ASMS
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

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Tēnā koe Ken

Draft Professional Standards for Physician Associates

Thank you for seeking feedback from the Association of Salaried Medical Specialists (Toi Mata Hauora) on the above consultation. The consultation period is less than three weeks, which will limit the feedback Council receives on this consultation.

Physician associate regulation in New Zealand should have been strongly guided by recommendations from the Leng Review in the United Kingdom to prevent the serious issues that occurred internationally from replicating in New Zealand. Unfortunately, the regulatory approach in New Zealand diverges from several key recommendations in the Leng Review.

1. Unique context of the physician associate profession in Aotearoa New Zealand

Toi Mata Hauora recognises that professional standards documents can only go some way towards mitigating the risk of international issues replicating in Aotearoa New Zealand. However, it is critical the unique context of the physician associate profession in Aotearoa New Zealand is considered when setting professional standards. This context includes:

- The title has been confirmed by the Minister of Health as Physician Associate, despite international and local evidence demonstrating the title is confusing for patients who often mistake physician associates for doctors.
- There is no accredited training programme or recertification programme for physician associates in New Zealand. This limits Council's ability to ensure qualifications and continuing professional development are fit for purpose and protect patient safety.
- Physician associates will be able to see undifferentiated patients, despite the Leng review identifying this is where most patient harm occurred in the UK.
- The physician associate role is new and no organisation with oversight of the health workforce has described how this new profession will fit into existing multi-disciplinary team structures.
- The New Zealand Physician Associate Society promotes PAs on its website as "highly trained health care providers who practise medicine" alongside imagery traditionally associated with medicine (white coat, stethoscope). This is confusing.

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- The NZPAS website does not reflect the scope of practice and supervision arrangements recently announced by Council. For example, it specifies that onsite supervision is not required, lists diagnosis and prescribing as part of the PA scope of practice, and suggests PAs can be used to cover call if they have access to script signing and supervision.

2. Toi Mata Hauora feedback on the draft professional standards

We have considered the above context when reviewing the draft professional standards.

1. Patient care

The draft standards require PAs to "respect patients' rights". The emphasis on patient rights should be strengthened to require PAs to inform patients of their rights and enable patients to exercise those rights. This would align more closely to the duties of providers under the Code of Health and Disability Services Consumers' Rights.

The guidance on respecting patient rights could also be strengthened. Taking into account the context outlined in section one of our submission, the guidance should include:

- *Support patients to understand the role of the physician associate and support the rights of the patient to be seen by a doctor or another health practitioner.*

2. Safe practice

In the UK, the Leng Review identified scenarios where short staffing meant PAs were used to fill gaps left by doctors in medical rosters. The Review noted "this seems to have been done without taking into account the more limited training of the PAs and how the roles would interact, other than with the caveat that they would be supervised by doctors."

The NZPAS website also states "PAs can cover call as long as script signing and supervision can be accessed."

It must be made clear in section 2a of the professional standards that:

- *PAs must **never** fill roster gaps for health practitioners registered in a different scope of practice (for example, a physician associate must never fill a roster gap for a medical practitioner).*

The guidance under section 2a also states "recognise when to seek the assistance and input of a doctor, and when to refer to another health practitioner." This gives the impression that PAs practice autonomously rather than under the ongoing, onsite supervision of a vocationally registered doctor in a team environment. Section 2a could be strengthened by adding the following guidance:

- *Recognise the PA role is a supportive, complementary member of a medically led team, rather than an independent practitioner.*

Section 2b offers guidance to only practice when PAs have an onsite supervising doctor available. Having a doctor available is not in itself a clinical safeguard. Supervision is a relationship that requires collaboration, oversight and support with clinical decision-making. We recommend making the nature of the supervisory relationship much clearer in the document and including minimum guidance on when a PA must involve a supervising doctor.

3. Good communication and informed consent

Feedback on the title Physician Associate both locally and internationally demonstrates the title is confusing for patients, and results in PAs being mistaken for doctors. As this is a new profession in New Zealand that is not well-established, the PA role is unlikely to be understood by the public. This issue must be addressed clearly and directly in section 3b.

As part of the guidance for section 3b, we recommend including:

- *Recognise that the title Physician Associate can be misunderstood, and patients may think they are seeing a doctor. Explain to patients that a Physician Associate is not a doctor but works in a team and is supervised by a doctor.*

4. Collaboration

A major challenge identified by the Leng Review in the UK was that no vision for the physician associate profession had been set out by health sector leaders, and there was poor understanding of how the physician associate role was supposed to fit into team structures with existing health practitioner groups including doctors, nurses, and allied health professionals. Poor understanding of the different roles, responsibility, and accountability of team members leads to fragmentation of patient care, increasing risk of harm.

The guidance under 4a should include:

- *Recognise the physician associate role operates as part of a medically led team structure, and understand the different roles, responsibility, and accountability of all members of the team.*

5. Professionalism

Section 5f on lifelong learning and professional development needs to be strengthened. It must be specified that physician associates are required to meet recertification standards set by Council, through participation in an accredited recertification programme, including meeting any minimum recertification requirements set by Council.

6. Other issues

There needs to be clear guidance on what is required for a PA to be able to shift between different areas of practice (for example moving from general practice to taking up a new role in a hospital-based specialty).

For medical practitioners, changing to a different vocational scope of practice would require retraining in that scope or working in a collegial relationship with a colleague registered in that vocational scope. A medical practitioner with either general registration or vocational registration has significantly greater depth and breadth of training and experience than a PA with general registration, yet still rightly has stringent conditions placed on working in another scope.

However, it appears that once a PA has obtained general registration they could work in any area of medicine so long as they were credentialled and supervised. We recommend that careful thought is applied to how PAs could safely move to different areas of practice and what would be required to support this. This will need to be addressed in the standards documents, at a minimum.

Nā māua noa, nā

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