16 July 2026

Te Kaunihera Rata o Aotearoa | Medical Council New Zealand
By email: PAconsultation@mcnz.org.nz

Tēnā koe

Draft professional standards for Physician Associates

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, thanks you for the opportunity to provide feedback on the draft professional standards (the Standards) for Physician Associates (PAs).

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 around10,000 fellows and trainees in anaesthesia and pain medicine, about 1,300 of whom work in Aotearoa New Zealand. The college has consulted with our national committees (National Committee NZ and FPM NZ) and education and policy advisors in Australia and Aotearoa, whose feedback informs this submission. ANZCA is a member of Te Kaunihera o Ngā Kāreti Rata o Aotearoa | The Council of Medical Colleges and supports its submission.

Overview

This is generally a sound, well-constructed document that clearly sets out the professional standards for PAs in a way that is equally accessible to PAs and the public. The college supports prioritising patient interests and the guidance to all areas of PA practice that the five standards together provide. We welcome the clear expression that the Standards are not all-encompassing, and that PAs are expected to use their professional judgment and be able to justify their actions.

Unaccountably, however, Te Tiriti o Waitangi, which underpins culturally safe practice in Aotearoa New Zealand, is not mentioned; this is a significant departure from the progress made over the past two decades to try to get to the root cause of, and address, entrenched health inequity for Māori, and others facing structural discrimination. Professional, culturally safe practice requires an awareness of Te Tiriti o Waitangi as the foundation of Aotearoa's unique bicultural constitution, which is materially different from the UK and US, where most PAs are from. It also requires a commitment to health equity. The college recommends the Standards explicitly reference Te Tiriti o Waitangi, Māori health rights, and health equity, including for Pacific peoples, rural communities, disabled people and vulnerable people.

Greater clarity and detail around clinical competence, supervision, medical leadership, thresholds for seeking medical advice and escalation requirements, and continuing professional development (CPD), along with stronger provisions to support transparency and patient safety, would strengthen the document; we have made some suggestions to that effect below. We also recommend that the connections between the Standards, the PA scope of practice and the supervision framework, are more explicitly articulated, particularly in areas relating to clinical responsibilities, supervision, and decision-making. Similarly, although we are aware from your recent presentation to the medical colleges that the next stage will be to develop the CPD requirements for PAs, ongoing education, professional development and maintenance of competence must be recognised as fundamental professional obligations.

It is disappointing that the Minister chose the title of Physician Associate. A change of title was the first recommendation of the Leng Review[1] because of demonstrable patient confusion about whether a PA was a doctor resulting in serious adverse outcomes, including the recent death of an eight year old[2]. The college urges the Medical Council to continue to advocate for a title that offers clarity about this newly introduced non-medical role, such as clinical assistant or physician assistant.

The Council asks whether the Standards are "*workable across the range of settings in which PAs practice*". This is somewhat problematic since doctors have had no education or training and very little experience of working with PAs and the range of settings in which PAs practise is not clear or established. However, we have done our best given the brief consultation period. We draw your attention to the constant scrutiny that colleges are under to be accountable for submissions and look forward to a return to the more usual timeframe of 4-6 weeks for consultation.

The college would also like to inform you that ANZCA is currently reviewing its Position Statement *PS60 Statement on the role of non-medical health care professionals in anaesthesia, pain and perioperative medicine-related roles* which we think will be of interest as it offers a very solid framework about what can and should be expected of PAs, giving a clear understanding of clinical competence.

PS60 also reflects the college's position that high-quality clinical care is medically led. The nature of the association between the PA and supervising physician is not clearly articulated in the Standards. There is little emphasis on the fact that the physician will carry overall responsibility for the patient and their welfare. While the Standards do refer to practise within the limits of competence and employer credentialling, ANZCA suggests emphasising that competence alone does not determine scope of practice. Clinical responsibilities should remain defined through organisational credentialling, governance processes and agreed clinical pathways.

Draft Professional Standards

1. Patient care

The Standards should reinforce that Physician Associates operate within a **medically led model of care**, with overall responsibility remaining with the supervising physician. This would reinforce that supervision extends beyond the physical availability of a supervising doctor to include appropriate consultation, collaboration and escalation when clinical circumstances require.

