The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

13 February 2026

Dr Rachelle Love
Chair
Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Level 28, Plimmer Tower
WELLINGTON

By email: health@mcnz.org.nz

Tēnā koe

MCNZ – The regulation of Physician Associates/Assistants (PAs)

Our position

The College supports regulation of Physician Associates/Assistants by MCNZ as a necessary safety baseline but does not support expansion of the scope being deployed to general practice and primary care until safeguards are integrated and evidence of effectiveness is proven.

Introduction

The Royal New Zealand College of General Practitioners (the College) acknowledges the role of the Medical Council of New Zealand (MCNZ) in regulating the Physician Associate (PA) workforce and welcomes the opportunity to contribute to this consultation. Regulation will provide an important baseline for a workforce that is currently internationally trained and unregulated in Aotearoa New Zealand (NZ).

While PAs may add capacity in some clinical settings, their integration into general practice must be approached cautiously. Regulation must be accompanied by strong safeguards to ensure PA roles complement rather than compromise the specialist GP-led model of multidisciplinary, comprehensive, continuous, equitable and safe first-contact patient care. Clear role parameters, cultural safety expectations and robust supervision arrangements are essential to protect patient safety, uphold Te Tiriti o Waitangi obligations and maintain the integrity of GP training and workforce sustainability.

Our submission reflects feedback from College members who indicate broad support for regulation as a necessary step. However alongside this feedback are strong concerns about potential risks arising from undefined scopes of practice, inadequate supervision structures and limited local evidence on PA effectiveness. A planned, evidence-informed approach to integration is therefore required to ensure PAs work within their scope and training and contribute safely and effectively to clinical teams.

Member concerns

1. **PAs are not specialist GPs**
   College members emphasise that PAs are generalist clinicians whose training, clinical depth and decision-making responsibilities differ substantially from those of vocationally trained specialist GPs. Their value lies in supporting doctors within a team-based model and not substituting for the clinical leadership, diagnostic breadth, or independent practice expected of GPs.[1]

2. **Undefined scope and supervision requirements**
Members are concerned that the absence of a nationally mandated PA scope of practice, along with inconsistent or unclear supervision expectations, creates risk for patients, supervising clinicians and regulators. Lessons from the UK Inquiry [2] [3] demonstrate how poorly defined scopes and weak oversight can lead to systemic failure. Similar risks must be avoided in Aotearoa New Zealand through a clear, enforceable framework.

3. **Need for a clear professional status and regulatory oversight**
An ambiguous regulatory status undermines transparency, accountability and public confidence. Members expect MCNZ will set clear qualification standards, minimum competency expectations and regulatory requirements informed by international evidence and tailored to Aotearoa New Zealand's cultural context.

4. **Equity and cultural safety risks:**
Introducing a new workforce without explicit safeguards risks undermining cultural safety and equity and exacerbating inequities, particularly for Māori and other priority populations. Members stressed that regulation must include mandatory cultural safety expectations to reduce the risk of failing Te Tiriti o Waitangi obligations, Māori health rights and inadvertently widen disparities.

5. **Supervision challenges for specialist GPs**
Supervising PAs will require significant GP time and clinical oversight. Members are concerned this may divert capacity from GPEP registrars. Their supervision and training are our core priority and consideration of further strain on an already pressured general practice workforce must be factored into future planning. Clear guidance on supervision ratios, responsibilities and support is essential.

6. **Insufficient evidence on PA effectiveness**
Members note limited Aotearoa New Zealand-specific evidence on PAs' impact in primary care, including effects on access, quality, equity, workload and team functioning. International findings are mixed and highly context dependent. Before widespread deployment in general practice, robust evaluation is needed to understand impacts and ensure PAs do not displace or divert resources from proven regulated professions.

7. **Indemnity, liability and transparency**
Members expressed uncertainty regarding legal accountability, indemnity and professional responsibility when PAs are involved in patient care. Clear, enforceable regulatory settings and transparent lines of accountability are needed to maintain public trust and reduce role confusion.

College advice and recommendations

1. **Patient safety and equity are paramount**
The College upholds the Council of Medical Colleges' (CMC) position[4], on the regulation of Physician Associates and emphasises that any PA scope of practice must ensure safe, equitable and culturally grounded care. To achieve this, the following safeguards are essential:

   - **A clearly defined scope of practice**
   The PA scope must reflect the competencies, training, and clinical settings appropriate to the role, with unambiguous boundaries to prevent role confusion for patients, clinicians and employers.

