ANZCA
FPM

Te Whare Tohu o
Te Hau Whakaora

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Ministry of Health | Manatū hauora
By email: info@health.govt.nz

Tēnā koe

Proposed Specified Prescriptions Medicines list for designated paramedic prescribers (paramedic prescribers)

Te Whare Tohu o Te Hau Whakaora | The Australian and New Zealand College of Anaesthetists (ANZCA), which includes the Faculty of Pain Medicine (FPM) and Chapter of Perioperative Medicine, is taking this opportunity to provide more comprehensive feedback on the proposed medicines list for paramedic prescribers than the online survey allows.

ANZCA is the professional organisation responsible for postgraduate training programs of anaesthetists and specialist pain medicine physicians, and for setting the standards of clinical practice throughout Australia and Aotearoa New Zealand. Our collective membership comprises over 10,000 fellows and trainees in anaesthesia and pain medicine, about 1300 of whom work in Aotearoa New Zealand.

The college has consulted with our national committees (National Committee NZ and FPM NZ) clinical directors, member groups, and education and policy advisors in Australia and Aotearoa. Their feedback informs this submission.

Overview

ANZCA does not support the proposed specified prescriptions list (SPML) medicines list for designated paramedic prescribers which is premature, since Te Kaunihera Manapou | the Paramedic Council is "in the early stages" of this work, and its application[1] to Te Kaunihera Rata o Aotearoa | Medical Council New Zealand to introduce designated prescribing authority for paramedics has yet to be approved. The college is not opposed to expanded roles where there is a demonstrated need, within a robust well-understood health workforce system, that provides appropriate checks and balances for safety and efficiency. We are not sanguine that the proposal currently meets these criteria and therefore cannot support paramedic prescribing for **any** class of medication. Nevertheless, we have identified medicines that are emphatically not supported for paramedic prescribing, following a brief discussion of a number of our concerns.

We take this opportunity to draw your attention to ANZCA's professional documents:

- PG09(G) Guideline on procedural sedation which is widely accepted as the gold standard for sedation guidance in both private and public health services throughout Australia and Aotearoa New Zealand

[1] Te Kaunihera Manapou | Paramedic Council. Application for designated prescribing authority under the Medicines Act 1981 for paramedics in Aotearoa New Zealand. [Internet]. Wellington. Kaunihera Manapou | Paramedic Council. 2026 04 22. 52p. Available from: https://www.paramediccouncil.org.nz/common/Uploaded%20files/20260422%20Paramedic_Prescribing_Application.pdf

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- PS60 Statement on the role of non-medical health care professionals in anaesthesia, pain and perioperative medicine-related roles, which is currently under development and review.

ANZCA, along with the majority of medical colleges was, unfortunately, unaware of the short high-level survey on paramedic prescribing conducted by the Paramedic Council late last year, or the analysis[2] of the 253 responses in February this year. With respect, for such a significant change to a newly regulated scope of practice, direct engagement and consultation with relevant professional colleges is essential and should have been a prerequisite.

ANZCA would welcome the opportunity to discuss paramedic prescribing of the range of medications used in anaesthesia and pain medicine for which our members have extensive expert training, knowledge and experience. High-quality care, patient safety, and optimising health are central to the college's purpose, vision and strategic plan. We want the best outcomes for patients and a sustainable well-educated workforce able to meet the current and future health needs of New Zealanders. Both require open communication between policymakers, regulators, employers *and* the professions representing clinicians.

Discussion

Rationale

The SPML comprises a comprehensive list of powerful, potentially harmful medicines for the treatment of acute and chronic conditions in unspecified settings. The proposal is that these be prescribed by a regulated non-prescribing practitioner group for which no specific qualifications, competence and training requirements for prescribing have yet been set by their responsible authority. The rationale provided in the brief Background document is entirely inadequate, drawing unwarranted conclusions from general and unsubstantiated claims of "sustained increased demand for urgent and primary care services" and "significant workforce pressures". There is no cited evidence or analysis to show that paramedic prescribing is a robust (safe, cost-effective, efficient) response to either increased demand or workforce pressures, or that this change in practice will address inequitable access to treatment for Māori, Pacific peoples and communities in remote and rural areas.

We note that under "Next Steps" there is no indication of how paramedic prescribing will be monitored or the outcomes assessed. We also caution that digital systems need to be at a point where safety checks can be done using patient records, or checking for contraindications, for example.