While the whole-person approach "appropriate to the patient and their family and/or whānau" and having respect for "patients' rights, values, beliefs, cultures, and perspectives" is welcome, it frames culture as respect and competence rather than cultural safety as an expectation of every regulated practitioner. Accompanying that expectation is the practitioner's responsibility to reflect on assumptions, bias and the influence of power in healthcare relationships. Clinical safety cannot be separated from cultural safety. The Standards need to be explicit regarding Te Tiriti o Waitangi

[1] Leng, G. The Leng review: An independent review into the physician associate and anaesthesia associate professions. UK. Department of Health and Social Care. 2025. Avaialbe from: https://www.gov.uk/government/publications/the-leng-review-an-independent-review-into-the-physician-associate-and-anaesthesia-associate-professions [assets.pub...ice.gov.uk]

[2] Wise, J. Death of 8 year old after assessment by advanced practitioner triggers coroner's warning for GPs. [Internet] *BMJ* 2026;394:e100144.doi: https://doi.org/10.1136/bmj-2026-100144

and specific measures to ensure cultural safety in Aotearoa. ANZCA recommends that the Standards:

- explicitly acknowledge Te Tiriti o Waitangi, hauora Māori, Māori health rights, Māori health rights, and health equity, including for Pacific peoples, rural communities, disabled people and vulnerable people.
- require approved Aotearoa New Zealand cultural safety and hauora Māori training for registration and ongoing practice, with priority during provisional registration.
- set clear, measurable cultural safety expectations to support consistent assessment and accountability by the Council and employers.

2. Safe Practice

Some concerns were raised about employers defining clinical responsibilities through credentialling, and the lack of clarity around thresholds for seeking medical advice. The document refers to PAs practising "*within their competence*" and "*under supervision*", but the operational threshold for involving the supervising doctor is vague. Supervision should be understood as more than physical availability and should include collaboration, oversight, and appropriate clinical decision-making support.

2a The document states that an associate should "*recognise when to seek the assistance and input of a doctor*" and "*only practice when you have an onsite supervising doctor available*". We suggest these statements are inadequate. Having a supervising doctor physically available is not in itself a clinical safeguard; it carries the potential for misinterpretation and even abuse.

2b. The requirement for onsite supervision by a doctor is welcomed but needs to be more explicit about the context and support the doctor can provide. The term "*onsite supervising doctor*" lacks precision. It raises questions around how the standard for a "*supervising doctor*" is determined; whether the PA is responsible to a named physician or to medical staff in general; and if there is a defined relationship with the PA in the specific context. For example, an anaesthetist or doctor with airway skills is necessary if minimal to moderate sedation is being undertaken as per ANZCA's Guideline on procedural sedation 2023 PG09 (G)[3]. In this context we also raise concerns about the impact of supervision of PAs on specialist training pathways.

Consideration must be given to clarifying:

- what constitutes "onsite"
- whether the supervision relationship is with a named supervising physician
- the qualifications and competencies required of the supervising doctor
- circumstances where expertise is required (for example an anaesthetist or doctor with airway management skills when sedation is provided).

and setting clearer expectations around:

- consultation
- escalation pathways
- circumstances requiring mandatory involvement of the supervising doctor.

Autonomous practice is not equivalent to independent decision-making in complex cases. As PS60 emphasises, the need for clearly defined scopes of practice, explicit escalation pathways,

[3] Australian and New Zealand College of Anaesthetists. Guideline on procedural sedation (PG09(G)). Melbourne: ANZCA; 2023.Avaialbe from:

consultation when the case exceeds competence, and recognition of medical leadership in the key areas of diagnosis and strategic clinical management. We suggest you consider the following addition:

"*You must seek timely advice from your supervising doctor when the patient's condition is outside your defined scope of practice, when diagnostic uncertainty exists, when a patient's condition is deteriorating or fails to respond as expected, or when significant clinical risk or complexity is present*".

This changes expectations from simply recognising the PA's limitations to specifying circumstances in which medical consultation is mandatory.

