# NZRDA submission on Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand's Consultation on regulation of physician associates/assistants

16th February 2026

Thank you for the opportunity to submit on Te Kaunihera Rata o Aotearoa Medical Council of New Zealand's consultation on the regulation of physician associates/ assistants.

The **New Zealand Resident Doctors' Association (NZRDA)** represents 3,000 resident doctors (referred to as Resident Medical Officers 'RMOs') in Aotearoa New Zealand. We are the largest and most experienced RMO union: run by RMOs for RMOs since we were founded in 1985. Our membership is spread across all specialties including ED, ICU, paediatrics, pathology, radiation oncology, psychiatry, public health, obstetrics and gynaecology, general practice, and paediatric surgery, at house officer and registrar level.

Too often, submissions from organisations such as ours are seen as a single submission. We urge the Medical Council to resist this view: our submission comes from consultation with our membership, as we say comprising over 3,000 registered medical practitioners in New Zealand. Appropriate weight should be given to our collective views.

## Background to our submission

We are reassured that Council's main focus remains patient safety and public confidence in the care they receive. This continues to remain our primary concern with the regulation of this clinical assistant* workforce and serves as the lens for our submission.

Regulatory settings must be proportionate to the nature and level of risk posed, which for this group, has been shown to be high. While clinical assistants might be an established workforce in the US and UK, we must be cautious about duplicating models of care shaped by very different regulatory pressures and economic incentives. Our health system continues to deliver better patient outcomes than both of these countries, particularly in terms of avoidable mortality rates.[1] It is of utmost importance that we maintain this standard. Improper regulation of clinical assistants must not be allowed to undermine this safety record.

Our position on the five key consultation aspects is detailed in the relevant subsections and summarised briefly in the table overleaf.

*This is our recommended term for this workforce, as discussed in section 5 of our submission.

**Table 1. RDA summary position on key consultation aspects**

| Consultation aspect | Position | Core reasoning |
|---|---|---|
| Scopes of practice | Oppose as drafted | Risk of 'taskification' and lack of explicit exclusions on practice. |
| Qualifications | Oppose expedited 'NZ experiential' pathway for general registration | Variability in overseas training and assessment poses too great a risk in the absence of an accreditation framework. |
| Supervision | Support with key revisions | Must be onsite, SMO-led, and capped. |
| Cultural safety | Support in theory | Absence of detail makes it unclear what is being proposed. |
| Proposed title | Strongly oppose | Any link to the 'physician' title will cause public confusion and safety risks. |

## 1. Scopes of practice

We generally support a 'two scope' graduated pathway from provisional into general registration, but we have significant concerns with the list of activities included – and those not explicitly excluded – within these scopes. For one, the proposed scope reads exactly like the scope of a doctor – despite the significant shortcomings (in breadth and depth) of clinical assistant training.

We also have concerns with the 'taskification' of medical practice evident here: the outsourcing of seemingly discrete tasks to less qualified or skilled workers. This "decouples the technical knowledge from the clinical knowledge and professional qualities needed to use procedures appropriately and safely in clinical care". It overlooks how well a task is done as opposed to whether it is completed,[3] and has been implicated in UK Coroner reports linked to clinical (physician) assistant actions.[2]

In the table overleaf we outline our position on Council's proposed list of in-scope activities, followed by a recommended list of exclusions. This is aligned with the original intention of the role to "support doctors with administration tasks and [a] defined range of low-risk clinical tasks".[4]

