NZRDA submission to Medical Council consultation:

Professional standards for physician associates (PAs)

16 July 2026

Thank you for the opportunity to provide feedback on the Draft Professional Standards for physician associates (PAs).

The **New Zealand Resident Doctors' Association (NZRDA)** represents 3,000 resident doctors ('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.

General feedback

It is essential that Council, as the regulator of PAs, ensures these professional standards are robust and unambiguous to minimise the risk of avoidable patient harm, or in the worst cases, patient death. We have several examples of lived experiences from RMO members who can attest to issues with PAs providing incorrect treatment or failing to clearly identify themselves as physician associates to patients and other doctors, including when making referrals. Even as we submit this feedback, the professional body continues to publicly misrepresent the role by claiming that PAs can practise without an onsite doctor and undertake activities such as prescribing and diagnosing that fall outside Council's mandated scope. We urge Council to take a firm and proactive stance – before it is too late – by requiring PAs to clearly identify themselves as physician associates, and explicitly state that they are not doctors, in all interactions and communications. Council should also restrict the use of titles and terminology, including 'medical professional', that may create confusion about a PA's qualifications, role, or scope of practice.

Relatedly, Council must also consider how these standards interact with those for medical practitioners. For instance, the Medical Council statement on *Informed Consent: Helping patients make informed decisions about their care* notes that "the doctor undertaking the treatment is responsible for the overall informed consent process" but how will this now intersect with a physician associate's duty to disclose their own title, scope, and competence? If a patient is misinformed or confused about who is treating them, then the overall consent process is compromised. Council must explicitly outline delegation of care (by the supervising doctor) and liability so that in these scenarios the ultimate legal and clinical responsibility does not unfairly fall on supervising doctor or other clinicians.

Specific feedback

Introduction

Where the Introduction states these standards apply to "all PAs", we suggest this explicitly clarifies "all PAs practising in Aotearoa New Zealand under both provisional and general scopes".

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2. Safe practice

Section 2a requires PAs to "recognise when to seek the assistance and input of a doctor, and when to refer to another health practitioner". This pathway must be restricted to their designated supervising doctor. Allowing PAs to bypass their supervisor and refer directly to other health practitioners is clinically dangerous. Other doctors and practitioners may be entirely unfamiliar with the individual PA's scope, specific credentialling, or the patient history. This is a huge clinical risk for another doctor to then take on a patient who may have been 'worked up' by a PA.

Our recommendation: "Recognise when to seek the assistance and input of ~~a doctor, and when to refer to another health practitioner~~ your supervising doctor."

3. Good communication and informed consent

PAs must communicate to patients their title, role, and non-doctor status with absolute clarity and no room for misrepresentation. We recommend the following amendments:

- Amend section 3b to ensure PAs "clearly identify yourself as a physician associate and explicitly identify that you are not a doctor" and communicate this to "patients, any whānau/family present during the consultation, and the public"
- "~~Avoid~~ Never use words or language that could cause confusion about your qualifications, profession, skills, or experience"

We also urge Council to include a dedicated section on the use of titles, specifying a list of terms that PAs must never use in referring to themselves or their scope. This must include "doctor", "physician", "medical practitioner", "medical professional", "registrar", "resident", "consultant", and "specialist".

This is especially important given the Minister's decision to proceed with the use of the 'physician associate' title despite evidence of its links to public confusion, patient harms, and avoidable deaths. The UK is currently consulting on extensive corrective work to remedy this confusion by proposing a list of prohibited and protected titles. We must learn from these failures and implement these safeguards from the outset.

4. Collaboration

Part of respectful and collaborative working in health care teams includes recognising and respecting the roles of other members within the team. We suggest the addition of the following:

Section 4a. "You must recognise and respect the roles, responsibilities, and qualifications of other members in the health care team."

5. Professionalism

We recommend the following amendments:

Section 5d. "Declare up front and manage conflicts of interest, and not allow personal, financial, or other interests to compromise patient care."

Section 5g. "Tell the Council, your supervisor(s), employer, and any person or organisation that has a reasonable expectation to know, about any matter (in New Zealand or overseas) that may affect your practice … Employers, your supervisor(s), and others you work with will ~~generally~~ need to be informed if your ability to practise, or the scope of your work, is impacted by conditions or suspension."