18th December 2023

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Manatū Hauora /Ministry of Health
via email to [redacted]

Tēnā koe Steve,

Submission: Regulating the Physician Associate profession under the Health Practitioners Competence Assurance Act 2003

Firstly, thank you for extending the targeted consultation to include Specialty Trainees of New Zealand (STONZ). This issue has the potential to be hugely impactful on Resident Medical Officers' (RMOs) training and employment and we welcome the opportunity to represent their views / concerns in this consultation.

STONZ is a union representing Resident Medical Officers, with a focus on maximising training to ensure the next generation of Senior Medical Officers has the appropriate knowledge and skills to serve the people of Aotearoa New Zealand. We represent 1800 RMOs of all professional stages (House Officer, Non-Training Registrar, Training Registrar, Fellow). Our aims involve safeguarding the future of the health workforce to ensure we can meet the needs of all peoples now and in the future in a safe and sustainable manner.

STONZ has several concerns with the proposal to regulate Physician Associates (more commonly known as Physician Assistants), which are not addressed by the current questions posed in this consultation. STONZ believes that the question is not whether we should be regulating PAs under the HPCAA, but whether this is a profession we want to enter the Aotearoa New Zealand health workforce at all.

STONZ is strongly opposed to the regulation of Physician Assistants in New Zealand.

- PAs offer sub-standard care, compromising patient safety
  Doctors complete six years of medical school, plus on average ten to eleven years working as an RMO before becoming an SMO, often training under specialised vocational scope and completing the required examinations and supervision. Physician assistants complete two to two and a half years of graduate level education including only 2,000 hours of clinical care and no further training requirement[1].

  A UK pilot of PAs found that only 1%-16% of contacts with the PA's supervisor were for the purpose of reviewing treatment plans, with 42%–48% of contacts in A&E being for treatment plan review[2]. We would expect, given the 2-year nature of their course, that this would be much

higher. A highly qualified RMO in practice for 10 years would still be required to discuss almost 100% of their treatment plans with an SMO, due to openly acknowledged inherent risks to patient safety of a limited and untested knowledge base.

Research into PAs is limited, but studies from the USA have shown that when looking at the percentage of malpractice allegations related to misdiagnosis, which can be taken as a proxy marker of medical knowledge, physicians had significantly fewer (31.9%) than PAs (52.8%) or NPs (40.6%), with PAs having the highest rates of incorrect diagnosis-related complaints[3].

There is a wealth of evidence that PA training is not comparable to doctor's training. This is consistent over all countries where PAs are licenced. The aim of this submission is not to give a full review of the literature, which we assume will have been performed prior to the decision to consult on the regulation of PAs, but select examples to illustrate this point are as follows:

- In one large primary care system over 10 years, physicians performed better than Advanced Practice Providers (Nurse Practitioners and PAs) in 9 out of 10 quality measures, including "double digit improvements" in flu and pneumococcal vaccine administration. Patients who had an APP as their primary care provider were 1.8% more likely to visit an ED than those who had a physician, despite being younger with less past medical history, and were more likely to visit an ED than patients with did not see a primary care provider. APPs were 8% more likely to refer to secondary care. Spending was $43 higher per patient per month in patients who saw an APP ($119 if adjusted for patient complexity). Patients also gave higher ratings to physicians than APPs in all areas.[4]
- In primary care, PAs were more likely to prescribe a controlled substance per visit than a physician or an NP (19.5%, 12.4%, 10.9%, respectively).[5] A further study demonstrated 9.8% of PAs met at least one definition of overprescribing opioids compared with 3.8% of physicians. 8.8% of PAs and 1.3% of physicians prescribed an opioid to at least 50% of patients. NPs/PAs practicing in states with independent prescription authority were >20 times more likely to overprescribe opioids[6]
- When looking at quality standards in antibiotic prescribing, correct antibiotic use for acute otitis media was followed by 14.1% of PAs versus 41.4% of doctors. No antibiotic use for upper respiratory tract infection was followed by 51.9% of PAs verses 60.0% of doctors[7]
- When looking at medical teams staffed either by residents (RMOs) or APPs, patients were more likely to be discharged to their own home, length of stay was shorter by 1.26 days, and per-patient costs were lower by $617 in teams staffed by residents. Patient satisfaction scores were higher for resident teams[8]

