ASMS
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

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Tēnā koe Rachelle

Toi Mata Hauora feedback on regulation of clinical assistants

Thank you for the opportunity to provide feedback on the regulation of physician associates/assistants (PAs) in New Zealand. Throughout this submission, we will sometimes refer to PAs as clinical assistants, which we consider a more appropriate title that better reflects the role.

The Association of Salaried Medical Specialists (ASMS) is the union for senior salaried doctors and dentists, representing over 6,000 members employed in New Zealand's health system. The clinical assistant role is designed to work under the close supervision of senior medical officers, making this consultation highly relevant to the ASMS. The PA scope of practice is dependent on the scope of practice of their supervising doctor, meaning successful implementation of the clinical assistant role relies on establishing confidence and trust within the medical profession.

Our members are aware of the significant problems that occurred with the rapid expansion of the PA workforce in the United Kingdom, which led to an overwhelming loss of confidence from the medical profession. This situation became untenable, prompting the UK government to commission the independent review led by Professor Gillian Leng. ASMS members have expressed significant concern that New Zealand is following in the footsteps of the United Kingdom and must be guided by the recommendations that have come from the Leng review to avoid making the same mistakes.

Unfortunately, many of the deficiencies identified in the Leng Review are already evident in New Zealand. This includes no national vision for how the clinical assistant role would be deployed within the existing system; legitimate concerns of the medical profession being ignored; and no consideration of how the clinical assistant role would be utilised in local level services. These deficiencies are largely the result of a poor policy process by the Ministry of Health, despite feedback from medical practitioner groups encouraging the Ministry to articulate a strategic, long-term view about what gap a new workforce would fill, and how it would work with existing craft groups within the health system.

New Zealand has an added challenge to the UK in that there are no PA training programmes available locally, and clinical competencies have not yet been defined in the New Zealand setting.

In this context, the ASMS considers regulation of clinical assistants in New Zealand must be approached carefully, with prescribed and clearly defined scopes of practice and in-person

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supervision by a named responsible vocationally registered doctor. This will require a number of elements in the Medical Council's regulation proposal to be strengthened and tightened– including the scopes of practice; registration pathways; and supervision arrangements for clinical assistants working in New Zealand.

We are aware that rapid expansion; poorly defined scope; lack of confidence with supervision arrangements; and growing evidence of patient-harm contributed to significant issues in the United Kingdom. Following the Leng Review, a number of UK-based training programmes have paused; employment opportunities for clinical assistants have tightened; legal action has been initiated against employers by physician associates; and physician associate groups have described the impact on their profession as devastating. This is an unfair situation for all involved and could have been avoided.

The UK scenario underscores that starting with wide and poorly defined scopes of practice that subsequently needed to be narrowed causes harm to patients, resident medical officers, and the PA profession itself. In New Zealand, we must begin with tightly defined scopes of practice and supervision parameters, with potential for expansion as local evidence on safety and efficacy of the role grows.

We urge the Medical Council to draw these issues to the attention of the Ministry of Health and Health New Zealand, and to recommend a programme of work to develop a national vision for deployment of the role. This must include what workforce issues clinical assistants might address; what resources would be required; the impact on the workforce training pipeline and working conditions for other practitioner groups; and what models of care would look like. Government departments must engage genuinely with medical practitioners across a range of services when developing this work.

Our members have also raised concerns about whether indemnity insurance will cover medical practitioners supervising clinical assistants, or clinical assistants themselves. We are also unaware whether the Accident Compensation Corporation accepts clinical assistants as health providers and will therefore cover any treatment injuries patients may incur. These issues must be resolved, clarified and communicated.

The ASMS has reviewed the Medical Council's proposed scope, registration pathways, and supervision requirements for the PA profession. Our feedback is attached as appendix 1.

We would also like to meet with you to discuss our feedback further. I look forward to hearing from your office about an appropriate time to meet.

Nā māua noa, nā

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Appendix 1: ASMS feedback on the regulation of clinical assistants

The ASMS has a number of concerns about the Medical Council's proposals for regulating PAs in New Zealand. Based on lessons from international jurisdictions, coupled with poor policy processes to date locally, and in the context that this is a new professional group in New Zealand, we consider:

1. The proposed scopes of practice must be more clearly defined and specify tasks that are included and excluded from the scope of clinical assistant practice.
2. The proposed registration pathways must include an assessment of clinical competence prior to general registration, rather than simply being time-based.
3. Supervision requirements need to be tighter for clinical assistants registered in the general scope, with a named responsible vocationally registered doctor included as an endorsement on the practicing certificates for clinical assistants.
4. Further clarity is needed on how cultural safety will be assessed, and who will provide induction and orientation.
5. "Clinical assistant" would be the most appropriate title for this role in New Zealand.

More detailed feedback is provided below.

