

11 February 2026

**Dr Rachelle Love, Chair**

**TE KAUNIHERA RATA O AOTEAROA | MEDICAL COUNCIL OF NEW ZEALAND**

### **Regulation of physician associates/physician assistants (PAs)**

#### **Tēnā koē Rachelle**

Te Whare Piki Ora o Māhutonga – the Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Aotearoa New Zealand and Australia. Our mission is '*To improve access, equity, quality and delivery of surgical care that meets the needs of our diverse communities*'. Health advocacy is a central competency of a surgeon, and a core value of this College.

RACS welcomes the opportunity to contribute to shaping the regulatory framework for PAs working in Aotearoa New Zealand. Sarah Rennie, Aotearoa NZ Surgical Advisor and I were pleased to be able to work with Te Kaunihera Rata o Aotearoa (MCNZ), doctors, physician associates, unions, consumers, and other health sector organisations to get to this stage.

RACS opposed the introduction of the PA scope of practice in Aotearoa. However given government's decision to regulate PAs and allocation of responsibility to MCNZ, we have been pleased to contribute to work to design the regulatory framework.

We support the overall framework of the proposed provisional and general scopes of practice, the qualifications and registration pathways, supervision requirements, and expectations around cultural safety and equity in healthcare delivery. However, we want to see a more prescribed scope of practice for PAs, with tighter supervision requirements, and the addition of explicit expectations of inclusion and exclusion activities delivered by PAs across the framework. We would also like there to be greater emphasis on the requirements for cultural competence, cultural safety and hauora Māori.

RACS recommends the following key changes to the proposed framework:

1. Professional title – RACS prefers Clinical Assistant. At a minimum the title should include Assistant, not Associate. This would prioritise patient safety and understanding over the preferences of the small current PA workforce.
2. Tighter scope for PAs in both the provisional and general scopes with exclusions for:
  - diagnosis of new conditions unless closely supervised in-person
  - undifferentiated pain, which should be referred to a doctor
  - endoscopy
  - minor surgical procedures - excision of skin lesions and subcutaneous lesionsRACS is concerned scope creep - by PAs or employers facing workforce pressures – would put patient safety at risk and could displace vocational trainees from essential training opportunities.
3. Supervision requirements must be tighter and more explicit. MCNZ consideration of supervision ratios and approval of supervision plans must ensure:
  - the supervising vocationally registered doctor can prioritise the supervision of trainees in their own vocational scope over supervision of PAs
  - the supervision of PAs does not place unsafe workloads on already overstretched doctors
  - under no circumstances is supervision of PAs assigned or transferred to doctors in training.
4. RACS supports the emphasis on cultural safety and hauora Māori as core components of the regulatory framework for PAs, particularly given all PAs initially practising in Aotearoa New Zealand will have trained overseas. We would like to see greater emphasis on demonstrated cultural competence, particularly for registration in the general scope. Ensuring culturally safe practice is essential for patient trust, equity, and quality of care. We support the clear framework developed so far and the intention to develop requirements for the recertification programme for practising PAs to demonstrate they are maintaining their competence. Cultural safety is a system responsibility, not an informal training burden to be shifted onto other members of the medical workforce.



5. More detailed comment follows.

### **Section 1. Scopes of Practice**

6. RACS submits the scope of practice for a PA, whether for the provisional and general scope, should be more limited in the interests of patient safety. The framework should provide more explicit guidance to both PAs and the vocationally registered doctors who will supervise them on the scope of the role.
7. The scope of practice for a PA, whether provisional or general, should contain not only enabling provisions but also explicit exclusions. Prescriptions without proscriptions is likely to create ambiguities which create risk.
8. Diagnosis: RACS proposes the following important prohibitions.
  - No patient should be diagnosed only by a PA; there must be some medical involvement.
  - Patients with undifferentiated pain, which should be referred to a doctor.
  - Endoscopy should only be undertaken by trained or in-training vocationally registered medical and nursing practitioners
9. Both the provisional and general scope should in relation to minor surgical procedures:
  - include suturing, if appropriately trained and supervised by a doctor with general registration
  - explicitly exclude excision of skin lesions and subcutaneous lesions, as these all require surgical training and have potential for significant complications
  - explicitly exclude cosmetic procedures
10. The framework must also include for both the provisional and general scope an explicit prohibition on scope creep.
  - Scope creep by PAs or their employers in response to workforce pressure would put patient safety at unintended risk.
  - RACS is also concerned scope creep by PAs could displace doctors in training who also need opportunities to undertake minor surgical procedures, along with wider range of assessments, examinations, ordering tests, diagnosis, development and implementation of treatment and management plans, providing health promotion and disease prevention advice.
  - For RACS, this translates as the need for explicit protection and prioritisation of surgical trainees in training posts, training lists, or procedural opportunities being prioritised for activities required for progression and credentialling.