**Table 2. RDA position on Council's proposed list of in-scope activities for clinical assistants.**

| Activities | Our position |
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| Offer health assessments | The term 'health assessment' is so broad as to include relatively low risk checks (e.g., blood pressure, cholesterol) through to higher risk, complex assessments of mental health – the latter being entirely inappropriate for clinical assistants.<br><br>**Recommendation:** Clarify the type of low-risk health assessments that can be included in scope |
| Take detailed patient histories and perform physical examinations | Physical assessments and taking detailed patient histories are specialised skills contributing to around 80% of the diagnostic process.[5] The ability to take a focused history is especially important given our nation's high incidence of comorbidities and chronic conditions, as well as the fact that many illnesses don't present in straightforward way. Allowing clinical assistants to perform these tasks creates significant risk for the doctors who must then take responsibility for a patient already "worked up". It also detracts from training these essential skillsets in RMOs.<br><br>**Recommendation:** Exclude clinical assistants from undertaking patient histories and performing physical examinations for any undifferentiated patients (discussed later) |
| Order relevant diagnostic tests | Clinical assistants should not independently order diagnostic tests. Evidence consistently shows this group practices defensively, but overcautiousness is a poor substitute for clinical expertise. Data from the US indicates a 441% increase in X-ray ordering and double the number of biopsies compared to doctors.[6] This adds inappropriate demand on our diagnostic services, increases costs, and can lead to iatrogenic consequences.[7-9]<br><br>This also underscores the fact that in healthcare, 'any' pair of hands will not do. If the plan is to fill gaps in our health system with clinical assistants, but that 'filled' gap then creates more costs, generates a greater resource burden (including clinician time, inappropriate referrals, delayed patient appointments) and adds significant risks to patients – including the risk of substandard care and inappropriate management requiring further clinical encounters, what is the point of having this workforce?<br><br>Therein lies the challenge of trying to reverse engineer a scope of practice for a group of workers that do not offer a unique skillset or value add to the system.<br><br>**Recommendation:** Exclude clinical assistants from independently ordering diagnostics |

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| Under supervision, contribute to diagnosis and the development and implementation of appropriate treatment and management plans | Although the consultation document does not speak to this, clinical assistants should have no role in initial diagnosis and seeing undifferentiated patients (see discussion below). Their involvement in post-diagnostic patient care would be appropriate – specifically, the implementation of ongoing treatment and monitoring of diagnosed patients, after having been first assessed by a doctor, and under supervision.[10] |
| | **Recommendation**: Exclude clinical assistants from initial diagnosis and seeing undifferentiated patients |
| Offer health promotion and disease prevention advice | It may be appropriate for them to offer health promotion and disease prevention advice, although many practices already employ Health Improvement Practitioners and other professions specifically trained for this work. |
| Undertake relevant non-patient contact activities | We support this only if defined as administrative tasks (e.g., care coordination). Referrals to other providers, specialists, or secondary care must be restricted until clear guidance is established by external agencies (e.g., ACC, Work and Income, Oranga Tamariki). |
| | **Recommendation:** Clarify what is meant by 'non-patient contact activities' |
| Perform the listed minor surgical procedures in low- risk clinical situations | We strongly oppose permitting clinical assistants to undertake the listed (or any) minor surgical procedures. |
| | **Recommendation:** Exclude this activity |

In addition to our views on the above, Council must also specify clear exclusions by introducing a 'ceiling' on the scope of practice. We recommend clinical assistants should not be permitted to:

- **Diagnose or see undifferentiated patients.** The Leng Review was conclusive that this workforce is "underequipped" to recognise clinical complexity and uncertainty, and to manage undifferentiated morbidity.[11] Physician assistant educators in the US have also identified differential diagnostic skills as a current deficit in education programs.[12]
- **Independently determine admission or discharge plans** in secondary care, without the direct supervision or direction of their primary supervisor.
- **Undertake supervision themselves.** This was a common occurrence during the local pilots with the two clinical assistants participating in the training of fourth- and fifth-year medical students.[13] Representatives of the New Zealand Physician Associates Society also continue to claim this workforce "offers an added teacher for nurses and junior doctors".[14] They are not qualified medical practitioners, let alone qualified to teach or supervise actual medical practitioners.

We also recommend including under 'core requirements' that clinical assistants **must stop consulting with patients immediately**:

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

Finally, while Council acknowledges the potential for future development of extended scopes of practice in specialty areas, until this work has been completed, we recommended this workforce is **excluded from working in high-risk specialties** (e.g., surgery, emergency department, psychiatry and mental health). Unlike with doctors, no additional speciality-specific training is required for clinical assistants and very few such programmes are on offer. This leaves the door open for inappropriate credentialling mechanisms, inadequate supervision controls, and scope creep; all carrying significant patient safety risks.

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

We oppose an expedited (i.e., the New Zealand 'experiential') pathway to general registration. Our issue is not length of local experience, but the nature and quality of overseas training.

Training quality varies vastly; some US institutions have recently lost accreditation while UK training has only recently become regulated.[15,16] Claims of training in the 'medical model' are also greatly exaggerated. Many who have since transitioned into medicine retrospectively reflect on significant knowledge gaps, lack of awareness around their own limits, and fears around being a safe clinician in complex clinical settings.[17-19]

The variability in entry requirements – including programs in the UK admitting non-science backgrounds and some in the US allowing a 'pre-professional' phase open to high school graduates – means there is no guarantee of foundational knowledge.[20,21]

Assessment quality also remains questionable, requiring either one structured clinical examination (PANE) or no practical assessment of clinical skills at all (PANCE).

