

16 February 2026

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Via email: consultation@MCNZ.org.nz

Tēnā koe Joan,

The Council of Medical Colleges | Te Kaunihera o Ngā Kāreti Rata o Aotearoa (CMC) is writing to provide feedback to the Medical Council of New Zealand (MCNZ) on its proposals for the regulation of physician assistants / physician associates (PAs). This submission represents the majority view of the Council of Medical Colleges.

The Council of Medical Colleges acknowledges the Council's work in developing this consultation. While our [2025 Position on the Regulation of Physician Assistants](#) maintains that existing regulated professions could perform tasks delivered by PAs, we recognise that regulation will proceed. Our submission focuses on ensuring patient safety through a robust framework that reflects the unique contexts of Aotearoa New Zealand's health system. In particular, we submit that:

- Greater emphasis is needed on the cultural safety requirements of a workforce that is solely overseas-trained and is unlikely to have had much experience in caring for Māori and Pacific patients.
- The scope of the work of PAs is not sufficiently defined, and tighter language is needed to make clear the roles of PAs in diagnosis, delegated prescribing and their area of vocational practice.
- At least to start with, regulation should not allow PAs to work in situations in which they are the only practitioner that patients may see in acute and urgent care situations.

The following sections provide further detail about these concerns. Individual Colleges have also collected feedback from their members, and we collate some of the issues raised by those members at the end of this submission.

1. Greater emphasis is needed on the cultural safety requirements of a workforce that is solely overseas-trained and is unlikely to have had much experience in caring for Māori and Pacific patients

CMC's *Position on the Regulation of Physician Associates* states that "regular professional development must include cultural safety and cultural competency training".

At least initially, the PA workforce will be solely overseas-trained and CMC has a serious concern about the ability of the workforce to meet the needs of Māori and Pacific patients. Cultural safety expectations and training will be vital in ensuring that PAs are able to deliver safe and clinically appropriate care. Our view is that while section 4 of your proposal appropriately emphasises the importance of cultural safety, the requirements and support for cultural safety training are not strong enough. Further, we are concerned that these expectations are not visible enough through the remainder of the document and that taking the step up from provisional to

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general scope should be dependent on demonstrating competence in this (and other) areas of skills, knowledge and expertise.

Requirements and support need to be strengthened

Undergraduate and vocational medical training in New Zealand appropriately incorporates high-quality cultural safety requirements, and provides doctors-in-training 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.

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, in an environment of workforce limitations and high patient demand, employers and supervisors will be limited in the support and guidance that they can provide. We submit that in such circumstances, external support is needed, especially during the provisional registration period.

We refer the Council to CMC’s [Cultural Safety Kete](#). 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, that incorporates didactic and peer group learning alongside self-directed learning and self-assessment. Importantly, responsibility for delivery needs to sit with the Council or a provider approved by the Council for this purpose.

Expectations should be more visible

We are also concerned that, section 4 aside, the importance of cultural safety requirements are not visible enough through the rest of the proposal. In particular, these expectations need to be woven through the sections on supervision, and the descriptions of the role of the employer and supervisor.

Progression from provisional to general scope

Progression from provisional to full registration is proposed to be time-based, when our preference would be that it is competency based. We are also concerned that 6 months practice is too short a time to assess whether a provisional PA is ready to progress to the general scope of practice. Our concern about the time-based and short period of provisional registration is particularly sharp when it comes to the importance of ensuring that an overseas-trained practitioner appropriately develops cultural safe practices and is assessed to meeting expectations in this regard.

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2. The scope of the work of PAs is not sufficiently defined, and tighter language is needed to make clear the roles of PAs in diagnosis, delegated prescribing and their area of vocational practice

The UK experience has demonstrated that the PA role needs clearly defined areas of practice¹ and CMC's *Position on the Regulation of Physician Associates* states that a PA's "scope of practice [should reflect] competency, skillset and clinical practice setting" and "roles and positions [should be] well-defined".

The Council proposes to define the scope and role of PAs through a combination of scopes of practice and credentialing. While this approach seems to strike a sensible balance, we are concerned that some of the language used is insufficiently tight and inconsistent with CMC's position. This may lead to confusion, scope creep and unsafe practice.

Role of the PA in diagnosis

One area of particular concern is that both the Provisional PA and General PA scope of practice include the statement that a PA may "under supervision, contribute to diagnosis...". This phrasing is confusing, and it is unclear whether the expectation is that a PA may give advice to a colleague to help inform that colleague to make a diagnosis, or whether it is the PA who will take primary responsibility for making the diagnosis. The Council's expectation here needs to be explicit.

