



Australasian College
for Emergency Medicine

Non-medical practitioners working in emergency departments

P67 v4

August 2025

acem.org.au

Document Review

Timeframe for review:	Every five years, or earlier if required
Next major review completed:	August 2030
Content Owner:	Council of Advocacy, Practice and Partnership
Approval Authority:	ACEM Board
Document maintenance:	Public (website)

Revision History

Version	Date	Pages revised / Brief Explanation of Revision
V1	March 2014	First version
V2	September 2019	New template adopted
V3	November 2022	Last paragraph added to Policy section
V4	August 2025	Approved by Board. Major revision of title and content to reflect changes in legislative and work practices and the expansion of non-medical practitioner roles working in emergency departments

Copyright

2025. Australasian College for Emergency Medicine. All rights reserved.

1. Purpose and Scope

This policy, a document of the Australasian College for Emergency Medicine (ACEM), is applicable to all EDs in Australia and Aotearoa New Zealand and relates to all practitioners who do not hold a medical degree (non-medical practitioners) working in EDs including extended scope practitioners.

ACEM recognises that there is much variation in the training, experience, scope of practice, and models of care in which the array of non-medical practitioners practice. Therefore, this policy provides a set of overarching principles regarding the supervisory, collaborative, professional and governance requirements of all non-medical practitioners to work as a member of an ED team.

2. Definitions

The definitions below describe the most common non-medical practitioner roles that currently practice or are proposed to practice in EDs in Australia and Aotearoa New Zealand. However, this is not an exhaustive list, and new non-medical practitioner roles may be added in the future and should be regarded as being in the scope of this policy.

Non-medical practitioners

A non-medical health practitioner has completed specific training that contributes to the management and care of patients seeking emergency care. These practitioners include extended role practitioners such as extended role nursing and allied health practitioners, and other non-medical practitioner roles such as physician assistants/associates and extended scope paramedics.

Advanced practice physiotherapist / advanced scope physiotherapist

Advanced practice/scope physiotherapists primarily work with the musculoskeletal system. They manage fractures and dislocations, spinal pain and soft tissue injuries in EDs.

Extended role nurse

An extended scope nurse is a registered nurse with the experience, additional training and authority to diagnose and treat people of all ages with a variety of acute or chronic conditions. They work in many parts of the health system (including EDs) and will have undergone specific training to work within a locally defined scope of practice.

Extended scope paramedic

An extended scope paramedic specialises in acute primary care in the community with a focus on patients with low acuity and often high-complexity clinical conditions.¹ They are trained as 'generalists' and work collaboratively with doctors, nurses and allied health practitioners.² In Aotearoa New Zealand they are called extended care paramedics (ECP) and in Australia they are called advanced practice paramedics (APP) or paramedic practitioners (PP).

Physician assistant/associate

A physician assistant or associate (PA) is a practitioner working as a member of an interprofessional team under the delegation and supervision of a medical practitioner. PAs can specialise and undergo specific training in emergency medicine, working within a locally defined scope of practice.³ Physician assistants are currently not registered in Australia. Physician associate registration in Aotearoa New Zealand is to be enacted in 2025.

Collaborative model of care

An ED collaborative model of care is an integrated, interprofessional approach to healthcare that emphasises a team-based approach that maximises the skillsets of the interprofessional team to provide high-quality, patient-centred care in the ED. Ongoing clinical governance, professional development and quality improvement are key tenets of the ED collaborative model of care.⁴

¹ Paramedic Council. *Scope of Practice*. June 2025. [Scope of practice](#)

² Allied Health Professions Australia. *Paramedic Practitioners*. [Paramedic Practitioners — Allied Health Professions Australia](#)

³ Queensland Health. *Health Employment Directive No. 02/24*. May 2024. [Physician assistants](#)

⁴ Lowe G. Scope of emergency nurse practitioner practice: where to beyond clinical practice guidelines? *Australian Journal of Advanced Nursing*. 2010 Sept;28(1):74-82

Director of Emergency Medicine

The Director of Emergency Medicine (DEM) has overall clinical and administrative responsibility for all patients in the ED. All staff in the ED report to the DEM on operational and clinical matters. This does not preclude matters of policy and ethical responsibility that interprofessional team members have to others in the hospital.

Direct supervision

Direct supervision is when the supervising clinician (SC) is in the same physical location and is immediately available to provide advice and support to a non-medical practitioner and, if required, an immediate review of a patient. Given the acuity and complexity of patients presenting to EDs, this level of supervision is the most appropriate for non-medical practitioners in the ED environment.

Indirect supervision

Indirect supervision is when a supervising clinician (SC) is available to provide advice to a non-medical practitioner but may not be in the same physical location. If required, the SC must be able to provide an in-person review of a patient within a reasonable time frame. This level of supervision for non-medical practitioners is not ideal in the ED setting, however in some cases, may be a pragmatic solution (for example, telehealth supervision of small, remote centres).

Interprofessional team

An interprofessional team consists of healthcare practitioners from different professions working collaboratively to provide patient-centred care.