Standing orders and access to medications

Standing orders and the various guidelines developed to support using them, including the Ministry of Health's, assure safety around the administration and/or supply of medicines, including by paramedics. They are useful because there is a requirement to review each use with the person that administered the medication – an audit process to confirm the action was correct. Prescribers can fall into an environment without such close or specific audience, which is less safe for both patient and paramedic. Safe prescribing encompasses diagnosis, knowledge of the range of appropriate treatments, not just pharmaceuticals, and awareness of indications, contraindications

[2] Te Kaunihera Matapou | Paramedic Council. DRAFT Prescribing Authority for Paramedics 2025-26: Full Consultation Analysis Report. [Internet]. Wellington. Te Kaunihera Matapou | Paramedic Council. 2026 02. 35p Available from: https://paramediccouncil.org.nz/common/Uploaded%20files/FINAL%20-%20Consultation%20Report%20Paramedic%20Prescribing%20Jan2026%2012.2.26.pdf

and side effects. There needs to clarity around the context of medications proposed for paramedic prescribers: those that are being prescribed afresh and those that are a continuation of an existing medically prescribed drug. There is also a significant difference in the education and training needed to prescribe a potentially dangerous drug, and that needed to administer it. The costs, and opportunity costs, need to be considered in the context of health workforce funding as a whole.

The proposal seems to have taken the paramedic medication standing orders and transferred them into the SPML, circumventing the very rules that currently enable paramedics to administer and supply a range of medicines safely, according to their training and experience. For example, no patient would be prescribed a neuromuscular blocking drug, but a standing order allows a paramedic to administer a single dose or two under specific conditions. Similarly, problems with access to medications in rural and remote areas often relate to (not) having a pharmacy that can dispense, rather than prescriptions. Healthcare facilities which stock medicines are generally the default after hours supplier. Replacing the strict guidance and audit of user that standing orders ensure with a prescribing ability without rules is a significant risk to public safety and to paramedics.

Continuity of care

The development of non-medical designated prescribing roles, such as Registered nurse (RN) prescriber, have generally been developed over time within an established multidisciplinary framework. RN prescribers work collaboratively within inter- and multi- disciplinary teams; they prescribe repeat medicines initially prescribed by a doctor or nurse practitioner (NP) and have an ongoing relationship with patients managing care over time, for example managing chronic conditions. By contrast, paramedics are acute care health professionals providing emergency response in the community and there are a number of medications on the SPML which could be useful to provide emergency care for rural populations.

Many of the listed medications are for managing long-term and non-acute conditions; the circumstances and context of some of these non-emergency prescriptions needs to be clarified, specifically if it is a continuation of a medication prescribed by a GP for a stable condition where the patient can’t access a GP or starting new treatment. The college recognises that in some vulnerable communities, paramedics are providing primary care in the absence of doctors.

A key requirement would be for a paramedic to be linked with the usual primary health care team. There are risks. For example, where a patient out of hours asks for and is given an opiate. If the GP has been managing to keep them off opiates through agreement, but the paramedic does not have that context, the therapeutic plan breaks down. There is potentially a risk to the paramedic too, of being pressured to prescribe. And will there be a cost to the patient, as with an ambulance call out for respiratory arrest?

Workforce shortages / substitution

The underlying assumption that one health workforce gap can be plugged with an entirely different workforce by dispensing with established practice and rules, such as standing orders, is fundamentally flawed, but consistent in the current context of hastily designed and implemented changes to the health workforce. Blurred boundaries, substitution and the forced imposition of new scopes of practice from other countries pose a real risk to health practitioners and patients alike, particularly in a small country like Aotearoa New Zealand with a diverse population and limited resources.

Safe and effective practice relies on health practitioners having a clear understanding of the roles, responsibilities, and professional boundaries of the teams they work within. The introduction of new roles without adequate planning, policy support, clinical guidance, or stakeholder engagement

can create uncertainty, undermine confidence, and potentially compromise patient safety. This risk is heightened when considering roles that are not currently established or supported within the Aotearoa New Zealand health system, such as physician assistants.

New Zealand's small but highly skilled health workforce does not have the scale of larger jurisdictions to support an extensive range of specialised roles. However, the solution is not to blur professional boundaries or create interchangeable workforces where everyone undertakes the same functions. Rather, it is to maintain and strengthen our successful generalist-specialist model, which has evolved over decades and is well understood by practitioners, employers, and the public. Preserving clear role definitions supports professional confidence, workforce sustainability, and safe patient care. Robust workforce planning that incorporates appropriate training, education, and credentialling is needed to support the development of new models of care and avoid unnecessary duplication / unsafe substitution and 'scope creep'.