   - **Mandatory cultural safety training**
   PAs must complete cultural safety education aligned with Te Tiriti o Waitangi obligations and Māori health rights. This is critical to ensure PAs contribute to equity in Aotearoa New Zealand.

   - **No independent clinical practice**
   PAs must not work in isolation or engage in unsupervised clinical practice. Independent activity is unsafe, inconsistent with PA training and incompatible with the general practice team model. Suitable supervision must be documented for every clinical shift.[5]

- **Team-based care grounded in competency and formal supervision**
  PAs should practice within a structured, competency-based team environment. Specialist GPs must retain responsibility for assessment, diagnosis and treatment decisions, supported by clear supervision arrangements. [v]
- **Renaming the role to 'Clinical Assistant'**
  To improve transparency and reduce public misunderstanding, the College recommends renaming the PA role to "Clinical Assistant," which better reflects the intended scope and avoids confusion associated with the term "physician."
- **Built-in evaluation mechanisms**
  Regulation must include ongoing monitoring of PA effectiveness, their impact on equity and workforce implications and needs within general practice settings. Evaluation should find risks early, ensure patient safety and assess whether PAs complement existing regulated professions.

2. Our recommendations:

2.1 Regulation must build trust and confidence
That a deliberate and well-resourced approach ensures regulation strengthens, rather than compromises patient safety, public trust, cultural safety obligations and the sustainability of the specialist GP workforce.

2.2 Regulation mitigates unintended harms
That regulating PAs under the MCNZ will clarify roles, responsibilities and lines of accountability, and set stronger expectations around cultural safety and equity. While regulation will reduce risks to patients and limit vicarious liability for specialist GPs, rapid expansion of the PA workforce without a clear strategy, structured training pathways, or well-defined supervision arrangements could create unintended harms.

2.3 Regulation provides evidence of PA effectiveness
That evidence for improving access is based on effectiveness and quality, and is shown to have a positive impact on equity in Aotearoa New Zealand. Robust evaluation would be built in to ensure the integration of PAs does not divert resources, compromise supervision capacity for GPEP trainees and create workforce pressures in already overstretched practices.

2.4 Plan for effective PA supervision
That a supervision framework acknowledges current pressures including, workforce shortages, increasing patient complexity and rising demand to ensure any new supervision requirements are carefully assessed and implemented to avoid compromising care quality or diverting capacity from GPEP registrar training - this is a core priority for the College. [6]

2.5 Embed designated supervision into workforce planning
That designated PA supervision is fully integrated into national and local workforce planning, with specific resourcing for cultural competency, cultural safety and equity training relevant to Aotearoa New Zealand to ensure supervision is safe, sustainable and aligned with the realities of general practice.

2.6 Define designated supervision clearly
That national guidance articulates expectations, responsibilities, limits and accountability for PA supervision, ensuring consistency across settings and reducing risks for patients and supervising clinicians.

2.7 Adequately resource the supervision framework
That general practices and clinical teams are supported with the necessary time, funding and infrastructure to meet supervision requirements without compromising patient care or the training of GPEP registrars.

In summary

Our submission reflects the lessons from international experience and the concerns raised by College members, all of which underscore the need for strengthened understanding of the PA role and its place within the health workforce. General practice is too broad a scope for independent practice by clinicians with limited training, and the College considers PAs to be most effective when working alongside, and under, the close supervision of specialist GPs.

We signal our continued commitment to working with MCNZ in the codesign of the PA scope of practice and its future integration into the health workforce. Ongoing collaboration is essential to protect patients and clinicians, uphold Te Tiriti o Waitangi obligations and ensure any new workforce contributes meaningfully to safe, equitable and sustainable general practice care.

The College remains committed to working with MCNZ and sector partners to ensure that regulation strengthens, rather than compromises, the quality and safety of care delivered to communities across Aotearoa New Zealand, on the basis that a regulated PA workforce can add value, but only if introduced with clear safeguards, robust supervision structures and a strong commitment to cultural safety and transparency.

Nāku noa, nā

Dr Luke Bradford
BM(Hons), BSc(Hons), FRNZCGP
President | Te Tumu Whakarae

Appendix

Our response to MCNZ Questions:

Q1. What feedback do you have on the proposed scope of practice for Physician Associates (PA)?

