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

Tēnā koe

Consultation on the Regulation of Physicians Associates/assistants (PAs)

Te Whare Tohu o Te Hau Whakaora | The Australian and New Zealand College of Anaesthetists (ANZCA, the college), which includes the Faculty of Pain Medicine (FPM) and Chapter of Perioperative Medicine, thanks you for the opportunity to provide feedback on the above. 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, 1300 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. It is also informed by discussion with other medical colleges and health professions. ANZCA is a member of the Council of Medical Colleges | Te Kaunihera o Ngā Kareti Rata o Aotearoa (CMC) and supports their submission.

Executive summary/Overview

As you will be aware, ANZCA does not support the regulation of a health practitioner scope which is outside the training and education offered in Aotearoa New Zealand, because of the inherent risks to patient safety and workforce sustainability. It is not our intention to repeat the well-canvassed concerns of medical and other health practitioners submitted over the past decade, but we do note that those concerns have been somewhat substantiated in both the UK and Queensland, Australia, jurisdictions similar to our own. The Leng Review[1] found significant patient safety and workforce issues with the introduction of PAs in the UK, while in Queensland, anecdotally, the attraction of a comparatively short (two-year postgraduate) training period and $130,000 salary is suspected to have been the cause of fewer applications for doctor training. (Competition for training resources is an identified concern of several medical colleges including The Royal Australasian College of General Practitioners[2].)

[1] NHS The Leng review: an independent review into physician associate and anaesthesia associate professions. Jul 2024. Accessible at: https://www.gov.uk/government/publications/independent-review-of-the-physician-associate-and-anaesthesia-associate-roles-final-report/the-leng-review-an-independent-review-into-physician-associate-and-anaesthesia-associate-professions

[2] Medical Republic. Queensland physician assistants paid more than junior doctors. 24 July 2024. Accessible at: https://www.medicalrepublic.com.au/queensland-physician-assistants-paid-more-than-junior-doctors/109188

In Aotearoa, pilot PA programmes have delivered mixed results[3] but currently around 50 PAs are employed in various health settings throughout the country, an indication of the shortage of health workers, rather than a specific gap in skills. PAs perform a range of activities that without appropriate training, oversight and governance, present a serious risk of patient harm. Regulation is therefore appropriate, though it is disappointing that a full analysis of how PAs fit within a long-term health workforce plan was not undertaken.

Aotearoa's small population precludes the capacity to train and support every new scope of practice, but generalist allied health, nursing, medical and medical specialist scopes have ensured a safe, innovative, fit for purpose health workforce. Entrenched over-reliance on, and lack of retention of, internationally trained health practitioners points to the need for growing the workforce we need for our unique population, as noted in the CMC's 2025 Position Statement on the Regulation of Physician Associates[4]. ANZCA suggests the regulation of PAs be considered in the context of providing an entry point for overseas trained PAs to work in Aotearoa's health system, rather than laying the foundation for an entirely new profession that duplicates established and supported roles. There is no clear vision apparent for this role in New Zealand health settings or in health workforce planning that clarifies the role of the PA and what they do.

Accordingly, the college recommends that the PA scope of practice the Medical Council has been required to regulate be clearly aimed at enabling the skills of overseas trained PAs to be utilised safely within a narrow well-defined scope, prior to being retrained in a scope which is supported and integrated in New Zealand, for example Nurse Practitioner (NP), Anaesthetic Technician (AT), or Paramedic roles. This would achieve the immediate benefit of increasing the number of health practitioners, without compromising patient safety, or the stability of the existing health workforce. It would also pre-empt the need to develop extended PA scopes of practice, or establish new training programmes for PAs, reducing the risk of fragmenting training opportunities for our already over-extended and under-resourced health workforce[5,6]. ANZCA's responses to the consultation questions below are predicated on this recommendation.

We suggest that it would be appropriate, even reassuring, for Council to remove references to, or intimations of, potential future development, for which, at this stage, there is no evidence. For example, the Introduction states: "There is *currently* no tertiary training programme in Aotearoa New Zealand, so all PAs *initially* working here *will have* been trained overseas" (ANZCA emphasis, p2) which implies that this may change. Focusing on the reality that all PAs *are* overseas trained, without second guessing the future, should make it easier to develop a limited, well-defined role

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[3] For example: New Zealand Nurses Organisation. Critical review of the final Evaluation of the Physician Assistant pilot, 2012. Accessible at: https://www.nzno.org.nz/Portals/0/publications/Critical%20review%20of%20final%20Evaluation%20of%20the%20Physician%20Assistant%20pilot%202012.pdf and note the apparently successful integration of PAs in a well-resourced practice in the Far North reported at the CMC Policy hui on MCNZ consultation on Physician Associates, 29 January 2026.