There are also high-profile incidents of patient harm following management by PAs, such as the case of Emily Chesterton who died of a pulmonary embolus after management by an unsupervised PA, and who was not aware she had not seen a fully qualified doctor.[9]

- <u>PAs will negatively impact RMO training.</u>
  It is likely that RMOs will be expected to supervise PAs, impacting their own training and that of junior doctors they would otherwise be supervising. PAs in the UK do not have the ability to prescribe or order investigations involving ionising radiation.[10] Any RMO who prescribes or orders a test for a PA must ensure that this is indicated and safe. Not only does this take the RMO away

from their current work, it also requires a duplication of work to ensure patient safety. The work could more easily and safely be done by employing another RMO.

It is likely that less training positions will be available for RMOs due to PA employment and ongoing supervision requirements, further impacting the already under resourced doctor workforce in Aotearoa. At its simplest, adding an increased supervisory burden by employing a less qualified substitute to an already stretched medical workforce is counterintuitive.

There are many examples in both the USA[11] and UK[10] showing where RMO training has suffered due to PA presence. There are reports of PAs being given preferential access to clinics, training lists and procedures, as they are permanently employed within a department, unlike RMOs, whose training is rotational. In addition, there are reports of PAs supervising RMOs in GP practice[10], despite being a less qualified workforce. This obviously could have a significant impact on the training of the future specialist doctors of Aotearoa New Zealand, and will lead to a poorer training experience, and therefore less qualified SMOs at the end of training.

- <u>PAs are a perpetual burden on a health system, rather than a long-term investment.</u>
  This contrasts with the employment of RMOs, who are then trained and transition into the SMO workforce, to not only work independently, but also train the next generation of doctors.

  The consultation document states "Although PAs must currently work under the supervision of a designated medical practitioner, the supervisor is not required to be in the same room or facility as the PA but rather must be readily available for consultation or advice as necessary." We have serious concerns about this. Any clinician is put under more pressure to make decisions that are out of their scope of practise if their supervisor is not on site, and this may lead to clinical error, which risks patient safety.

- <u>There is no PA education program in Aotearoa.</u>
  This limits access to work-force training for our Māori and Pasfika populations, with not only flow-on effects for culturally appropriate patient care, but a complete disrespect for Te Tiriti obligations. STONZ does not support promoting use of an overseas trained workforce unfamiliar with the Aotearoa New Zealand context or Te Tiriti o Waitangi.

  In addition, this means that Aotearoa New Zealand has no control over the content of the curriculum. The problem with this is twofold. Firstly, PAs, who often do not have a medically related bachelor's degree, must be taught a significantly shortened form of the information regularly taught in medical school. This means they do not have a fundamental understanding of the underlying physiology and pathology of disease, which leads to compromised healthcare. Secondly, as they are taught in a different healthcare system, they will not recognise patterns of common diseases in Aotearoa. This will negatively affect Māori and Pasifika, who it is well recognised present with diseases that are more uncommon in other parts of the world (such as rheumatic fever), as well as later and with more severe or atypical symptoms.

- <u>The employment of PAs is contrary to Te Tiriti o Waitangi, and will not benefit those patients the consultation document aims to serve.</u>

In addition to the points discussed above, the consultation documents states "workforce changes may see more PAs employed, particularly in hard-to serve communities." This is not borne out by the evidence in countries which employ PAs. In the UK, 72% of PAs are employed in secondary care and it is likely that recruitment to primary care will fall short of targets[12]. This is similar in the USA, where only 21% of PAs are employed in primary care.[13] In addition, there is evidence that those PAs working in primary care are not located in hard to staff areas. The American Medical Association have compared the locations of doctors and APPs in primary care, and found that they tend to practice in the same areas of the state.[14]

Looking at APPs in primary care in the UK[15], there is evidence that compared to doctors, they are responsible for a significantly higher total NHS expenditure and significantly lower patient satisfaction.

