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The Royal Australasian College of Physicians' submission to Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Regulation of physician associates/assistants (PAs)

Huitānguru | February 2026

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to submit feedback on the Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand's consultation on regulation of physician associates/assistants (PAs).

The RACP works across more than 40 medical specialties to educate, innovate and advocate for excellence in health and medical care. Working with our senior members, the RACP trains the next generation of specialists, while playing a lead role in developing world best practice models of care. We also draw on the skills of our 32,000 members across Aotearoa New Zealand and Australia, to develop policies that promote a healthier society. By working together, our members advance the interest of our profession, our patients and the broader community.

RACP position on physician associates/assistants

To introduce a new role in healthcare requires a compelling case that there is no appropriate alternative. That is not the case for Physician Associates (Pas).

The Royal Australasian College of Physicians (RACP) does not see PAs as addressing any gaps or unmet needs in the Aotearoa New Zealand healthcare system. They do not offer any skills or special qualifications not already being offered by existing regulated health professions. In addition it should be noted that PAs are not educated in Aoteaora New Zealand and will require significant supervision and upskilling in cultural competencies.

The focus for the Aotearoa New Zealand Government, regulators and stakeholders must be on supporting and growing the existing Aotearoa New Zealand trained and recognised healthcare workforce, rather than on roles which lack the necessary grounding and well-established practice in our healthcare system.

While the RACP does not support the introduction or widespread expansion of PAs, it recognises the Government decision to regulate them in Aotearoa New Zealand and MCNZ's responsibility as their regulator. Regulation such as this is critical for PAs.

The regulation of PAs must mitigate risks; we do not want to repeat mistakes made in overseas jurisdictions. Lessons from international literature and the Leng review[1] in the United Kingdom must be considered.

RACP has a broad range of key concerns including:

- PAs are not a substitute for physicians or physician trainees. More broadly, they should never replace any doctors on rotas or in clinical decision-making roles requiring specialist knowledge.
- PAs cannot replace investment in locally trained healthcare professionals.
- Reliance on PAs may undermine long-term workforce sustainability.

[1] Department of Health and Social Care. The Leng review: Independent review of the physician associate and anaesthesia associate professions. Government UK, 2025. Available from: Independent review of the physician associate and anaesthesia associate roles: final report - GOV.UK

- PAs should not assess or manage undifferentiated patients independently, perform complex procedures alone, or supervise physician trainees.

- Trainees should never be requested to supervise PAs. Supervision requirements are intensive and resource heavy. If physicians and other vocationally registered doctors were to be considered as potential supervisors of PAs, they must have protected time for supervision, which is especially challenging in rural and regional settings. Any role they may have with PAs should not be to the detriment of their existing clinical or supervisory responsibilities. In a workforce under pressure as in Aotearoa New Zealand, this is a critical consideration for workforce wellbeing and sustainability.

- Medical training must be protected. PAs should not reduce opportunities for trainees – both physicians and other healthcare professionals. Aotearoa New Zealand cannot provide the healthcare that their communities need without training the next generation of physicians and other healthcare professionals.

- Clear governance and regulation are essential. Scope of practice, titling and responsibilities must be nationally standardised.

- Cultural safety training should be mandatory and equity monitoring is essential to prevent a two-tiered health system. PAs should not exacerbate disparities, particularly in Māori and Pasifika communities and rural and regional areas.

- The title of Physician Associate/Assistant is concerning and likely to lead to confusion for the public. As such it should be altered and should remove the term “physician”. This will avoid public and professional confusion. The term “associate” should not be used; instead, titles should clearly reflect the supportive nature of the role and specify the clinical area of practice, such as Clinical Assistant (with the speciality of the role in parentheses, e.g. Clinical Assistant – Gastroenterology or Clinical Assistant – Internal Medicine).

The RACP’s position on PAs is outlined in a statement on the RACP website released in October 2024. The short statement raises concerns about:

- The potential impact of the role on patient safety

- The need for PAs to receive adequate training and certification which integrates within the existing health workforce training and registration models

- PAs supervision and fit within multidisciplinary teams

- PA scope of practice

- Clarity about who would be responsible for what PAs do, and

- How PAs communicate with other team members.

