schedule II controlled substances should take steps to make sure that patients have access to the healthcare they need by ensuring that PAs are utilized to the fullest extent of their education and ability.

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[16] Cawley JF, Rohrs FC, Hooker RS. Physician Assistants and Malpractice risk: Findings from the National Practitioner Data Bank. *Fed Bull* 1998; 85:242-247.
[17] National Practitioner Data Bank, 2005 Annual Report. Bureau of Health Professions, Health Resources and Services Administration, US Department of Health and Human Services.
[18] *Id.* at 26.
[19] "CDC Grand Rounds: Prescription Drug Overdoses — a U.S. Epidemic." US Centers for Disease Control, Morbidity and Mortality Weekly Report, January 13, 2012.