Supervising clinician

A supervising clinician (SC) is a qualified senior medical practitioner who is responsible for supervising a non-medical practitioner. This clinician retains clinical and professional responsibility for patients treated under their care. A SC must:

- be a fully qualified, registered medical practitioner
- be a senior emergency medicine practitioner (Intermediate and above expertise level as outlined in ACEM G23 Guidelines) ⁵, preferably a FACEM.

Interns and early career doctors should not be responsible for the supervision of non-medical practitioners. Non-medical practitioners should not supervise other non-medical practitioners except for education and training purposes.

Non-medical practitioners should not supervise interns or early career doctors.

3. Background

EDs are most effective when care is provided by an interprofessional team under a collaborative model of care. However, due to workforce shortages and long-term deficits in health workforce planning and resourcing across the health system, governments in Australia and Aotearoa New Zealand are increasingly looking for short and medium-term options to expand the existing health workforce.

To meet patient demand there is increasing pressure for ED teams to be expanded to include larger numbers of extended role practitioners, such as nurse practitioners and allied health practitioners, and increasing the utilisation of other non-medical practitioners, including physician assistants/associates and extended role paramedics. Whilst these roles can be very effective in the ED, any expansion of the workforce must ensure patients receive the high level of care they deserve. The expansion of non-medical practitioners working in EDs must be approached in a balanced way, ensuring EDs are not under resourced and that all practitioners working in EDs are well supported and not overburdened.

4. Policy

4.1 General Principles

- ACEM acknowledges that within a stable ED workforce and with adequate supervision and a clear scope of practice agreed to and understood across the ED team, non-medical practitioners are effective and valued members of the ED workforce. An interprofessional team-based approach to patient care

⁵ Australasian College for Emergency Medicine. Constructing a sustainable emergency department medical workforce (G23).

ensures patients receive high quality emergency care in EDs. The role of the non-medical practitioner within ED teams should be to support and enable doctors and other members of the interprofessional team to work at the top of their scope of practice.

- ED teams work under a collaborative model of care, where care is shared within a medically led interprofessional team led by the Director of Emergency Medicine (DEM) or Head of Department (HOD). By nature of the length and depth of their training, FACEMs provide the highest level of care in EDs, and it is ACEM's position that all interprofessional teams providing care in emergency settings should be led by a FACEM.
- Non-medical practitioners working in EDs must have a senior emergency medicine practitioner available to provide direct supervision (see definition above). They should not work in an ED without an appropriate level of medical supervision and support.
- Non-medical practitioners should be rostered to complement and not replace a doctor on an ED roster. They should not be regarded as a substitute for a doctor.
- Expanding ED teams to include non-medical practitioners must be well planned, in consultation with emergency doctors, to ensure their successful integration into existing ED teams. Emergency medicine has a strong history of successfully integrating innovative, complementary roles within EDs where these role descriptions have been designed by individual departments for local needs with input from emergency doctors.
- EDs must ensure that they are able to meet the FACEM training program requirements for emergency medicine trainees in relation to access to patients, range and acuity of presentations and/or supervisor time. The supervision of non-medical practitioners should not compromise the supervision or training experience of early career doctors and trainees in the ED.
- Workforce shortages are seen across all sectors of the health system. This is magnified in regional, rural and remote settings. It is important to ensure that all communities, including those in regional, rural and remote areas, can access the highest quality, safe emergency care provided by suitably qualified doctors in medically led EDs. Governments must strive to ensure suitably qualified doctors are placed in all settings providing emergency medical care.

4.2 Clinical governance

Workplaces must have a clear governance structure and processes that provide oversight of all practitioners working within the ED team, including non-medical practitioners. As the designated clinical lead in charge of the ED, the DEM or HOD is accountable for the clinical and operational performance of the ED and retains primary responsibility for patient care irrespective of who provides the care. To ensure high quality, safe patient care in EDs, it is paramount that all clinical care provided in the ED has medical oversight.

The reporting structure within the department must be clear to all members of the ED team. As DEMs or HODs are responsible for overseeing operational performance and clinical care in the ED, they should also have responsibility for recruitment, rostering and ongoing performance management of all practitioners employed in the ED, including non-medical practitioners. Different practitioners within the ED may also report to a senior manager within their craft group to ensure ongoing professional development.

4.3 Regulation of non-medical practitioners

Unlike medical training, there is currently no nationally standardised curriculum or scope of practice for the broad range of non-medical practitioners currently practicing in Australia and Aotearoa New Zealand. Therefore, DEMs or HODs and SCs are often unsure what tasks non-medical practitioners in their ED can competently complete, meaning the scope of practice of each non-medical practitioner needs to be individually negotiated. **ACEM recommends the standardisation of training programs and scopes of practice for each non-medical practitioner role across Australia and Aotearoa New Zealand.**

Once a standardised scope of practice is established for each non-medical practitioner role, clearly defined role descriptions can be developed within EDs to ensure these roles are integrated into the collaborative model of care. The scope of practice of these roles must be clearly understood by all members of the ED team and should complement the scopes of practice of existing clinicians rather than duplicate services/tasks being provided by other practitioners.