The statement also raises a key issue regarding the impact on the training of medical students and junior doctors. The statement also flags that the introduction of these roles widely across the healthcare system would be a complicated process that may lead to major disruptions and significant community concern if it is done without proper planning and consultation.

In early 2025, the RACP published a media release which reiterates some of the key points from the October 2024 statement.

RACP is currently developing a binational position statement on PAs (due for publication later in 2026).
Any consideration of the PA role requires much work and consultation with stakeholders before implementation or further roll out.

Need to change professional title

The terms “Physician Assistant” and “Physician Associate” are misleading and inappropriate in the Aotearoa New Zealand context.

“Physician” denotes a medically qualified specialist who has completed advanced training and is recognised as such by the relevant regulatory body.

The term ‘physician assistant’ originated in the United States, where the term ‘physician’ is used more broadly than in Aotearoa New Zealand, for example, ‘family physicians’ in the United States perform a similar role to general practitioners in Aotearoa NZ.

The work of PAs in Aotearoa New Zealand has been focused on primary and emergency care settings. That work does not generally involve physicians or physician trainees delivering care in those settings (with the exception of emergency physicians). This means PAs are practising in settings where the term ‘physician’ is not commonly used nor appropriate for those providing care. Instead, patients are seeing a broad range of professionals, ranging from general practitioners, through to nurses and nurse practitioners, and a wide range of allied health professionals.

The practice of Physicians and Physician trainees generally involves a referral or request (usually by a GP or hospital doctor) for a specialist consultation, or those primary health or emergency care professionals working collaboratively with physicians or trainees. The physician or trainee does not deliver primary or emergency care. This is very different to how PAs work in those settings, or elsewhere overseas.

In overseas settings, PAs can be used in surgical settings where the term ‘physician’ is rarely, if ever, used. If their role was to be expanded to surgical settings in Aotearoa New Zealand, further confusion would likely be created by incorporating the term ‘physician’ in their title.

In the minds of health professionals and communities, the practice of physicians and trainees is generally associated with the care provided in various physician specialties, not primary, emergency or surgical care.

Clearly, a broader term than ‘Physician’ is needed to accurately represent the range of contexts in which PAs may work and to avoid misleading impressions about the nature of their role.

Risks of adopting the international title include:

- Public misunderstanding of qualifications, including the risk that patients may believe they are being assessed or treated by a fully qualified medical practitioner or receiving physician speciality care.

- Confusion among healthcare teams.

- Potential compromise of informed consent and patient trust such as what occurred in the United Kingdom when managers rostered PAs on for medical roles at weekends when they were short of Medical Officers[2].

The RACP recommends the title of Physician Associate/Assistant should be amended to remove the term “physician” to avoid public and professional confusion, and the term “associate” should not be used; instead, titles should clearly reflect the supportive nature of the role and specify the clinical area of practice.

Recommended alternative titles, particularly those which encompass the breadth of settings where these roles could practice include:

- Clinical Assistant (with the speciality of the role in parentheses, e.g. Clinical Assistant – Emergency Medicine or Clinical Assistant – General Medicine).

- Medical Care Assistant.

- Health Practitioner Assistant.

- Assistant in Medicine.

Clear distinctions between professional roles are essential to maintaining patient trust and safety, The public must be able to understand who is providing their care, what qualifications that person holds, and where ultimate clinical accountability lies.

Scopes of practice

RACP notes that MCNZ is proposing a broad scope of practice that relies heavily on credentialing rather than tightly defined scope boundaries.

Experience from overseas [3] shows the role needs clearly defined areas of practice working alongside a senior clinician, for example in secondary care settings where there is direct clinical supervision.

[2] British Medical Association. BMA calls for independent investigation into hospital trusts replacing doctors with physician associates on medical rotas. [Internet]. United Kingdom: BMA, March 2024. Available from: BMA calls for independent investigation into hospital trusts replacing doctors with physician associates on medical rotas. - BMA media centre - BMA Accessed on 12 February 2025

[3] McKee, M, Vaughan, L. K, & Russo, G (2025). A continuous intervention to support the medical workforce: a case study of the policy of introducing physician associates in the United Kingdom. Human resources for health, 23 (1), 4 A contentious intervention to support the medical workforce: a case study of the policy of introducing physician associates in the United Kingdom | Human Resources for Health | Springer Nature Link (accessed 3 February 2026).