1.1 A robust evidence base is needed to show the value of PAs in New Zealand:

Support regulation that defines a clear, bounded scope aligned to PA training and delivered within supervised, team-based care. Do not support deployment into general practice until safeguards and local evidence are in place.

- The current PA workforce is internationally trained and unregulated in Aotearoa New Zealand. Regulation should establish baseline safety, minimum competencies, and clear role boundaries.
- International experience [viii] [7] is mixed and context-dependent; local evidence on PA effectiveness in primary care (access, consistency[8], quality, equity, workload, team function) is limited.
- Introducing PAs without explicit parameters risks role confusion, inequities, and diversion of scarce supervision capacity away from GPEP registrars.

Scope expectations:

- No independent practice and no undifferentiated/first-contact care.
- PAs must not independently diagnose or initiate treatment plans. Diagnostic and treatment decisions remain with doctors.
- Clinical activities should be protocol-driven, standardised tasks that match PA training (e.g., recording vitals, routine observations, dressings, calculating risk scores, delivering standardised health education).
- Procedural scope is tightly defined with competency-based sign-off; excludes high-risk procedures (e.g., biopsies/minor surgery) unless directly supervised by the requesting clinician.
- Any future consideration of prescribing rights must be tightly bounded and specialty-appropriate, with demonstrable competencies and supervision.
- Cultural safety and Hauora Māori training are mandatory and ongoing.

Recommendation 1:
Establish and publish a national PA scope with a permitted-procedures list, competency requirements, and explicit exclusions; require documented supervision for every clinical session.

Recommendation 2:
Fund national and local evaluation to assess PA impact in primary care and general practice settings (access, quality, equity, team function, training pipeline) before wider deployment into general practice.

1.2 Equity, cultural safety, and patient safety are prime considerations

Cultural safety and Hauora Māori training must be mandatory and ongoing and aligned with Te Tiriti o Waitangi obligations to ensure care is culturally safe and responsive in the Aotearoa New Zealand context. Introducing PAs without explicit provision for equity, cultural safety, and patient safety risks undermining efforts to build a workforce that reflects Aotearoa New Zealand communities and supports Māori health equity goals.

Scope expectations:

- There is an expectation that PAs will be supported to undertake mandatory cultural safety training to enable them to support the provision of culturally safe and culturally responsive care in the Aotearoa New Zealand context.

- It is expected that training in cultural safety, Hauora Māori, and Te Tiriti o Waitangi training will ensure PAs are able to provide culturally safe and responsive care, understand local context, and uphold their obligations to Te Tiriti o Waitangi.
- Clear expectations in the above areas are critical to prevent widening disparities, particularly in communities where health literacy is lower and where continuity of continuity of care is vital.

Recommendation 3:
Require approved cultural safety, Hauora Māori, and Te Tiriti o Waitangi training for registration and ongoing practice, with clear expectations for providers and supervisors.

1.3 Oversight & employer responsibilities under supervision

Employers play a critical role in ensuring PAs practise safely within a clearly defined, locally credentialled scope. Effective oversight requires structured onboarding, documented supervision, and ongoing professional development to maintain safe, high-quality PA practice. Employers must ensure PAs are credentialled to their local scope during onboarding and practise only within their documented scope.

- The nature of supervision is a critical determinant of PA safety, quality, and team integration.
- We expect that employers will have a responsibility to ensure oversight and training, and support PAs to become credentialled in the onboarding process to ensure they can undertake tasks within their scope of practice and be given the opportunity to participate in ongoing training and development.

Scope expectations:
- As PAs undertake clinical tasks under supervision, clear expectations, task limits, and escalation pathways are essential to protect patients and supervising clinicians.
- Variation in international PA training and unfamiliarity with Aotearoa New Zealand's context calls for a provisional period with heightened oversight and compulsory cultural safety/Hauora Māori orientation.
- Examples of activities under supervision with competency-based sign-off and documented escalation pathways, include: suturing simple wounds, ECG acquisition, taking histories and performing examinations, ordering and interpreting selected tests per protocol, contributing to diagnosis and treatment discussions, delivering standardised patient education, undertaking specified low-risk minor procedures—all within competency-based sign-off and escalation pathways.
- A provisional period for new registrants should be in place to prevent variation in the Aotearoa New Zealand context, and this includes heightened oversight and compulsory cultural safety/Hauora Māori orientation.
- The provisional period for new registrants should be time-limited and apply when PAs first register in Aotearoa New Zealand. During this period:
    - PAs are under heightened supervision and closer review
    - Supervisors provide structured support with clear milestones
    - PAs must complete compulsory cultural safety and Hauora Māori training to orient them to Aotearoa New Zealand's clinical, cultural, and community context

The time-limited provisional scope for all new PAs, should be linked to:
- documented supervision milestones.
- satisfactory supervisor sign-off.
- completion of cultural safety/Hauora Māori training.
- confirmation that the PA is practising safely within their local scope.