3. Good communication and informed consent

The communication standard should explicitly include communication with:

- medical colleagues
- other health professionals
- members of multidisciplinary teams.

3b. *Clearly identify yourself as a physician associate and ensure patients and the public understand your role.*

ANZCA suggests the first bullet point should be amended to explicitly state that a PA must not use the term doctor to describe themselves to a patient or clinical colleagues at any time, even if they have a doctorate.

Collaboration

Because the Physician Associate (PA) profession is new to Aotearoa New Zealand and was developed outside national health and education systems, precise guidance is needed on communication, safe handover, and transfer of patient care. The Medical Council's Good Medical Practice[3] offers clear guidance for doctors on these issues, particularly in paragraphs 39–52 and the supplementary guidance on transferring patients, referring patients, and planning for transfer of care. Similar requirements should be included in the Standards for PAs.

Accountability is also important. PAs should work under an active supervision plan with clear escalation pathways and processes for handover and transfer of care. These arrangements should be understood by both the PA and their supervising doctor. Templates or guidance for supervision plans, escalation pathways, handover procedures, and transfer-of-care arrangements, would support consistent and safe practice.

4. Professionalism

5f *Maintain and develop your knowledge and skills through a commitment to lifelong learning and professional development*.

The college has significant concerns about the absence of clear CPD requirements for PAs, notwithstanding that their development is anticipated in the next phase. There is strong consensus that CPD should be explicitly identified as a requirement of maintaining both safe practice and professionalism. Questions were raised about whether CPD requirements will align with those required for doctors, how competence will be assessed and who will assess compliance. Consideration should be given to specifying:

- Annual Cultural Safety CPD requirements

- Maintenance of Advanced Cardiovascular Life Support (ACLS) and other relevant certifications
- Additional requirements for those working with paediatric or vulnerable populations.

Professional standards should include explicit expectations for continuing education and recertification where relevant. In addition, the standards should reinforce the responsibility of PAs to practise within defined scopes of practice and recognise their professional limitations. Expectations regarding accountability to supervising physicians, employers and professional regulators should be clearly articulated.

5g *Tell the Council, and any person or organisation that has a reasonable expectation to know, about any matter (in New Zealand or overseas) that may affect your practice.*
Reporting requirements should be sufficiently broad to capture significant concerns about professional performance, including circumstances where practice restrictions or reductions in scope have been imposed because of competence, conduct or health concerns. Current reporting requirements focus on criminal, employment, regulatory findings. Consideration should be given to requiring notification where:

- clinical privileges are restricted
- the scope of practice is reduced
- additional supervision requirements are imposed due to concerns about competence conduct or health.

Such measures may identify significant practice concerns before they result in suspension or dismissal.

Conclusion

We trust the comments above are useful and **recommend** that you:

- advocate to the Minister for a change of title from associate to assistant to protect public safety.
- ensure the standards are relevant to Aotearoa by acknowledging Te Tiriti o Waitangi and specific measures for PAs pertaining to:
  - hauora Māori and Māori health rights,
  - cultural safety
  - health equity in general, including for Pacific peoples, rural communities, disabled people, and those with high health needs.
- strengthen the document by providing more detail , including reference and direct links to other documents particularly the PA scope of practice, guides, relevant templates:

  - supervision
  - medical leadership
  - handover and transfer of care arrangements
  - escalation requirements
  - continuing professional development.

- note ANZCA's current review of *PS60 Statement on the role of non-medical health care professionals in anaesthesia, pain and perioperative medicine-related roles* and the framework it provides for clarity around clinical competence, medical leadership, thresholds for seeking medical advice and notification of adverse legal circumstances.

Thank you again for the opportunity provide feedback on the draft document.

ANZCA
FPM

Nāku noa, nā

Rachel Dempsey
Chair, New Zealand National Committee

Brendan Little
Deputy Chair, New Zealand National Committee

Australian and New Zealand
College of Anaesthetists
& Faculty of Pain Medicine

ANZCA
FPM

For further information please contact: Michele Thomas, Executive Director New Zealand
mthomas@anzca.org.n.nz, Ph +64 27 570 4963