Given all this evidence, STONZ has concerns that the introduction of PAs will create a two-tiered healthcare system, especially in primary care. Given that PAs have significantly less training, it is likely that the cost to visit them will be lower. This means that those patients who are of a lower socio-economic status, including many of our Māori and Pasifika patients, will preferentially visit them. This will widen the already disparate outcomes seen in these populations, and go against the main principles of Te Tiriti o Waitangi.

The effect of PAs in comparable healthcare systems

Currently the UK does not regulate PAs, despite being employed since 2010, and now having over 3000 PAs working in the NHS.[16,17] A similar consultation on regulation of PAs has drawn concerns around the impact on training of RMOs, and the confusion of patients, who may not know whether they are being treated by a doctor or a PA, or the differences between them. Recent opposition (within the last three months) to the increased scope of practice and regulation of PAs by the same regulator as doctors has come from the British Medical Association[10,18], the Royal College of Radiologists[19], the British Society of Interventional Radiology[20], the Academy of Medical Royal Colleges[21] and the Royal College of Anaesthetists[22], as well as vocal objections from doctors working in a range of specialties as listed above as well as Physicians[23], General Practitioners[24] and Ophthalmologists[25].

Another concern throughout those countries that employ PAs is so called "scope creep," which has prompted the American Medical Association to write to the House of Representatives raising their concerns that "nonphysician practitioners [could] perform tasks and services outside their education and training and could result in increased utilization of services, increased costs, and lower quality of care for patients."[1] PAs are university educated young professionals who have no clear career progression. It is therefore inevitable that they will attempt to extend their scope of practice over time, and we have significant concerns that regulation of the profession could open the door to this, with disastrous consequences on patient safety.

It is important to look to those countries that utilise and employ PAs in their healthcare system, and critically evaluate the effect their employment has had. It is very clear that caution should be undertaken and we at STONZ believe that PAs are a profession we should not utilise within Aotearoa New Zealand.

Alternative suggestions to streamline the existing workforce.

We already employ a workforce that fill this role, RMOs. Instead of employing a new and less qualified workforce, as documented above, we should be focusing on improving conditions and support for RMOs.

- House Officers (HOs) spend a significant amount of time doing paperwork. If this were to be prepared by administrators, it would free up HO time for patient facing duties and improve their training experience. This could be supplemented by improving our tech systems abilities, integration and continuity across the motu as this is where large gains in reducing the burden can be made.
- To signpost current PAs to admission to New Zealand Medical Schools under the Alternative admissions category, where they can have some qualifications cross credited[28].
- Explore further training of Nurse Practitioners. This profession fills many of the criteria suggested to be filled by PAs. They are an Aotearoa New Zealand trained workforce, who have significant clinical experience prior to entering further Masters study, and are often trained to work in one specific subspecialty area to support the RMOs and SMOs.
- There are many overseas doctors who would like to work in New Zealand. These doctors are limited by access to the NZREX examination, and the requirement for supervised placements. The supervision required is similar to that of PAs, however these doctors are more highly trained, and will progress within the workforce and therefore offer a much more valuable contribution in time.

Why limited submission?

We are concerned that the decision to regulate seems to have already been made and that this has occurred without consultation of all relevant stakeholders.

We also note that the independent Expert Panel, referred to in Appendix 1, does not contain any Te Whatu Ora representatives, let alone representation of all impacted workforces employed by Te Whatu Ora. It appears that the voice of secondary and tertiary level care has been excluded from the decision-making process. We are concerned that not all those with an interest, or who will be affected by the introduction of an entirely new workforce, have been invited to submit.