This ensures PAs are safely integrated into local practice environments before progressing to a full scope.

Recommendation 4:
Require employers to maintain written supervision plans outlining supervisory responsibilities, task limits and permitted activities, escalation pathways, case-review frequency, documentation requirements, onboarding and ongoing credentialling arrangements.

Recommendation 5:
Implement a time-limited provisional scope for new PAs, linked to documented supervision milestones and completion of cultural safety requirements before progression.

Recommendation 6:
A 'provisional' period is put in place when PAs first register to ensure they are under close watch by the MCNZ and their supervising doctor. This period should include compulsory training in cultural safety and Hauora Māori to aid orientation toward working in Aotearoa NZ.

Trained PAs also lack essential knowledge of Te Tiriti o Waitangi, Hauora Māori, and Aotearoa NZ's cultural context.--making. In practice this means-contact patients. This exceeds their training and is unsafe. -based assessment -off aligned with nursing/NP models.

Q2. What feedback do you have on the proposed framework for how PAs will be supervised?

2.1 Supervision expectations linked to quality & cultural safety

PAs are overseas trained so supervision should reflect GP workloads, protect patient safety, and support PA orientation to Aotearoa New Zealand. Supervision must include local context for, cultural safety mentoring, support to understand local communities, and guidance to practise ethically within Te Tiriti o Waitangi expectations. This requires structured, documented, consistent, and culturally safe supervision that is not left to informal arrangements.

- As an overseas-trained workforce means PAs need explicit cultural safety mentoring and orientation to local communities and Te Tiriti o Waitangi obligations.
- PA training does not fully prepare practitioners to independently manage investigations, diagnosis, or treatment planning, or prescribing; therefore, doctor oversight is essential.
- Supervision imposes material workload on GPs; without clear guidance and resourcing, it may compromise patient care or divert capacity from GPEP registrar training.

Scope expectations:
- Direct or immediately available oversight by specialist GPs is a requirement for all new or unstable patients, or patients with complex needs., this includes all diagnostic decisions; and any prescribing-related activity.
- Written supervision plans for every PA, specifying supervisor responsibilities, task limits, escalation pathways, case-review frequency, and documentation standards.
- Culturally safe supervision includes mentoring and support to practise ethically under Te Tiriti o Waitangi, with orientation to local population needs.
- Transparent patient information ensures patients and whānau are informed of provider roles and supervision arrangements at the time of appointment booking, upon arrival, and at relevant consent points.
- PAs should focus on protocol driven tasks aligned with their training, such as, recording vital signs, routine observations, dressings, calculating risk scores, and delivering standardised lifestyle or health education, while doctors hold responsibility for medical decision making.
- Clear supervision policies should also enable patients and whānau to make informed choices about who is providing their care.

Recommendation 6:
That national supervision guidance is developed to inform direct supervision and suitable levels of practice for PAs, and defines levels of supervision, supervisor responsibilities, indicative ratios/caseload considerations, documentation standards, and cultural safety support.

Recommendation 7:
Apply a time-limited provisional period and scope for newly registered PAs with heightened oversight and compulsory cultural safety/Hauora Māori orientation before progression.

Recommendation 8:
Ensure PA supervision time and infrastructure are funded and planned, so GPEP training and patient care are not compromised.

Q3. What feedback do you have on the title of the role (i.e., Physician Associate/Assistant or something else)?

3.1 The term physician associate is misleading to the public.

International evidence shows the PA title is confusing and has led patients to assume PAs are doctors, leading to confusion and patient harm. Keeping the title poses inherent safety risks and potentially compromises public trust in clinicians in general.[9]

Expectations:
- Use of the term 'Clinical Assistant' would more accurately describe the PA workforce, and support public understanding of their role.
- Patients and whānau can struggle to differentiate between health professions, especially where professional titles include the term 'physician', and implies a level of training, scope, or autonomy that does not align with the current qualifications and experience of physician associates.
- A clearer title that signals a supporting, supervised role protects whānau, particularly where health literacy is lower, and strengthens informed consent and trust.