[4] Council of Medical Colleges. 2025 Position Statement on the Regulation of Physician Associates, 2025. Accessible at: https://www.cmc.org.nz/media/yygla0yx/2025-pa-regulation-statement-final.pdf

[5] NZIER. 2025. Health priorities? A comparison of New Zealand's public health and disability expenditure against selected OECD countries. A report for Medicines New Zealand.
[6] Tenbensel T, Lorgelly P. New Zealand's health financing and expenditure: a comparative and historical review – 2000-2023, Section 4.1, ASMS 2025.

and target cultural safety and competence requirements for PAs to support the delivery of safe health care to New Zealanders, including Māori and Pacific peoples.

ANZCA does not support the proposed PA scopes of practice. We suggest that boundaries need to be further defined, particularly with regard to patient assessment, diagnosis and referrals, and remote supervision, and that activities such as prescribing need to be specifically excluded, not just "not referenced". We appreciate there is a fine line between having a scope that is too broad or too prescriptive, however, the lack of clarity around who is ultimately responsible for supervision of PAs, including supervision of cultural safety, needs addressing.

Following the precautionary principle, the introduction of PAs should proceed cautiously, with regular review of data, including feedback from PAs, consumers, clinicians and employers. Clear outcome measures should be established for safety, supervision burden, patient experience and training impacts. ANZCA would prefer the title "clinical assistant" to either physician associate or physician assistant as neither are appropriate descriptors of this role.

SECTION 1 Scopes of practice

The two proposed scopes of practice that "outline at a high level what PAs can do" offer little in the way of certainty since they are qualified by indications that there will be future changes. Even more problematic is the within the "broad scope", the specifics of what is in and out of scope appears to be employer credentialling. This is a risk to public safety. A recent systematic review on public health workforce (PHW) regulation and credentialing concluded that "*While the public health workforce looks substantially different across international contexts…what appears consistent is inconsistency. Some occupations within the PHW require credentials, but not all, and it appears that within countries those credentials may vary, potentially quite a bit*." [7] Credentialling may be useful for a small number of site-specific activities **within** a well-defined scope but should not be used as a means of **determining** the parameters of a scope that is largely unknown.

Proposed scopes of practice

ANZCA supports having a time-limited provisional scope with tighter supervision prior to full registration but does not support the proposed scopes. The proposed time limitation (up to 36 months) for the Provisional PA scope of practice is far too long when the purpose is to enable/ facilitate overseas trained PAs to practice safely in Aotearoa in the first instance, before retraining into a supported role here. Verified competence via assessment must be an additional criterion for general registration.

The 'high level' scope is without specific boundaries providing a broad framework for, but not a defined, PA scope of practice. As such the proposal follows the same high-risk pathway the *Leng Review* identified as causing "confusion among patients and professionals about the role of the PA" in the UK and subsequent calls for "a defined scope of practice, not to introduce added rules and complexity but to provide clarity about the new role".

As detailed in the CMC's submission, there is a lack of clarity around key provisions for diagnosis, prescribing and vocational scope /area of practice and, we would add, around supervision.

Defining the role should not be left to credentialling by employers who are vulnerable to external pressures and demands, and who are not responsible for the regulating what health practitioners can do. ANZCA members have also expressed concern that rotational training opportunities for

[7] Gershuni O, Orr JM, Vogel A, Park K, Leider JP, Resnick BA, Czabanowska K. A Systematic Review on Professional Regulation and Credentialing of Public Health Workforce. Int J Environ Res Public Health. 2023 Feb 24;20(5):4101. doi: 10.3390/ijerph20054101. PMID: 36901111; PMCID: PMC10002239.

vocational trainees may be lost, as employers may be motivated to support employees' training needs over those of vocational trainees.

The college recommends specifically **excluding**:

- Prescribing
- Seeing or diagnosing undifferentiated patients.
- Undertaking mental health assessments.
- Making independent assessments of deteriorating patients.
- Undertaking 'minor' surgical procedures (suturing, punch biopsies, cutaneous exclusions) without the supervising SMO always being available.
- Independently admitting or discharging patients from secondary care.
- Ordering diagnostic tests, including referrals for diagnostic imaging, except under the direct delegation of the supervising Senior Medical Officer (SMO).
- Covering or participating in medical rosters designed for doctors.