Role of the PA in prescribing

Similarly, the proposal is not clear on the ability of PAs to prescribe medicines. Section 1 includes a statement that the "scopes of practice do not include reference to prescribing" and that prescribing rights are set out in the Medicines Act 1981. Is the Council's intent here to communicate that PAs cannot prescribe medicines? Because the proposal does not explicitly preclude PAs from prescribing under a delegated authority. Our view is again that the Council's expectations need to be explicit.

Role of the PA in ordering tests

Again, the draft scope is vague on what sort of testing PAs will be able to order. The term "relevant testing" could be interpreted to include both high-risk and high-cost tests, along with most pathology, radiology, microbiology, transfusion, genomics and screening tests. We are concerned that this will create a risk of unnecessary or irrelevant tests being ordered, creating higher health system costs and putting additional strain on already stretched pathology, radiology and laboratory services. More explicit parameters are needed, ideally developed in partnership with relevant Colleges.

Vocational scope / area of practice

The supervision requirements make clear that a PA "...must have a Council-approved primary supervisor who is vocationally registered in a scope of practice relevant to the PA's area of practice." The implicit expectation here appears to be that the PA's practice is limited to that same area of practice / vocational scope, but that is not made explicit within the wording of the scope. CMC's view is that both the provisional and general scope of

¹ McKee, M., Vaughan, L. K., & Russo, G. (2025). A contentious intervention to support the medical workforce: a case study of the policy of introducing physician associate associates in the United Kingdom. *Human resources for health*, 23(1), 4. <https://doi.org/10.1186/s12960-024-00966-1>

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practice for PAs should include reference to the supervisor’s vocational scope, and a statement that the PA’s scope is limited to that same area of practice.

3. At least to start with, regulation should not allow PAs to work in situations in which they are the only practitioner that patients may see in acute and urgent care situations

CMC’s *Position on the Regulation of Physician Associates* states that PAs should not be practising in urgent care or general practice settings. Our view is that PAs should (initially at least) be working as part of a large, well-resourced multi-disciplinary team with strong supervision capacity and team-based practice structures. This view is informed by the perspective that PAs are untested, and that urgent care and general practice are areas of heightened risk given that:

- a. workers in these environments are often the only practitioner that a patient will see; and
- b. these are areas of high patient demand and acute need.

Acute mental health and after-hours care are fields that present the same risks.

It may be that in the future PAs will come to play an important and useful role in these settings. However, because of the heightened risk in these areas our view is that the Council should take a cautious approach to test and evaluate the effectiveness and safety of PAs in more supported environments first.

4. Other feedback

Individual Colleges have sought feedback from their members, and this feedback was discussed at a CMC Policy meeting on 29 January 2026. We collate some of the concerns raised at that meeting below:

Concerns about the current proposal

- The term “physician” in the title should be removed, as this will create public and professional confusion, and “clinical assistant” is preferred.
- Supervision requirements will put further burden on a senior doctor workforce that is already stretched, and exposes them to legal risk.
- There are concerns that there may be situations where legislation may impact on the ability of PAs to practice. For example, there are legal restrictions on who can issue medical certificates and provide some mental health services.
- Council will need to educate both the public and doctors about the role, training and background of PAs.
- The onsite supervisor should always be a vocationally registered doctor
- While ACLS training is important and a baseline for safety, it should not be regarded as a reflection that a PA has the competence to perform a full range of procedures.
- The scope should not include excision of skin lesions and cutaneous cysts, or punch biopsies.

General concerns about the introduction of PAs into an already crowded system

- One of the rationales for introducing PAs is that it will allow doctors to practice at the top of their scope all of the time. However, this may lead to burn-out.
- There are also concerns that the introduction of PAs will lead to further fragmentation of patient care, and information being missed at the point of diagnosis.

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- The introduction of PAs may negatively impact on medical training environments, by creating competition for supervision, training opportunities and building clinical experience.
- The introduction of PAs may divert funding away from existing valued professions, such as nurses, nurse practitioners and paramedics.
- The introduction of PAs presents risks of over-treatment and over-referral, because differences in training and clinical experience may influence thresholds for investigation and referral.

Conclusion

The CMC view is that the Council should take a slow and cautious approach to the regulation of physician assistants, that incorporates careful evaluation and assessment. We would welcome the opportunity to be further involved and to provide additional feedback as new processes and policies are embedded and reviewed.

Thank you again for the opportunity to comment. If you have any questions or concerns, please do not hesitate to reach out to Michael Thorn at Michael.thorn@cmc.org.nz.

Nāku noa, nā



Dr Samantha Murton

Chair
Council of Medical Colleges

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