Recommendation 9:
Adopt the title of 'Clinical Assistant' to reflect the work of PAs more accurately in their supporting clinical role**.**

Recommendation 10:
That strong regulatory guidance and public education must form part of the framework to ensure patients and whānau clearly understand a PA's training pathway, scope of practice, and limitations, particularly in communities where health literacy may be lower.

Q4. Do you believe the proposals will improve equity of access to healthcare services? – (Yes – Somewhat – No – Not sure)

4.1. Answer – Not sure

Until the effectiveness and contribution of the PA workforce and their scope of practice is tested and trialled and there is a system to support supervision, we are not supportive of the workforce practicing in primary care settings.

There are crucial differences between primary and secondary care that make it essential for PAs to gain at least two-year experience in secondary care. We suggest exposure to a narrower range of specialties prior to working in a general practice – which is a much broader scope. While potential exists to improve equity, the evidence is insufficient.

Expectations:
- Without robust policy settings, there is a risk of variable care quality, role confusion, and widening inequities, especially for Māori, Pacific peoples, and other priority groups.
- PAs may increase access in underserved areas, but access must not come at the expense of quality, safety, or cultural safety.

- Primary care is broad and undifferentiated. PAs should not see undifferentiated patients, except within clearly defined protocols and supervision.
- Until evidence of effectiveness is proven, we do not consider that PAs should practice in general practice or primary care settings. We advise at least two years' experience in secondary care before any PAs practice in general practice settings.
- Employers need to be aware of the risks to public confidence if patient safety is compromised by PAs working outside their scope of practice.

Recommendation 11:
Trial and evaluate PA roles before wider deployment into general practice, with a focus on equity, quality, patient experience, team function, and impacts on the GPEP pipeline.

Recommendation 12:
Develop a secondary-care runway: Require at least two years of secondary-care experience prior to any consideration of practice in general practice settings.

Q5. What recommendations would you suggest in response to this proposal?

5.1 Overseas-trained workforce & cultural safety

Prioritise **c**ultural safety, equity safeguards, and ongoing evaluation as the PA workforce is set up and align workforce design to complemen**t** specialist GPs and avoid lower-standard of care through other workforce streams.

- Overseas training does not automatically equip PAs with the cultural knowledge and expertise to deliver culturally safe and responsive care in Aotearoa New Zealand, especially when considering Te Tiriti o Waitangi and Māori health rights.
- We strongly support mandated cultural safety training as a core requirement, but recommend this be specifically tailored to Aotearoa New Zealand contexts and focused on developing practical competencies, including understanding diverse worldviews, Te Tiriti o Waitangi obligations, Māori models of health, and how to work effectively with Māori patients and their whānau in clinical settings.
- Cultural safety standards should be systematically tracked, evaluated, and reported, over time.

Recommendation 13:
That MCNZ cultural training addresses the cultural competency and cultural safety gap, and keeps the sector informed about progress on standards and training, as a matter of urgency.

Recommendation 14:
Mandate approved cultural safety programmes at registration and as part of ongoing practice, with sector reporting on uptake and outcomes.

Recommendation 15:
Measure equity outcomes within the regulatory framework (access, treatment, referrals, outcomes, patient experience), with explicit reporting for Māori, Pacific, and underserved groups.

5.2 Safeguard equity while expanding access

We recognise that PAs can potentially improve access to care, particularly in underserved or rural communities where GP shortages are most acute.

Expectations:

- Access must not be pursued at the expense of safety and quality.
- Regulatory settings should ensure that workforce design complements GPs and other regulated professions, without creating parallel streams of care that vary in quality or equity.

Recommendation 16:
That equity outcomes be explicitly measured as part of the regulatory framework, such as, disparities in treatment experiences and outcomes, referral pathways, and patient satisfaction across populations, especially for Māori, Pacific, and other underserved groups.

5.3 Equity Impact Assessment & ongoing review

The draft framework should commit to an equity impact assessment as part of finalising regulation.

Expectation:
- Reviewing whether the model benefits or inadvertently disadvantages specific groups.
- Ensuring data capture mechanisms are in place to understand disparities going forward.
- Regularly reviewing the effectiveness of cultural safety requirements for PAs against real-world outcomes.

Recommendation 17:
That the proposal includes a mechanism for whānau and consumer representation in ongoing evaluation of the PA role's impact on equity, including Māori, Pacific Peoples, and other equity priority populations.

Q6. Do you have any other feedback you'd like to provide on this consultation?

