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What counts as competent? A documentary analysis of minimum clinical hour requirements across four health professions in Aotearoa New Zealand

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Abstract

Background

Minimum clinical hour requirements are a central feature of health professional education in Aotearoa New Zealand. Although these requirements are widely considered as indicators of preparedness and public safety, the rationale for determining the minimum requirement is rarely articulated. Regulatory Authorities operate under the Health Practitioners Competency Act, which requires practitioners to be competent and fit to practice but does not prescribe how competence should be developed or measured. Although these requirements are widely embedded across health professions, their underlying rationale and evidentiary basis are not always clearly articulated.

Methods

An iterative document audit using qualitative document analysis was conducted. Data were extracted and evaluated using the Currency Relevance Authority Accuracy and Purpose framework. Regulatory standards, policy documents, organisational records, and grey literature were systematically identified and analysed.

Results

Analysis found that clinical hour requirements are largely historically derived and vary across professions. Nursing and midwifery retain structured hour-based requirements, while physiotherapy has transitioned to a competency-based model without prescribed hours, and occupational therapy aligns with international fieldwork expectations.

Conclusion

Across professions, there was limited explicit rationale and little empirical evidence linking specific hour thresholds to competence. Regulatory obligations, stakeholder consultation, professional expectations, international standards, and workforce and system constraints shape current requirements more strongly than research evidence.

Introduction

Health practitioners in Aotearoa New Zealand are regulated by the Health Practitioners Competence Assurance Act (HPCAA) (1). This Act establishes a framework to protect public health and safety by ensuring practitioners are competent and fit to practise (2). Under this legislation, responsible Regulatory Authorities (RAs) such as Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand, Te Tatau o te Whare Kahu Midwifery Council of New Zealand, Te Poari Tiaki Tinana o Aotearoa Physiotherapy Board of New Zealand, and Te Poari Whakaora Ngangahau o Aotearoa Occupational Board of New Zealand are authorised to prescribe qualifications and accredit educational programmes (1). The HPCAA itself does not specify educational inputs such as minimum clinical practice hour requirements, leaving decisions about clinical education to professional RAs.

Clinical education programmes require students to undertake supervised placements in healthcare settings, where learning is supported, enabling the development of clinical competence (3). Structures and expectations for clinical learning vary across professions, reflecting differences in their scope of practice and professional identity.

In Aotearoa New Zealand, regulatory standards require nursing programmes to include at least 1000 hours of supervised clinical learning across diverse practice settings (4). Midwifery programmes require a minimum of 2400 hours of clinical learning, undertaken across hospital and community contexts (5). Physiotherapy programmes do not require but include approximately 1000 hours of supervised clinical practice prior to registration (6, 7). Occupational therapy regulation emphasises the demonstration of competence across defined professional domains rather than specifying minimum clinical hour requirements (8).

Although health professional education in Aotearoa New Zealand emphasises the development and assessment of competencies required for practice (9), the development and assessment of clinical competence remains problematic. For example, Borren et al. (10), report that in undergraduate nursing programmes in Aotearoa New Zealand, assessment of clinical competence is a central component of professional education, despite institutions facing challenges in ensuring students consistently develop and demonstrate competence across programmes. These challenges arise from several factors, including inconsistencies in assessment tools, differing interpretations of competence among educators and clinical supervisors, difficulties in applying assessment criteria and documenting student performance reliably (11). These collectively influence the complexity and challenges in standardising evaluation.

Variability in clinical placement contexts and inconsistencies in assessment processes also contribute to differences in how competence is evaluated, making standardisation across programmes challenging (12). Studies highlight that factors such as time constraints, learning tasks, and the nature of clinical placement environments can influence students' clinical learning experiences (13, 14). Understanding how these clinical hours requirements were established is important for education, as well as for transparency and accountability in regulatory decision-making.

To date, no systematic examination of regulatory documentation related to mandated clinical hour requirements in Aotearoa New Zealand for nursing, midwifery, physiotherapy, and occupational therapy has been explored. Understanding how these requirements were determined, what evidence or principles informed them, and how they have changed over time is important for informing future regulatory review, educational reform, and workforce planning. This study, therefore, aimed to examine the original rationale and decision-making basis for current minimum clinical hour requirements for professional registration in nursing, midwifery, physiotherapy, and occupational therapy in Aotearoa New Zealand. These professions were selected as they reflect the accredited graduate-entry master's programmes currently offered at Auckland University of Technology, providing a relevant and contemporary educational context for this study.