1 Scope of practice

The Medical Council's proposed scope of practice for both provisional and general PA registrants is broad and requires substantial further definition, including a list of specific tasks that are included and excluded from the PA scope. Currently, the proposed scope reads more like a framework with actual scope definition devolved to the employer. Many issues that arose in the UK related to lack of defined scope, and employers being left to define scopes of practice. This led to unrealistic expectations for PA practice among a young cohort of practitioners, who are now facing reduced scopes following the Leng Review.

A clearly defined scope is particularly important considering clinical assistants are a new professional group in New Zealand; international evidence on safety and efficacy remains scant; there is no national vision for how the role will be deployed or utilised within services; and no local training programme with clinical competencies established for the New Zealand setting. A narrow, well-defined scope will support safe practice.

We have heard concerns from members who work with PAs in New Zealand that PAs have been deployed inappropriately to cover medical roles on medical rosters, despite not having the skill set to do so. Unless scopes of practice are crystal clear, practitioners with limited training may not recognise when they are out of scope and need to seek help.

Scope exclusions

Both the provisional and general PA scopes of practice **must specifically exclude** the following activities:

- Seeing or diagnosing undifferentiated patients. In the United Kingdom, the Leng Review recommended that physician assistants should not see undifferentiated patients except within

clearly defined national protocols. This is because safety concerns raised in relation to PAs *"were almost always about making a diagnosis and deciding the initial treatment, particularly…where patients first present with new symptoms."* (Professor Gillian Leng, 2025) The ASMS has also heard from members who have worked with PAs and report regularly picking up and rectifying patient safety issues including misdiagnosis, missed infections and inappropriate treatment. It will not necessarily be clear to a patient that poor care has occurred, so these instances don't tend to translate to formal complaints.

- Undertaking mental health assessments under the Mental Health Act.
- Making independent assessments of deteriorating patients.
- Undertaking minor surgical procedures (suturing, punch biopsies, cutaneous excisions) except under the direct delegation of the supervising SMO, who must be available to assume direct clinical care should the need arise. This is because even minor procedures can be high risk. One member provided a recent example of an elderly patient admitted to hospital with a major infection following a punch biopsy on the anterior shin (a known high-risk spot) undertaken by a practitioner who was not medically qualified. The member felt a qualified General Practitioner would not have undertaken the procedure given the known complications in an older, frail, patient. It is unlikely that a PA would have the depth of knowledge to avoid such a scenario.
- Independently admitting or discharging patients from secondary care.
- Independently undertaking outpatient clinics.
- Ordering diagnostic tests, except under the direct delegation of the supervising SMO or under agreed and signed off protocols under established clinical pathways. International evidence suggests PAs are more likely to order to unnecessary diagnostic tests, increasing cost and placing further pressure on laboratory and radiology services (Anderson,A; et al, 2018). ASMS members who work with PAs in New Zealand have raised similar concerns with us that PA practice is defensive, with unnecessary investigations ordered.
- Covering or participating in medical rosters designed for doctors, including doctors in training.

This is not an exhaustive list, and we recommend the Medical Council works with medical practitioners across the vocational scopes it regulates to determine what activities should be included and excluded in each area of practice.

Core requirements

- The ASMS also supports the NZRDA's recommendation that under 'core requirements' it should be specified that clinical assistants must stop consulting with patients immediately and handover to their supervising doctor 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.

Credentialling

The Medical Council's proposed scope relies heavily on credentialling to determine what tasks it is appropriate for clinical assistants to undertake. Although the ASMS considers credentialling should be undertaken, it is not a sufficient safeguard in the absence of clearly defined scopes of practice.

There is limited evidence as to the efficacy of credentialling (Ministry of Health, 2010), and because it is employer-led it is vulnerable to workforce or financial pressures. This means conflicts of interests may arise, where patient safety is not deemed as important as cost or service provision. Media reports suggest that tensions have arisen in New Zealand when doctors have raised concerns about the safety of PAs with employers previously, with employers taking an opposing view to SMOs (Shaw, 2024). This echoes what has occurred in the UK, with the legitimate concerns of the medical profession being dismissed for a number of years.

Credentialling will likely be useful for defining activities that can be undertaken in different services with different supervisors, but this must be in the context of clearly defined scopes of practice set by the Medical Council.

2. Qualifications for registration and to change scope of practice

The ASMS strongly recommends that an assessment of clinical competence is required before PAs can move from provisional to general scope. The requirement for an assessment of clinical competence must apply to PAs in all three registration pathways (UK trained; USA trained; New Zealand experiential).

The ASMS is concerned that the Medical Council's current proposal offers no reliable assessment of clinical competence. As described above, there are no local PA training programmes based on locally defined clinical competencies that meet the needs of the New Zealand health system. This means that comparability of international qualifications, and therefore levels of competency, cannot be assessed based on qualification alone. This is compounded by the sheer number of training programmes in the USA, Canada and UK, with varying requirements that likely produce graduates with varying clinical competencies.