6.1 The place of a supervision framework in the health system workforce strategy

Success depends on a resourced, clearly defined supervision framework, strong public understanding of the role, and transparent qualification standards that include cultural safety.

Expectation:

- Designated supervision must be fully resourced, to support PA supervision requirements, and specific supporting resources are available, including training for cultural competency, cultural safety, Hauora Māori and health equity in the Aotearoa New Zealand context.
- Qualifications and pathways should be transparent, with a common cultural safety standard for all entrants.
- The supervision framework should clearly define what constitutes designated supervision, and supervision plans must include the necessary resourcing to support this level of oversight.

Recommendation 18:
That national and local guidelines are developed to clarify the scope of practice for a PA and how the role would adapt to account for differences in primary and secondary care.

6.2 Improve public understanding about the role of PAs10

Public trust requires clear differentiation between PAs and doctors, especially in communities where health literacy may be lower.

Expectations:
- A clear public awareness strategy must sit alongside regulation to differentiate PAs from GPs and other clinicians, particularly in communities where health literacy inequities exist.
- Materials should be culturally appropriate, accessible in multiple languages, and co-designed with whānau and community representatives.
- A slightly different entry pathway is proposed to recognise PAs who have been working in Aotearoa New Zealand for several years – but they will still need to show they are qualified, trained and competent, and culturally safe.

Recommendation 19:
Develop and implement a national communication and public awareness strategy to inform Aotearoa New Zealand populations.

6.3 MCNZ - Proposed qualifications for PAs

All PAs regardless of the time they have been practising in Aotearoa New Zealand, must still demonstrate and provide evidence that they are appropriately qualified, trained and competent, and culturally safe to practice.

Expectations:
We support the MCNZ's proposed registration requirements for PAs which should include[11]:

1. A university qualification recognised by the regulator in the UK or the USA regulator.
2. A pass in the national PA examination in one of these countries.
3. At least three years of recent PA experience in the UK or USA.
4. A pass in a knowledge-based cultural safety programme approved by the Council (approved programme(s) yet to be decided),

- The MCNZ outlines a slightly different entry pathway which proposes to recognise PAs who have been working in Aotearoa New Zealand for several years.

Recommendation 20:
Confirm qualification and registration requirements (UK/US recognition, national exams, minimum experience) plus a mandatory, MCNZ-approved cultural safety programme that ensures the alternative New Zealand pathway meets identical standards.

References

1 Academy of Medical Royal Colleges. High level principles concerning physician associates (PAs). Academy Consensus Statement. 4 March 2024. Available at: https://www.aomrc.org.uk/wp-content/uploads/2024/03/Consensus_statement_High_level_principles_concerning_PAs_040324.pdf

2 Department of Health and Social Care. The Leng Review: an independent review into physician associate and anaesthesia associate professions. July 2025. https://www.gov.uk/government/publications/independent-review-of-the-physician-associate-and-anaesthesia-associate-roles-final-report

3 Hubbard E.Coroner warns about the use of physician associates in the NHS after woman's death. B*MJ* 2025; 388 doi: https://doi.org/10.1136/bmj.r425

4 Council of Medical Colleges. Position on the regulation of physician associates. 2025. Available at: https://www.cmc.org.nz/media/yygla0yx/2025-pa-regulation-statement-final.pdf

5 Academy of Medical Royal Colleges. ibid

6 The Royal New Zealand College of General Practitioners. 2024 Workforce Survey – Snapshot Report. 2025. https://www.rnzcgp.org.nz/documents/603/2024_WFS_snapshot_FINAL.pdf

7 British Medical Association position statement on Physician Associates and Anaesthesia Associates. Available at: https://www.bma.org.uk/news-and-opinion/bma-position-statement-on-physician-associates-and-anaesthesiaassociates

8 Showstark M, Smith J, Honda T. Understanding the scope of practice of physician associate/physician associate comparable professions using the World Health Organisation global competency and outcomes framework for universal coverage. Hum Resour Health. 2023 Jun 23; 21:50. doi: 10.1186/s12960-023-00828-2

9 Department of Health & Social Care (UK). ibid

10 Henderson K. ibid

11 Medical Council of New Zealand. Qualifications and registration pathways – proposed. 2025. https://www.mcnz.org.nz/about-us/consultations/consultation-medical-council-to-regulate-physician-associatesphysician-assistants-pas/qualifications-and-registration-pathways-proposed/