### **Section 2. Qualifications for registration and to change scope of practice**

11. RACS is generally in agreement with the proposed prescribed qualifications.
12. We note the reliance on initial qualifications and the length of experience, without the ability to assess competence until PAs have practised in Aotearoa under supervision for a period of time. RACS submits progression should be competence-based. We consider six months practice is likely to be too short to assess whether a provisionally registered PA is ready to progress to the general scope of practice. This concern relates particularly to demonstrating culturally safe practices and cultural competence against a defined standard.
13. The system places considerable reliance on credentialling by employers. Ideally credentialling should be undertaken by a neutral body such as MCNZ and should use a combination of time-based experience with competency assessment. The danger of employers completing credentialling is this may result in inconsistent standards and a conflict of interest over employment to fill a work schedule at the expense of patient safety.
14. The proposed qualifications require PAs in the general scope to “hold current advanced cardiac life support (ACLS) certification less than 12 months old at the standard of New Zealand

Resuscitation Council CORE Advanced for PAs working in hospital-based practice; or CORE Immediate for PAs working in general practice (or an alternative certificate approved by Council). RACS proposes the requirement for PAs in the general scope be to have completed and hold a current advanced CORE certificate whether they are working in a hospital or the community.

### **Section 3. Supervision of PAs**

15. The supervision requirements need to be both tighter and more explicit.
- Supervision must be in person, with the doctor and assistant working together for the duration of the period the PA is on duty.
  - The 'supervising registered doctor' should be a senior medical officer, specified as a 'supervising vocationally registered doctor and not a doctor in training'.
  - We note: "Supervision capacity: The Council has not set a limit on the number of PAs an individual doctor may supervise. However, for a PA registered in the Provisional PA scope of practice, the primary supervisor, supervision plan and place of work for each PA must be approved by the Council, and Council will consider the proposed supervisor's clinical responsibilities and existing supervision load. The employer has a responsibility to ensure a proposed primary supervisor has capacity and capability to meet their supervision obligations for each PA that they supervise.
  - The proposed supervisor should only accept the supervisory role if they have capability and capacity to meet their obligations under this framework."
  - RACS is concerned without careful design the introduction of PAs as employees in the same workplaces as doctors in training could structurally disadvantage the trainees and compromise the development on the vocationally registered medical workforce in Aotearoa.
  - MCNZ must examine the supervision capacity of each vocationally registered supervisor when approving the supervision plan for each PA. Your consideration must take into account and prioritise the supervision of trainees in the supervisor's own vocational scope.
  - Employers' compliance with the supervision framework is essential - it is not just a general guideline. We recognise this may restrict the number of PAs who can practice in smaller centres. MCNZ monitoring and compliance activity will be critical, especially as the framework settles into place.
  - The employer must incorporate protected time into the supervisor's work schedule to allow for effective supervision.
  - Despite the demand for additional workforce to support other vocational scopes, employment and consequential supervision of PAs must not become an additional stressor on overstretched doctors.

### **Section 4. Cultural Safety requirements**

16. RACS supports the emphasis on cultural safety and hauora Māori as core components of the regulatory framework for PAs, particularly given all PAs initially practising in Aotearoa New Zealand will have trained overseas. Ensuring culturally safe practice is essential for patient trust, equity, and quality of care. We would however like to see greater emphasis on demonstrated cultural competence, particularly for registration in the general scope.
17. We support the clear framework developed so far and the intention to develop requirements for the recertification programme for practising PAs to demonstrate they are maintaining their competence. This programme will include specific requirements relating to cultural competence, cultural safety, and hauora Māori.