Until Council defines accreditation standards to compare overseas training, we cannot conflate procedural or contextual familiarity with genuine clinical competence or medical acumen.

**3. Supervision**

Since clinical assistants are and will always be dependent practitioners, the nature of the supervision relationship is one of direct instruction.[22] As such, the primary supervisor must be present and overseeing practice in real time to ensure patient safety. This has shaped our position in response to Council's proposed supervision framework, summarised in the table overleaf.

## Table 3. RDA position on Council's proposed supervision framework

| Proposed supervision aspect | Our position |
|---|---|
| The delegation of supervision across 'primary', 'onsite', and secondary 'offsite' supervisors | While we are not entirely opposed to the idea of delegating supervision if the primary supervisor is unavailable, aspects of what have been proposed need further clarification. This includes the distinction between 'primary' and 'onsite' supervisor (and the responsibilities each entail), as well as any specific responsibilities that sit with a secondary 'offsite' supervisor. It is also worth noting that if a significant amount of supervision is being delegated to an 'onsite' or secondary 'offsite' supervisor, they will also need specific training in supervising clinical assistants.<br><br>**Recommendation:** Clarification of above terms. |
| Under the general scope, a suitable senior level general medical registrant (a Medical Officer or a doctor who has 7 or more years' relevant experience in the area of practice) can be used to supplement an offsite primary supervisor | Strongly oppose. Supervision must only be assigned to a vocationally registered doctor / SMO and should never be delegated to an RMO. This includes not signing off on requests for prescription or diagnostic tests.<br><br>If the primary or delegated supervisor is immediately unavailable, clinical assistants must halt their practice rather than transfer risk to other practitioners. If a practice is unable to provide the level of supervision and resourcing required to hire a clinical assistant, it would indicate they are being employed inappropriately to fill workforce gaps.<br><br>**Recommendation:** Framework must explicitly state supervision cannot be delegated to a RMO or other non-SMO practitioner. |
| Clearer definition of onsite supervision | Current specifications are contradictory in requiring 'onsite' supervision to mean the supervisor is "available to attend the facility promptly, if required". This suggests that primary supervisors may be off-site and may provide supervision remotely (i.e., "attend... if required").<br><br>We oppose any suggestion that supervision requirements can be relaxed to the point of occurring remotely or retrospectively. This would essentially mean clinical assistants are working independently, which would be inappropriate given the limits to their training and competencies. Instead, clinical assistants should never be recruited to shifts that do not have this supervisor physically co-located onsite.<br><br>**Recommendation**: Clarify 'onsite' supervision to mean physical and temporal colocation during work, and that the primary or delegated supervisor must be immediately available to provide support for clinical assistants. |

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| Requirements to "recognise when to seek assistance and input of a vocationally registered doctor" | Given all clinical assistants are dependent practitioners, even in the general registration scope, it's unclear why a clinical assistant would not immediately consult with their primary or delegated supervisor, seeking instead the input of another vocationally registered doctor. It's also unclear where the clinical responsibility lies if a clinical assistant consults with or seeks the input of a non-supervising doctor. |
| | **Recommendation:** Our suggested changes to scope of practice (inclusions and exclusions) and the above recommendations on supervision make this provision redundant. We suggest it is removed to avoid confusion. |
| No limit on supervision capacity | We are concerned by Council's position on not imposing a supervision limit for clinical assistants. Having a high number of supervisees thins out the level and quality of supervision for clinical assistants and any RMOs in training, while introducing a higher level of clinical risk. SMOs have already raised these concerns themselves.[23] The risks are even higher once clinical assistants become fully registered and are no longer required to be supervised under a Council-approved plan, meaning supervision load can become influenced by employer's economic incentives. |
| | **Recommendation:** Introduce a supervision cap on clinical assistants as an additional safeguard for patients and for the sustainability of our medical training pipeline. |

Our view on **credentialing** centres on having an appropriate scope of practice with clear ceilings on permitted activities. This prevents clinical assistants from being deployed to undertake inappropriate or high-risk activities (e.g., seeing undifferentiated patients).