Core requirements should specify that PAs must stop consulting with patients immediately and handover to their supervising doctor when:

- they are uncertain.
- When a condition exceeds their ability.
- When the patient is responding poorly or deteriorates.
- If the patient wishes to see a doctor.

SECTION 2 Prescribed qualifications, registration pathways and changing scope of practice

A clinical competence assessment prior to moving from provisional to a general scope is essential, regardless of registration pathway (UK trained, US trained or New Zealand experiential), as competence cannot be assumed from international qualifications. We suggest a training programme / online review to enable assessment of specific competencies may be required. (We note that the Medical Council has indicated that it is working on standards of clinical competence.) The college strongly supports the requirement for a pass in a knowledge-based cultural safety programme approved by the Medical Council.

In general, the qualifications, training and experience (three years practice) for the UK and US pathways to registration (1 & 2, respectively) in both the Provisional and General PA scope are appropriate, though independent assessment of clinical competence is lacking. While the rationale for restricting PA qualifications from the US (whose health care system is very different from New Zealand's) and the UK exclusively is not clear, we assume it is to reduce the risks and workload of assessing roles initially? In principle, however, ANZCA does not support selective recognition of qualifications based on country per se, rather than educational standards as per the principles the New Zealand Qualifications Authority (NZQA) uses for evaluation of international qualifications.

It is appropriate that the third pathway for PAs who have been practising in New Zealand for more than two years to be eligible to apply for registration in the General PA scope of practice will only be available for 12 months. Although the college has no objection to the shorter timeframe for supervision (6 months) for this group of PAs, timeframes are somewhat arbitrary; an assessment of clinical competence should be the main requirement for registration. We again refer to the purpose of regulating PAs: to protect public safety and, as directed by the former Minister of Health, to utilise available health workforce resources. It is vital for safe patient care that all members of multidisciplinary teams have a clear understanding of PA training, roles, scopes, competence and role boundaries. It is also vital that workforce resources are not diverted from core business. To achieve both requires a narrow well-defined scope assuring the clinical

competence of PAs who have three years clinical experience and a tertiary qualification, with the clear expectation (and opportunity) to retrain in a scope that is recognised in Aotearoa.

We agree that PAs registered in the Provisional PA scope of practice should be required to hold current Medical Council-approved Advanced Cardiac Life Support (or similar) certification to be eligible to apply for registration in the General PA scope of practice.

While the college supports the requirements for all PAs registered in the Provisional PA scope to have:

- a period of Medical Council-approved supervision in a Council-approved workplace
- a minimum period of satisfactory supervised practice
- a recommendation from the supervisor of the PA

for registration in the General PA scope of practice, more detail is needed around that supervision (see section 3 below), and we are cognisant of the pressures this will place on an already stretched senior workforce.

SECTION 3 The supervision framework

ANZCA has considerable concerns about the supervision framework which does not provide consistency or clarity about who bears ultimate responsibility for PAs; whether supervision must be onsite; whether any aspect can be delegated, and what provisions need to be in place (ie workplace capacity) to ensure adequate supervision of the PA, and protected time for the supervisors, including protection of their capacity to supervise vocationally registered trainees. We are particularly apprehensive about the potential for employers to assign supervision responsibilities (for example to RMOs) under the General PA scope. Employers have no role in the supervision of health practitioners, other than to ensure clinical supervisors have sufficient time to fulfill their responsibilities. The potential for PAs to be employed in rural and remote settings where there is generally less available supervision combined with the greater need for cultural knowledge, skills and competence to provide safe care, makes it imperative to have stringent, carefully articulated provisions for supervision.

The PA role is, by definition, a dependent one, therefore:

- PAs should always work under the supervision of a named, vocationally registered medically practitioner.
- Supervision should be onsite and continuously available.
- Supervision should not be delegated.

ANZCA recommends that the Medical Council establish limits on supervision capacity and supervisor workloads, ensuring time for supervising vocationally registered trainees is prioritised and protected.