The College believes PAs should operate within a defined scope of practice. We feel the proposed scope is too broad and insufficiently prescriptive.

The RACP sees a clear need for a narrow, prescriptive scope of practice, especially during initial implementation.

The MCNZ need to outline specific tasks that PAs may and may not perform. Tasks reserved for physicians must include:

- Independent assessment and management of undifferentiated patients
- Performing complex procedural interventions
- Supervising medical trainees.

There is significant risk of creep of scope of practice putting the public at risk, especially in environments under workforce pressure. Clear frameworks are needed to report and address breaches of scope.

Qualifications for registration and to change scope of practice

There is currently no domestic training programme for PAs in Aotearoa New Zealand. This is particularly concerning in a context where we do not have established approaches for assessing comparability to necessary local competencies.

PAs arrive with varied overseas training, making assessment of competency even more difficult.

The credentialing processes proposed by MCNZ are time-based rather than competency-based and not sufficiently tied to clinical competence or local standards.

The required assessment should be competency-based, rather than time-based with a mandatory Aotearoa-NZ specific orientation and competency assessment. All PAs should be required to demonstrate competence in Aotearoa NZ systems, cultural safety, and Te Tiriti obligations.

Supervision of PAs

Supervision of PAs must be in-person, continuous, and by a vocationally registered doctor. There must be absolutely not be any remote supervision.

The RACP notes that there are no limits on the number of PAs a doctor can supervise – this could potentially open up to commercial models with one doctor and many PAs. This should not be allowed to occur.

Supervision of PAs must not fall to trainees (registrars or residents). Consultant-level oversight is required, with protected time (minimum 0.25 FTE per PA supervised).

Supervision burden includes ongoing clinical oversight, escalation pathways, and documentation. Effective supervision would also require doctors to understand the PA role, scope of practice, and expected level of competence – an additional cognitive and administrative burden not currently accounted for in workforce planning. These burdens cannot be imposed without careful consideration of workforce capacity, potential adverse

impacts on wellbeing and consequent flow on effects for workforce sustainability and healthcare delivery.

The medico-legal implications of PA supervision require careful consideration. Supervisors must have defined legal accountability and indemnity/insurance. MCNZ must clearly define who is legally responsible for PA clinical actions. This is critical to ensure there can be no inappropriate allocations of responsibility or 'gaps' in insurance cover.

RACP request that MCNZ define:

- Supervisor workload thresholds
- Supervision capacity considerations
- Prohibition on delegation to junior doctors
- Supervisors' responsibility to prioritise vocational trainees ahead of PAs.

There are concerns that PAs may reduce training opportunities and degrade environments for RMO and vocational trainee development. PAs must not replace doctors in training roles or reduce exposure to core procedures, initial patient assessments or complex decision-making experiences.

In rural and regional settings or resource-constrained settings, it is imperative that any use of PAs does not impose additional burdens on supervisors or reduce physician training opportunities that are critical for developing and sustaining the necessary specialist workforce in those settings.

Impact on inequities

The RACP warns that increasing PA numbers will likely see them deployed to the most under-resourced areas, including those with significant Māori populations, further increasing inequity.

Deploying PAs in rural or regional settings or in Māori or Pasifika communities may create a two-tiered health system, delivering lower-standard care to already underserved populations. PAs have shorter training periods compared to doctors. In high-complexity rural settings, this may result in delayed diagnoses, fragmented care, and poorer outcomes for patients with chronic or multi-morbidity conditions.

This undermines trust and reinforces systemic inequities. The challenge is compounded by limited supervision capacity: rural regions already face shortages of senior doctors, and introducing PAs without strong oversight frameworks risks unsafe clinical practice and accountability gaps. Clear supervision ratios, rural safeguards, and transparent governance are essential to prevent this outcome.