Study Design

This study employed an iterative document audit process to investigate the historical rationale and decision-making basis underpinning minimum clinical practice hour requirements for professional registration in nursing, midwifery, physiotherapy and occupational therapy in Aotearoa New Zealand. Audit-type studies involve the systematic review of current practices against established standards to identify gaps and inform quality improvement (15). In this study, the audit approach was applied to documentary and regulatory materials rather than clinical practice. Iterative research processes are commonly used in policy and regulatory investigations, allowing the identification and interpretation of relevant documentary evidence to be refined as the study progresses (16). Accordingly, the study involved repeated cycles of searching, reviewing, and interpreting documentary evidence rather than a strictly linear process.

The study was guided by the research question: *What is the original rationale and decision-making basis for the current minimum clinical hours required by regulatory authorities for professional registration of nursing, midwifery, physiotherapy, and occupational therapy in Aotearoa New Zealand?*

Figure 1 provides an overview of the study design using a three-tier framework consisting of Input, Process, and Output stages. The Input stage outlines the identification of evidence, including the searching and collection of relevant documents. The Process stage represents the screening and selection procedures used to determine eligibility for inclusion. The Output stage presents the application of the Currency, Relevance, Authority, Accuracy, and Purpose (CRAAP) framework evaluation (17, 18), as well as data extraction and synthesis steps undertaken, and interpretation of findings.

Data Sources

Evidence selection followed a structured two-step process. First, inclusion and exclusion criteria were established to determine the relevance of sourced documents. These criteria (Table 1) were applied to all materials to ensure alignment with the study's scope and purpose. All documents meeting the inclusion criteria were retained for extraction and analysis.

Table 1
Inclusion and Exclusion criteria

Inclusion criteria	**Exclusion criteria**
Graduate attributes or profile – linked to competencies - thresholds	Non-registered health professionals
Assessment of clinical competencies	Post-registration and post-graduates
Clinical practice information such as hours, areas of practice	Medical doctors
How 'clinical competence' is reached	Over 10 years old
All countries	
Grey literature and organisations	

Initial searches were carried out by two of the research team (CN and TD) who identified several publicly available documents from regulatory and governmental sources. Initial sources did not provide explicit explanations regarding the original rationale or decision-making basis for the establishment of minimum clinical hour requirements. Instead, they offered contextual information that supported broader understanding of regulatory frameworks and educational standards. To obtain more detailed evidence directly relevant to the research question, the same two researchers (CN, TD) contacted representatives from each of the four RAs under investigation for more relevant information (see Fig. 1).

Data Extraction & Analysis

Data were extracted by CN and TD onto a shared table in Microsoft Word recording relevant profession, organisation/author, date, type of document, source, and key summary points. The CRAAP evaluation framework (Benedictine University Library, 2025; Blakeslee, 2004), was applied to assess the credibility and contextual value of each included source. The framework was used to evaluate each source by examining credibility, applying critical judgement, and reflecting on potential biases in interpretation (19). Within this framework are; ("C") currency assesses the timeliness of the document; ("R") relevance examines the extent to which the content addressed the research question; ("A") authority evaluates the credibility of the issuing organisation or author; ("A") accuracy considers internal consistency and the presence of supporting evidence; and ("P") purpose assesses whether the document was intended to inform, regulate, justify, or advocate (17).

Data were analysed using qualitative document analysis to examine and interpret regulatory decisions and policy development within the evidence (20). The identified data were categorised into thematic groupings based on recurring explanations, influences, and justifications related to the establishment or revision of minimum clinical practice hour requirements. The analytical process involved multiple readings of each document to identify explicit and implicit references to the rationale underpinning minimum clinical hour requirements, descriptions of decision-making processes, and references to relevant historical, regulatory, or policy contexts.

Relevant segments of text were extracted and compiled into an evidence table (Appendix A) to organise the documentary data systematically. All included evidence was then compiled into a summary table. Regular meetings were held with the wider research team (CN, TD, TF, VS) to present findings and contribute to theme construction.