We note that the Medical Council has included a time-based component for establishing eligibility for registration. Once again, this provides no assurance of clinical competence.

3. Supervision of clinical assistants

The ASMS supports the preamble in the Medical Council's supervision framework that PAs must always practise under the supervision of a vocationally registered doctor; must never be rostered to practise solo in any healthcare setting; and must always have onsite, in-person supervision from a SMO available.

However, the ASMS considers the proposed supervision requirements need to be substantially strengthened. Key findings from the Leng Review documented substantial concerns relating to models of supervision and risks to patient safety (Professor Gillian Leng, 2025). These included:

- Doctors were concerned about the time required to supervise and lacked understanding about how supervision should work in practice.
- Potential safety incidents were regularly picked up and prevented by supervising doctors.
- There was a discrepancy between what doctors and PAs felt were suitable tasks for PAs to undertake.
- Doctors lacked confidence that supervision was adequate.

- Evidence suggested that physician assistants practised safely and effectively when working under direct supervision and in post-diagnostic care. There was no evidence supporting the safety or efficacy of indirect supervision(Cooper, N; et al, 2025).

In this context, the ASMS recommends:

- Both provisional and general scope clinical assistants must work under the supervision of a named, responsible, vocationally-registered medical practitioner. The primary supervisor and place of work should be included on the practising certificate as an endorsement for clinical assistants registered in both the provisional and general scope.
- Supervision must be onsite and continuously available. The Medical Council's description of in-person supervision suggests that onsite supervision could be done offsite and only requires being readily contactable and available to attend the facility if required. This is inappropriate in the context of the Leng Review findings; the absence of evidence that indirect supervision is safe or effective; and the clinical assistant role itself which is by definition a dependent role.
- Supervision must be provided by a medical practitioner working in the same scope. For example, a general practitioner should not be the supervisor for a clinical assistant working in anaesthesia, and vice versa.
- Resident medical officers should never be placed in the position of supervising a clinical assistant, as they are still in training themselves. Currently, the proposed supervision arrangements could mean an employer can assign onsite supervision responsibilities to a resident medical officer if a vocationally registered doctor is not available onsite. The ASMS strongly opposes this.
- The Medical Council must be involved in establishing limits on supervision capacity and supervisor workloads. A common concern raised by ASMS members is around supervision capacity, with capacity to supervise PGY1s and 2s and RMOs becoming increasingly stretched amidst workforce pressures. There is risk that employers will pressure employees to provide inadequate supervision in response to workforce and financial pressures.
- The Medical Council must also be involved in protecting access to supervision for vocational medical trainees, to ensure supervision of clinical assistants does not reduce the supervision available to support the medical workforce training pipeline.
- The preamble must more clearly specify at what level Chief Medical Officers hold overall clinical responsibility for any PA employed or contracted to work. For example, does this clinical responsibility sit with the national CMO, or CMOs at the district or hospital level? It will need to be confirmed whether medical indemnity is available for CMOs who hold this accountability.
- It will need to be confirmed whether medical indemnity is available for medical practitioners supervising clinical assistants. It will also need to be confirmed whether treatment injuries that arise from clinical assistant practice will be covered by the Accident Compensation Corporation.

4. Cultural safety

The ASMS supports the Medical Council's intention to set cultural safety requirements at every stage of the PA regulation framework. This is particularly important for an internationally trained workforce.

However, it is not clear how the Medical Council would ensure that clinical assistants receive cultural competency and cultural safety training and Hauora Māori education during their orientation and induction processes. The ASMS is well aware that many Senior Medical Officers arriving in New Zealand receive no induction or orientation at all, let alone one that includes cultural competence, cultural safety or Hauora Māori education. If relying on the employer to provide, there is a high-risk clinical assistants may also not receive an induction or orientation.

5. Professional title

The Association of Salaried Medical Specialists strongly recommends that the title "clinical assistant" is adopted as the title for the PA scope of practice in New Zealand.

The Leng Review found that physician associate is an entirely inappropriate title. It was misleading for patients who mistook PAs for doctors and considered the name denoted authority and seniority. The ASMS considers that as 'physician' is well understood in New Zealand to mean medical doctor, the title 'physician assistant is also likely to be misleading for the general public. Already, there is evidence in the New Zealand setting that patients confuse physician associates for doctors (Hill, 2024).

The term clinical assistant accurately reflects the role and removes the risk of PAs being mistaken for doctors. It is likely to be a title that is far better understood by the general public.

The ASMS notes that PAs were originally referred to as Physician's Assistants. The term physician in the title denoted the medical practitioner rather than the assistant, but this distinction is less clear as the name has evolved.

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