Whatever benefits may be put forward in this consultation process in support of regulation, STONZ does not consider that the perceived benefits outweigh the negative impacts that regulation of this workforce would have. We are concerned that the Ministry is pursuing regulation as a method of growing a new workforce before exploring and assessing the potential impacts or other alternative solutions.

Again, we thank you for the opportunity to provide feedback on regulation of Physician Assistants in Aotearoa. We feel a broader consideration first needs to be undertaken in order to assess whether having Physician Assistants as a part of Aotearoa's healthcare system is of benefit to patients and medical staff. We believe it is not.

That being said, we have provided further answers to the specific questions raised in the consultation document below, which should be read in conjunction with this letter, rather than in isolation:

1. **Do you agree that the PA profession provides a health service as defined under the HPCA Act, and poses a risk of harm to the health and safety of the public?**

Yes, PAs provide a health service including assessing, diagnosing, and managing patients. They order tests, perform invasive procedures and prescribe in some jurisdictions. This poses a risk of harm to the health and safety of the public.

2. Do you agree with the Ministry's assessment of the nature and severity of the risk of harm posed by the PA profession? If not, please provide comment.
   Yes, the risk of harm is very great, as discussed above. STONZ considers the risk of harm is higher in PAs than in most other health professions, due to the disparity between the degree of education and the level of responsibility, including the omission of key concepts such as Te Tiriti o Waitangi and an Aotearoa context of disease.

3. Do you consider that, under the Ministry's guidelines, it is in the public interest to regulate the PA profession under the HPCA Act?
   No. Currently PAs are required to work under close supervision and are unable to perform some tasks that cause the most risk to health and safety of the public, such as prescribing. In STONZ's view, any regulation will legitimise a workforce we do not wish to enter Aotearoa New Zealand, and will enable a widening of scope and less supervision of those PAs already within the country.

4. Do you consider that the existing mechanisms regulating the PA profession are effectively and adequately addressing the risks of harm of PAs' practice? Please provide comment about your answer.
   Given that all PAs are currently employed by separate and individual employers, with variable and undocumented supervision arrangements, it is not possible to comment whether the existing methods of regulating PAs can adequately address the risks of harm.

5. Could the existing regulatory mechanisms regulating the PA profession be strengthened without regulating the PA profession under the HPCA Act? Please provide comment about your answer.
   If regulation under the HPCA Act is not pursued at this stage, existing measures could be strengthened to protect public health and safety, including accountability for PAs under the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. In addition, we would advocate for continued supervision of PAs by medical practitioners, and ensuring that indemnity for the actions of the PA is covered by that medical practitioner's indemnity insurance, as a legal means to ensure adequate supervision.

6. Are there other regulatory mechanisms, short of regulation under the HPCA Act, that could be established to minimise the risks of harm of the PA profession? Please provide comment about your answer.
   Currently there are no regulatory mechanisms in place. If a decision is made that PAs are to be part of healthcare in Aotearoa New Zealand, a position that STONZ does not support, the first steps would be a register of PAs, and a formal national standard for PAs including an exam similar to the NZREX. This would be a minimum first step to ensure suitability for employment within Aotearoa, before regulation in any instance can be considered.

7. Do you agree that regulation under the HPCA Act is possible for the PA profession? Please provide comment about your answer

No. Given the evidence from countries that currently employ PAs, we do not believe that regulation of this workforce will adequately service the needs of the public. PAs do not have a defined skill set or training pathway, and a broad and variable scope. Their employment will require significant oversight by already stretched and hard-working doctors, and in essence, will negatively affect the better qualified workforce already present, and therefore patient care.

8. Do you agree that regulation under the HPCA Act is practical for the PA profession? Please provide comment about your answer

9. Regulation of health practitioners under the HPCA Act is funded by members of that profession through practicing certificate fees. It will take substantial resource to regulate a new profession, and this will need to be funded from a very small number of PAs currently working in Aotearoa New Zealand. Also, there is variability in education and scope internationally, for example prescribing, which will lead complexity in regulation for what is currently a small profession. In addition, if there is a large influx from overseas, which would be needed to generate the funds needed, this will lead to the concerns of overseas training already raised in this document. Given our concerns, we do not feel regulation is practical until the issues raised in this response are addressed.