Impact on Māori Health and Equity

Introducing PAs into rural and Māori communities may appear to address workforce shortages, but it risks deepening structural inequities if not carefully designed. These concerns are underscored by the findings of Wai 2575 Health Services and Outcomes Inquiry, which confirmed that the Crown breached Te Tiriti o Waitangi obligations by failing to actively protect Hauora Māori as taonga. Any regulatory or workforce initiative that does not uphold the principles affirmed in the Wai 2575 Report , tino rangatiratanga, equity,

active protection, options, and partnership risks perpetuating these breaches and undermining Māori health rights.

Impact on Māori Workforce Development

Heavy reliance on overseas-trained PAs is expected because Aotearoa currently has no domestic PA training pathway. Recruitment is focused on experienced PAs from countries where the profession is well established, such as the United States and United Kingdom. Aotearoa is likely to receive an influx of PAs from the United Kingdom given the rollout of them there has been fraught and many have lost roles and are facing unemployment uncertainty.

This approach may divert investment and attention away from pathways for Māori clinicians, including medical students, registrars, and allied health professionals. It conflicts with long-term goals of building a sustainable, Māori-led health workforce and undermines tino rangatiratanga in health.

Regulatory Design – Key Considerations

Regulatory design must embed Te Tiriti o Waitangi obligations and prioritise Māori health protection. Key considerations include mandatory cultural safety standards with annual audits, clear scopes of practice and prescribing limits, and robust supervision requirements with rural safeguards.

Equity monitoring is essential to prevent two-tier care, alongside strategies that align with Māori workforce development and recruitment. Accreditation processes should distinguish local and overseas qualifications, supported by recertification and competency audits. Strong clinical governance, transparent communication with whānau, and clear complaints pathways are critical for safety. Deployment models must involve Māori providers, avoid scope overlap with existing professions, and ensure alignment with Pae Ora principles to uphold equity and Māori-led care.

Cultural safety requirements

Cultural safety, cultural competence, and Hauora Māori must be central to the regulation of PAs in Aotearoa New Zealand, especially given that all PAs will have trained overseas and will not have been educated in Te-Tiriti based or kaupapa Māori health contexts.

The current cultural safety expectations are unclear. Who will assess a PAs cultural competence? How will cultural safety be enforced across varied training backgrounds? A clear framework for cultural safety expectations is needed as well as clarity on who will assess a PA for cultural safety competence.

The regulatory framework should draw on established Māori-led examples such as Kawa Whakaruruhau from the nursing sector, which illustrate how mātauranga Māori, tikanga, whānau engagement, reflective practice, and accountability can be embedded into professional standards for safe and equitable care.

Annual cultural safety standards should be mandatory and assess real-world interactions with Māori patients and whānau, integration of Hauora Māori models, reflective analysis of bias, and clear evidence of Te Tiriti obligations guiding clinical decision making. These

audits should be Māori led to ensure culturally valid, consistent, and accountable evaluation processes.

To maintain registration, PAs must demonstrate competence in kaupapa Māori practice, including cultural humility, whānau centred care, understanding of structural determinants of Māori health, and the appropriate application of tikanga and mātauranga Māori within clinical contexts.
The regulatory framework must also ensure that Māori clinicians and junior doctors are not burdened with providing cultural supervision or informal training. We need to avoid displacement of cultural teaching responsibilities onto junior doctors or Māori health professionals, diverting them from critical clinical and supervisory responsibilities, and risk unsustainable burdens with consequent adverse impacts on their wellbeing.

Māori health professionals already carry disproportionate cultural labour, and it is essential that responsibility for PA cultural safety training and assessment is clearly assigned, properly resourced, and structurally supported to avoid further inequity.

Next steps

The RACP is of the view that the Council should take a slow and cautious approach to the regulation of PAs, that incorporates careful evaluation and assessment.

The RACP thanks Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand for the opportunity to provide feedback on this consultation. We would welcome further conversation about this important work.

To discuss this submission further, please contact Tanya Allen at the RACP's Aotearoa NZ Policy and Advocacy Unit at policy@racp.org.nz.