Non-medical practitioners are expected to work within their agreed scope of practice and consult with their SC when there is any clinical uncertainty or patient deterioration. Clear guidelines should be in place to define when and how to escalate matters to a doctor or another member of the ED team. These guidelines must

reflect Australian Commission on Safety and Quality in Health Care (ASQHS) Quality Standards in Australia⁶ and Taupuni mahi Workstreams in Aotearoa New Zealand.⁷

Employers must develop policies and procedures covering the role of non-medical practitioners in EDs that adhere to all national guidelines and must be aware of professional indemnity requirements. Employers should monitor the impact of non-medical practitioner roles in EDs on patient outcomes and the training of new doctors and respond to monitoring findings as required.

ACEM does not support any further expansion of current non-medical practitioner roles until all existing clinical roles being piloted are clearly defined, with appropriate relevant standards, training and evidence of improvement in care delivery.

44 Supervision of non-medical practitioners in the ED

Given the high volume, rapid turnover and undifferentiated nature of patients presenting in EDs, supervision and support requirements for non-medical practitioners are higher than in some other health care settings. All non-medical practitioners must work within their scope of practice under the supervision of a SC in the ED. The level of supervision required will be dependent on the level of training and experience of the non-medical practitioner and must be negotiated with the DEM and respond to the needs of the interprofessional ED team. SCs provide leadership and support for non-medical practitioners to utilise their skills and training to provide quality care in the ED within their clearly defined scope of practice and role description.

FACEMs who are supervising ACEM trainees, as well as non-medical practitioners, must be given an adequate time allowance to ensure they are available to provide the required level of support and guidance at any time. Supervision of non-medical practitioners should not negatively impact on the supervision capacity required for specialist international medical graduates (SIMGs), interns or early career doctors working in the ED (refer to ACEM policy P53 Supervision of early career doctors in emergency departments).

The number of non-medical practitioners rostered onto any shift must be commensurate to the number of available SCs and their other supervision and clinical commitments. Workplaces must ensure that the supervision of non-medical practitioners does not overburden emergency medicine doctors working in EDs.

45 Roles for non-medical practitioners in the ED

ED teams operate in a medically led, collaborative model of care. Non-medical practitioners have different scopes of practice and may fulfil different roles within the interprofessional ED team depending on their training and experience. In the absence of any standardised national processes, currently roles and scope of practice for non-medical practitioners in EDs are locally determined and individually negotiated and subject to ongoing monitoring and oversight by the DEM or HOD. Roles within ED teams can vary from workplace to workplace as what might be appropriate in one setting, may not be safe in another.

However, there are some tasks that are beyond the scope of practice of non-medical practitioners within EDs and should be conducted by a FACEM or senior emergency doctor. Non-medical practitioners **should not**:

- work independently in the ED outside of a medically led ED team
- act as a senior decision maker
- make independent assessments of deteriorating patients
- discharge patients and define discharge plans outside of their clearly defined scope of practice.

Although some non-medical practitioners are permitted by law to prescribe medication, order tests/scans, and make referrals (for example, nurse practitioners), within the ED all decisions should be made within a collaborative model of care in a medically led ED team.

Non-medical practitioners must be included in hospital clinical education, training, audit, risk management and quality improvement activities. Registered non-medical practitioners must complete ongoing Continuing Professional Development (CPD) as part of their professional requirements.

⁶ Australian Commission on Safety and Quality in Health Care. Recognising and responding to acute deterioration standard.

[Recognising and Responding to Acute Deterioration Standard | Australian Commission on Safety and Quality in Health Care](#)

⁷ Te Tāhū Hauora Health Quality and Safety Commission. Taupuni mahi Workstreams. [Workstreams | Te Tāhū Hauora Health Quality & Safety Commission](#)

4.6 Communication with patients

The general public have limited awareness of new roles in the clinical workforce, such as who is medically trained and who is not, especially with newly introduced roles such as physician assistants/associates. Titles used by non-medical practitioners should leave no room for confusion. ACEM recommends the use of the term 'physician assistant' rather than 'physician associate' to avoid any confusion on the scope of these roles.⁸ The prefix 'Dr' should only be used by doctors in the ED.

Non-medical practitioners must always inform patients and other staff of their role and clearly explain their role to patients and colleagues to ensure that patients understand their role in the ED. Patients need to be clear that they are not doctors and that they work under the supervision of a doctor. Patients must always be given the opportunity to be seen by a doctor if requested.

⁸ Government of the United Kingdom. The Leng review: an independent review into the physician associate and anaesthetist associate professions. July 2025. [The Leng review: an independent review into the physician associate and anaesthesia associate professions](#)



Australasian College for Emergency Medicine
34 Jeffcott Street
West Melbourne VIC 3003
Australia
+61 3 9320 0444
admin@acem.org.au

acem.org.au