10. Do you have anything to add to the consultation document's list of benefits and negative impacts of regulating the PA profession under the HPCA Act? Please provide comment about your answer.

We have significant concerns about the inclusion of these points as "benefits":

- workforce changes may see more PAs employed, particularly in hard to serve communities. This may help shorten waiting lists, thereby reducing risk to members of the public.
    - STONZ believes that this is both unrealistic, given the experience of the UK and USA, and will increase risk to members of the public, due to reduced supervision, lack of knowledge, and work outside of scope.
- This could lead to more confusion around healthcare roles and boundaries, while also providing consumers with a wider range of treatment providers.
    - Increased confusion around healthcare roles and boundaries is a significant negative, as discussed above, and we are unsure how a "wider range" of treatment providers is of benefit, especially as they represent a less well trained version of the doctors already working in the healthcare system.
- PAs are currently not able to practise to the top of their scope in New Zealand; in the absence of regulation, they cannot be granted prescribing authority and are restricted by current supervision requirements.
    - As outlined in the arguments above, PAs pose a significant risk to health and safety of patient care, particularly around the areas of prescribing or working without supervision. We do not advocate for removing these limitations on their practice. The ability to prescribe in a workforce that does not have universal prescribing rights, and therefore may have limited training in prescribing is a significant risk to patient safety and should not be encouraged.

11. Do you consider that the benefits to the public in regulating the PA profession outweigh the negative impact of regulation? Please provide comment about your answer.

No, we do not consider the benefits outweigh the risks, given the significant and numerous concerns raised within this document.

A. Do you have any comments to make regarding PA practitioners' general agreement on qualifications, standards, and competencies pursuant to s 116(b) of the HPCA Act?

The consultation document states a PA course is "27 months' duration with at least 2000 hours of clinical training and 2000 hours of didactic coursework. Most training programs require at least 1000 hours of health care experience prior to entering the program, and most applicants have extensive experience in nursing, paramedicine, lab science, or another allied health profession." This is grossly incorrect. In the UK, the course is 2 years, requiring a biomedical sciences or healthcare related degree, and over 1,600 hours of clinical training. There is no requirement for previous healthcare experience. Some universities are offering a 4-year intercalated master's degree which allows some to go from secondary school into working as a PA at the age of 22 with no clinical experience. We would like to raise a concern that that authors of this consultation document have not completed enough research into the international training requirements to make a decision on their fitness to practise in Aotearoa New Zealand, nor have they considered the substantial differences between a PA qualification and that of doctor.

We would also disagree with the comments: "training requirements and certification standards in these three jurisdictions are quite similar … Certification standards include qualifications, standards of practice (eg, codes of conduct or ethics), and competencies." There are vastly different competencies in the USA and UK, with regards to prescribing, supervision requirements and ordering investigations. In addition, there are multiple other countries who employ, train and utilise PAs. This document gives no reference to the standards in these countries.

Why physician associate, not physician assistant?

PAs in most of the world are known as physician assistants, and are known as physician associates only in the UK. Patients should always know who is treating them and whether this is a medically qualified doctor. Medical 'associate' roles may blur the distinction between doctors and non-medically qualified professionals. In the UK the British Medical Association has called for the reversion of the name 'physician associate' back to 'physician assistant', to reduce confusion for patients and better reflect the role within clinical teams[26].

In the USA, an American Medical Association survey has found 95 percent of respondents said it was important for a physician to be involved in their diagnosis and treatment decisions[27]. STONZ strongly supports this aim and we do not wish for there to be increased confusion as to the qualifications of any treating medical practitioner.

Given this, STONZ has significant concerns about the choice of title for this profession, and if the decision is to regulate, then our preference would be for use of the more common title 'physician assistant.'

Ngā mihi
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