SECTION 4 Ensuring PAs practise in a culturally safe way

The MCNZ defines culturally safe practise as a critical consciousness, not just cultural knowledge, requiring doctors to be accountable for their impact on patients[8]. ANZCA welcomes the Medical Council's *intention* to "set cultural safety requirements at every stage of the PA regulation framework", though this is not evident throughout, and warmly supports the pre-registration requirement to "satisfactorily complete a Council-approved knowledge-based cultural safety

[8] Medical Council of New Zealand Te Kaunihera Rata o Aotearoa. Cultural Safety Training Plan for Vocational Medicine in Aotearoa. MCNZ, 2023. Accessible at: https://www.mcnz.org.nz/our-standards/current-standards/cultural-safety/

program for health practice in Aotearoa". The college suggests that the 12-month timeframe for completion is reduced to a maximum of six months, or is made a prerequisite, since this is an identifiable gap in the knowledge and skills of internationally trained PAs. We draw your attention to the Medical Science Council recommendation for internationally qualified Anaesthetic Technicians (IQ ATs) to complete accessible online cultural orientation programs prior to application, for instance. Completion of a program, while an important start, does not prove competence. *Demonstrated* culturally safe practice should be part of the core requirements of the General PA scope.

Responsibility for cultural safety also sits with the employer, who should support a culturally safe workplace, and the supervisor; the Medical Council should be explicit about their respective requirements to support PAs to practise in a culturally safe way and the tools and supports needed. (We have noted the requirement that supervisors support ongoing development of cultural capability.)

SECTION 5 The title for PA scopes of practice in Aotearoa New Zealand

ANZCA does not support either title. PAs are not physicians or established and clearly understood associates or assistants to medical practitioners in Aotearoa, nor is the title or scope consistent in other countries. Clinical assistants would potentially be more accurate.

Conclusion

Without a clear vision of the purpose of the PA scope and how it can be safely interpolated into Aotearoa's health workforce, ANZCA cannot support the proposed regulation of PAs. International experience evidences the potential risks of introducing a new cadre of health workers without that vision being articulated, and without a shared understanding of the training, roles, competencies and boundaries of all members of multidisciplinary teams.

Additional concerns for Aotearoa include the risk of disrupting funding and/or training opportunities to support the practitioners we need and increasing supervisors' workloads. PAs are not part of Health NZ's workforce planning or practitioners' knowledge or experience of roles within the multidisciplinary framework in which health care is delivered in Aotearoa. ANZCA is not averse to innovation to improve access to the delivery of safe care; on the contrary, the college has grown, developed and incorporated new roles and scopes of practice where there is evidenced need and supported training. We also recognise and value the significant contribution of overseas trained health practitioners and are certainly aware of the need for more trained health workers. Accordingly, we **strongly recommend** that the introduction clarifies that the PA scope provides an entry to limited practise in New Zealand with the expectation that PAs will retrain in roles that are recognised and supported here. This may obviate the need for the third pathway, and you may also wish to reconsider timeframes.

On that basis, please find below a summary of ANZCA's recommendations for the proposed PA scope:

- Delete the italicised words in the following sentence "There is *currently* no tertiary training programme in Aotearoa New Zealand, so all PAs *initially* working here *will* have been trained overseas".
- Undertake to proceed cautiously, with regular review of data, including feedback from PAs, consumers, clinicians and employers.
- Establish outcome measures for safety, supervision burden, patient experience and training impacts.
- Establish clear boundaries for the PA scope by specifying what activities are in and out of scope.

- Exclude

  - Prescribing
  - Seeing or diagnosing undifferentiated patients.
  - Undertaking mental health assessments.
  - Making independent assessments of deteriorating patients.
  - Undertaking ‘minor’ surgical procedures (suturing, punch biopsies, cutaneous exclusions) without the supervising SMO always being available.
  - Independently admitting or discharging patients from secondary care.
  - Ordering diagnostic tests, including referrals for diagnostic imaging, except under the direct delegation of the supervising Senior Medical Officer (SMO).
  - Covering or participating in medical rosters designed for doctors.

- Remove or place very strict boundaries around employer credentialing.
- Require an assessment of clinical competence, including cultural competence for registration in the General PA scope.
- Note that ANZCA supports the following entry requirements to the General PA scope:

  - a period of Medical Council-approved supervision in a Council-approved workplace
  - a minimum period of satisfactory supervised practice
  - a recommendation from the supervisor of the PA

- Strengthen provisions around supervision by requiring:

  - PAs to always work under the supervision of a named, vocationally registered medically practitioner.
  - Supervision to be onsite and continuously available.
  - And prohibiting delegated supervision.

- Reduce the time frame to 6 months (and/or consider online prerequisites) for satisfactory completion of a Council-approved knowledge-based cultural safety program for health practice in Aotearoa
- Note ANZCA’s preference is for the title “clinical assistant”.

Thank you again for the opportunity to provide feedback on the regulation of PAs.

Nāku noa, nā

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