18. However, we recommend to taking the step up from provisional to general scope should be dependent on demonstrating competence in this (and other) areas of skills, knowledge and expertise. Undergraduate and vocational medical training in Aotearoa New Zealand appropriately incorporates high-quality cultural safety requirements and provides trainee doctors with the supports necessary to meet expectations. We are concerned that while section 4 does clearly outline the expectations on PAs, it does not provide them (or their supervisors and employers) with the tools and supports necessary to meet these expectations.
19. A particular concern is that the requirements post-registration lie solely with employers, supervisors and PAs themselves. We are conscious that for any health practitioner starting a new role in a new country can often be overwhelming. In such situations it can be common for practitioners to focus on the demands of their work, and for professional development to suffer as a result. Similarly with workforce limitations and high patient demand, employers and supervisors will be limited in the support and guidance that they can provide.
20. In such circumstances, external support is needed, especially during the provisional registration period. We refer MCNZ to the Cultural Safety Kete developed by the Council of Medical Colleges. Our view is that a similar level of guidance and support is needed for the PA workforce during the period of their provisional registration. This should include a cultural safety training plan incorporating didactic and peer group learning alongside self-directed learning and self-assessment. Importantly, responsibility for oversight and delivery of the training plan needs to sit with the Council or a provider approved by the Council. Expectations should be more visible.
21. RACS also highlights a particular risk in relation to PAs who are developing their cultural competence whilst working alongside trainee doctors. Overseas experience highlights that when PAs are unfamiliar with local cultural contexts, health system structures, and expectations of culturally safe care, responsibility for mitigating risk and addressing gaps often falls informally to doctors in training and doctors with general registration. This may include acting as de facto cultural intermediaries, revisiting consultations, or managing downstream consequences of miscommunication or misunderstanding.
22. This informal transfer of responsibility undermines the quality of culturally safe care delivered. creates an unrecognised supervisory responsibility for doctors in training, increases their workload and cognitive burden, and undermines their personal welfare. Under no circumstances should supervision of PAs be assigned or transferred to doctors in training, both to protect the doctor's own training opportunities and to avoid creating medico-legal risk for them. This is a specific concern for surgical trainees, for whom there is evidence of this happening in the UK. Doctors in training are not covered in their medical indemnity for supervision of PAs. There is evidence of doctors in training being asked to order investigations or provide prescriptions for the PA putting the doctor in training in a vulnerable position medicolegally with regards to responsibility of the investigation or prescription.
23. Cultural safety is a system responsibility, not an informal training burden to be shifted onto other members of the medical workforce.

## **Section 5. Title for scopes of practice**

24. RACS would prefer adoption in Aotearoa of the title Clinical Assistant. At a minimum the title should include Assistant, not Associate. This would prioritise patient safety and understanding over the preferences of the small current PA workforce.
25. Clinical Assistant would avoid confusion for patients and make it as clear as possible these practitioners are not physicians, nurses or doctors. Using the name of another vocational scope is particularly confusing and the word 'physician' must be avoided.
26. The word "Associate" is also confusing for patients and other health care professionals – one of the meanings of "associate" is "a partner or companion in business or at work" which implies a level of knowledge and skills similar to that of a doctor.

## **Conclusion**

Our feedback responds to your consultation document, following the order of your questions to facilitate collation of responses. You may publish our response to this consultation, and we will place it on our website.

We look forward to working further with MCNZ as you continue to develop and then implement the regulatory framework for this new Clinical Assistant workforce to help achieve a fair, safe, and sustainable health system in Aotearoa.

**Nāku noa, nā**

**Ros Pochin**

**Chair**

**Aotearoa New Zealand National Committee**

**RACS represents more than 8300 surgeons and 1300 surgical Trainees and Specialist International Medical Graduates across Aotearoa New Zealand and Australia. We are the accredited training provider in nine surgical specialities. Surgeons are also required by RACS and Te Kaunihera Rata o Aotearoa - Medical Council of Aotearoa, to continue with surgical education and review of their practice throughout their surgical careers.**