It is not clear whether alternatives to prescribing to **support** "contemporary models of mobile, community-based care" have been explored, for example, updating the standing order framework, dual scopes of practice, or systematically developing new robust workforce models that safely leverage existing workforce skills. ANZCA and the College of Intensive Care Medicine, for example, are about to launch a dual training pathway reducing the training period both specialities, and the Royal New Zealand College of GPs offers Dual Fellowship studying general practice and rural hospital medicine at the same time. These were developed carefully and collaboratively, extending well-established roles and existing training platforms to meet an evidence-based need.

The designated paramedic prescriber role posited is largely based on the UK scope of practice; but trauma and emergency care delivery in the UK, including the role of the paramedic, is significantly different. The UK has nationally co-ordinated ambulance and trauma teams and access to physician-based Helicopter and Emergency Medical Services (HEMS). Anaesthetists and trauma doctors are part of the HEMS teams. Aotearoa New Zealand does not have the same level of coordination, or HEMS. The systems are so different, that it cannot be assumed from the UK experience where paramedics have a lot of medical support, that a paramedic prescribing role is similarly right for Aotearoa New Zealand. Paramedics have been regulated since 2020 and specialist paramedic endorsements in critical care, extended care and intensive care have only been introduced recently. Should these not be embedded before embarking on prescribing?

Accuracy

One aspect of the specified prescription medicines list (SPML) which is of particular concern is antibiotic prescribing and the discrepancy between what drugs are recommended as alternatives in the context of antibiotic allergy. Tools such as artificial intelligence (AI) can be used to deliver updated, possibly tailored information, to prescribers trained to use it appropriately.

There are several incorrect recommendations in the SPML according to the excellent new national antibiotic guidelines Te Whata Kura[3]. For example, cellulitis with allergy to penicillin in the primary care environment should be treated with co-trimoxazole, not clindamycin. Clindamycin has poor antimicrobial activity and is not recommended as it is an inferior treatment choice. Co-trimoxazole is as readily available as clindamycin, so this is as unnecessary as it is inaccurate. Similarly, cefalexin is recommended as an alternative in penicillin allergy. This is an inappropriate choice for severe type 4 hypersensitivity reactions e.g. Stevens-Johnson Syndrome, as there is still a shared beta-lactam ring; it is contraindicated if the patient has had previous anaphylaxis to amoxicillin due to the structural similarity of the R1-side chain.

[3] Health NZ. Te Whata Kura Guidelines. [Internet] Wellington. Health NZ. Accessed 3 July 2026. Available from: https://tewhatakura.nz/guidelines

The above inappropriate indications and drug alternatives reflect that the current standing orders are out of date - they were written in 2021 – but so is the SPML, which was "informed" by the New Zealand Emergency Ambulance Service Clinical Practice Guidelines. Clearly guidelines have not been prepared with much, if any, appropriate consultation, but these inaccuracies are indicative of the knowledge of allergy cross-over and use of appropriate guidelines needed to ensure appropriate choices. Nuanced clinical decision-making that considers the severity of allergic reactions, and the selection of appropriate alternative medicines extends beyond the intended scope of a paramedic prescriber. However, if the proposal is approved, it will create a parallel prescribing framework that will require ongoing review and maintenance to ensure it remains current, clinically appropriate, and aligned with best practice. Further, as not all paramedics will undertake the additional training required to become prescribers, standing orders will continue to be necessary and relevant. Consequently, the standing order list will also require regular review and updating, resulting in the need to maintain two separate systems.

The most appropriate method for administration of most of these drugs is under a standing order. Additionally, many of these chronic medications should only be given if there is a supply issue for the patient and it is for the purpose of ensuring a patient does not have a significant break in therapy. Allowing paramedics to be a primary prescriber of these chronic medications is not appropriate without appropriate diagnosis, follow-up and therapy titration.