However, the inherent economic interests of the employer present a bigger risk. Some have already been vocal about their intent to expand use of this workforce, including in covering a 24/7 emergency service. Caution is therefore vital.

The Ministry of Health notes in its own *Credentialling Framework for New Zealand Health Professionals* that "to date there is little documented evidence of the effectiveness of credentialling",[24] so to leave this entirely to employers is a high stakes gamble that invites inconsistency, even among the well-intentioned.

The reason credentialling and privileging works in jurisdictions like the US is because there are other independent national certification bodies and state regulatory bodies/medical boards to establish competence and legal permission and serve as critical checks against employer conflict of interest. In these systems, employers are only performing a 'final' check. Without a standardised accreditation framework and given this is an entirely overseas-trained workforce, devolving credentialling responsibility to the employer creates a dangerous conflict of interest.

**Recommendation:** Until an appropriate accreditation framework is in place, the responsibility for credentialing should rest with Council, in collaboration with any relevant colleges as required.

**4. Cultural safety requirements**

It is difficult to provide feedback on this aspect without knowing exactly what the theory-based cultural safety course entails. There is also the matter of collegial support to acculturating clinical assistants to their local community context. For comparison, international medical graduates receive at minimum six months of collegial support. This is another resource that will need to be carefully managed.

In addition to Hauora Māori, another important element of cultural safety is the medical culture itself, which encompasses the nuances of how our medical system operates and the dynamics within medical teams. This too impacts patient safety and clinical assistants will need sufficient time to become socialised into this culture.

**5. Title for scopes of practice**

We acknowledge Council's continued reference to this group as "health professionals" rather than "medical professionals", and we are of the same view. In line with this, we do not think either of the proposed titles (physician assistant or physician associate) are appropriate. Ongoing claims by this workforce that they are "medical professionals" and they "practice medicine" boldly toe the line of legality, with the intention of misrepresenting themselves as doctors.[25] Indeed, Council is clear in defining 'the practice of medicine' as "assessing, diagnosing, treating, reporting or giving advice in a medical capacity, using the knowledge, skills, attitudes and competence initially attained for the **MB ChB degree** (or equivalent) and built upon in postgraduate and continuing medical education, wherever there could be an issue of public safety."[26] Any reference to the 'physician' title would therefore imply that a two-year PA training programme is "equivalent" to the foundational, specialised, and continuing medical education a doctor undertakes.

Most health professionals, let alone members of the public, would be hard pressed to distinguish between a 'medical practitioner' (a protected title) and a 'medical professional'. It is not hard to envision this resulting in inappropriate requests, referrals, or delegations from others in multidisciplinary teams, with potentially disastrous consequences for patients. Pursuing the line of 'physician associate/assistant' would only reinforce this entanglement with actual doctors.

The title of physician assistant itself has been implicated in widespread confusion internationally. In the US, where this profession has a decades' long history, a quarter of patients incorrectly believed they were doctors or were unsure about the difference.[27] Even in the UK, where the role has been established for nearly two and half decades, one in four members of the public still believed they were doctors.[28] Locally, patients and our own RDA members have relayed numerous instances where they believed they were consulting or speaking with a doctor instead of a clinical assistant. Setting aside intent, since the title is the main source of confusion, changing it is the most logical solution.

Scope should drive title, not the other way around. There is no compelling evidence that warrants use of either the 'physician associate' or 'physician assistant' title locally. Removing any link to the 'physician' title does not impact the quality of practice or patient outcomes. On the other hand, the continued use of the 'physician' title has been shown, and will continue, to cause harm to patients.[12] If this is truly about prioritising patient safety, the title must fully change.

We suggest ‘clinical assistants’ would be more appropriate. It is sufficiently distinct from medical practitioners, while also reflecting the nature of the role as being supportive rather than one of an independent practitioner. This is also consistent with other newly implemented professions in Aotearoa such as Psychology Assistants who have a postgraduate diploma qualification; who provide low- to moderate-level support in assisting but not replacing the role of Psychologists; and who are supported by clear supervision models.

Finally, in addition to providing clarity around the scope of practice and title, we recommend Council prepares clear communications to increase public awareness on what the role is, and how it differs from other well-established and trusted professionals they may already be familiar with – especially in the general practice and community setting.

**Recommendation:** Implement the title of ‘clinical assistant’ for this new-to-Aotearoa workforce.

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