Questions have also been raised about:

- the need for rocuronium in a CPR scenario where the patient is moving despite ketamine sedation and intubation.
- ACE inhibitors and angiotensin II receptor blockers for hypertension and heart failure - this needs careful titration and monitoring under the supervision of a long-term GP or physician and appropriate investigations for the disease before initiating.
- Rivaroxaban for DVT – this can be administered on suspicion of a DVT, but administration without access to investigations and tests is problematic. Is this access assured?
- Lipid-lowering agents are part of a package of managing cardiovascular risk taking into account many other factors, is the whole package being managed by the paramedic?
- diabetic drugs (outside of a hyper/hypoglycaemic crisis). The efficacy of treatment and other risk factors and complications of the disease need monitoring.
- Pregabalin for persistent pain - is this initiation or continuation of the therapy, is the patient being provided a full assessment and management plan for their chronic pain alongside this?

Paramedic prescribing in Australia

There is no relevant information on the Australian Health Practitioner Regulation Agency website about paramedic prescribing. Until recently paramedics administered medicines within permitted pathways of care but did not initiate/prescribe medication. However, some state governments have now trialled *Paramedic Practitioners* enabling paramedics who complete additional training to assess, diagnose and treat patients in the field, effectively to reduce pressure in emergency departments.

The Victorian State government passed the Paramedic Practitioners Bill 2024 to establish paramedic practitioners as a class of registered paramedics and to authorise paramedic practitioners to prescribe and administer scheduled medicines when treating patients. In parallel, Monash University launched a paramedic practitioners Master's degree program, covering conditions such as urinary catheter care, wound care and closure, minor infections, dislocations and fractures and Scheduled drugs. (A permit system governs Paramedic Practitioners

prescribing and administration of S8 drugs (opioids) under Victorian State law)[4]. 30 graduates are due to be deployed in 2026 to regional Victorian areas with expanded prescribing for specific acute and primary care conditions. There has been no evaluation of the program yet; the focus has been on altering training and credentialing frameworks to respond to changes in the legislation.

A proposed trial in Tasmania elicited this response[5] from the Australian Medical Association that echoes ANZCA's view that "Decisions about prescribing and the scope of practice must be driven by clinical evidence and patient safety...".

Proposed medicines for Anaesthesia

ANZCA does not at this time support any of the proposed medicines for the reasons given, but the following are emphatically rejected as being inappropriate for paramedic prescribers.

Broad Therapeutic Group	Proposed Prescription Medicine	ANZCA Recommendation
Antimuscarinic drugs	Atropine	NO
Local Anaesthesia	Articaine Lignocaine (lidocaine) Ropivacaine	NO
Neuromuscular blocking drugs	Rocuronium Suxamethonium	NO
Volatile Liquid anaesthetics	Methoxyflurane Nitrous oxide	NO
Cardiovascular system	Enoxaparin Heparin Captopril Enalapril Lisinopril Perindopril Quinapril Ramipril	NO
Antiplatelet drugs	Clopidogrel	NO
	Rivaroxaban	NO
	Ticagrelor	NO
Drugs for Arrhythmias	Adenosine Amiodarone	NO
Fibronolytic drugs	Alteplase Tenecteplase	NO
Lipid-regulating drugs	Atorvastatin Ezetimibe Simvastatin	
Sympathomimetics	Adrenaline Metaraminol Noradrenaline	NO
Antidepressant drugs	Amitriptyline Nortriptyline	NO

[4] https://healthlegal.com.au/current-news/new-authorisations-for-paramedic-practitioners-under-victorian-law

[5] Australian Medical Association. Political promises must not override patient safety. [Internet]. Australia. AMA. Media release. 2026 02 20. Available from: https://www.ama.com.au/articles/political-promises-must-not-override-patient-safety

Anti-seizure medicine	Levetiracetam	NO
Other analgesics and adjuvants	Pregabalin	NO
Second generation (atypical) antipsychotic drugs	Olanzapine Valproic Acid	NO
Diabetes mellitus	Gliclazide Insulins (as a class) Metformin	NO
Antibacterial drugs	Amoxycillin Azithromycin Benzathine penicillin Cefalexin	NO
Fluids and electrolytes	Sodium bicarbonate	NO
Drugs used in obstetrics	Oxytocin	NO
Oral contraceptives (for Contraception)	Ethinylestradiol Levonorgestrel Norethisterone	NO
Vaccines	Vaccines Rivaroxaban pregabalin	NO
Benzodiazepines	Lorazepam Midazolam	NO
NMDA-receptor antagonists	Ketamine	NO
Opioids	Codeine Fentanyl Morphine Oxycodone Tramadol	NO

Nāku noa, nā

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