Results

Twenty-one sources met the eligibility criteria. Most sources were regulatory or organisational documents, supplemented by a smaller number of academic sources (21–23). Table 2 identifies the profession associated with each source, the author or responsible authority, the year of publication, the document type, the link to the source (where available), and a summary of the key points.

Table 2
Detailed summary of the included evidence

Profession	Author/s; Organisation/s	Date or year	Type of document	Website Link*	Key Summary
All	Ministry of Health New Zealand (Manatū Hauora)	January 26, 2026	Website article	https://tinyurl.com/5n8rv7vb	• Responsible authorities are statutory bodies under the Health Practitioners Competence Assurance Act 2003 • Main purpose: Protecting the health and safety of the public • Every practitioner in a regulated profession must be registered • 18 responsible authorities operating under the Act • Authorities oversee performance reviews and competence processes • Not all health professions fall under this Act
All	Greg Coyle	2007	Peer-reviewed journal article	https://tinyurl.com/4cbe69hu	• New Zealand regulators cannot explain why 1000 hours is required • Some believe it originated from trade apprenticeships • Mandated hours give regulators a "good feeling" of safety • No agreement on what counts as a "clinical hour" • Some schools admit to fudging hours in audits • Mandated hours are the biggest barrier to increasing student numbers • District Health Boards reluctant to take students; no incentives for clinicians • No evidence linking hours to competence • Mandated hours used by schools to protect programmes from budget cuts
Nursing	Nursing Council of New Zealand	March 03, 2023	Website article with attached files within	https://tinyurl.com/yck26k9x	• RN education standards updated in 2020–2021, but clinical hours were not fully reviewed at that time • Existing minimum 1100 clinical hours was kept due to strong opposition to reducing hours • 2022 consultation launched to reconsider hours because of simulation advances and placement pressures • Three opinions consulted: keeping the 1100 hours, reducing to 900 hours, or keeping 1100 hours and allow up to 200 hours of simulation • 204 submissions received which majority supported keeping the 1100 hours • Little support for reducing hours • Simulation option received moderated support especially

Profession	Author/s; Organisation/s	Date or year	Type of document	Website Link*	Key Summary
					from education providers • Māori and Pacific respondents strongly favoured keeping 1100 hours • Students mostly supported keeping hours which some supported reduction and less support for simulation • Education providers more supportive of simulation and somewhat open to reduction • Council's decision was to retain 1100 hour minimum
Nursing	Nursing Council of New Zealand	February 20, 2025	Website article with attached files within	https://tinyurl.com/yyh268x5	• New minimum clinical hours confirmed: 1000 for registered nurses and 700 for enrolled nurses • Additional hours may be required to support student success • Transition to new standards begins February 2025 • Standards reflect Te Tiriti O Waitangi and focus on Māori health equity • 88% supported the new standards structure • Support for EN's 700 hours but mixed feedback in • reducing 1000 hours for RN
Midwifery	Midwifery Council	March 2023	PDF– File document	https://tinyurl.com/mvh2smkr	• Minimum 2400 clinical hours required (50% of total programme) • Clinical hours increase across the programme, with final year mostly practice-based (≥ 80%) • Clinical learning must occur in real practice settings across the full maternity continuum • Simulation limited to 15% (360 hours) of clinical time • Specific experience requirements include follow-through cases, births, and exposure to complications • Clinical hours are tied to demonstration of competency and required skills • All clinical learning must be supervised by registered midwives • Programmes must ensure adequate placement availability and range of experiences
Midwifery	Midwifery Council's senior advisor for midwifery education. J. Paine	Acquired through direct email (personal communication) on January 23, 2026.	PDF–File document	Not available	• 2400 clinical hours established as the minimum requirement for undergraduate midwifery programmes • Standard introduced following Midwifery Council review (2004–2006) to address variability across programmes • Clinical hours were set alongside 1920 theory hours within a ~

Profession	Author/s; Organisation/s	Date or year	Type of document	Website Link*	Key Summary
					4600–4800-hour degree structure • Decision influenced by need for national standardisation and consistency in education • Strong influence of international alignment (EU/UK 4600-hour benchmark) • Higher clinical hours reflect New Zealand's model of midwifery care (continuity, autonomy, high responsibility) • Emphasis on practice-intensive training to support immediate autonomous practice at registration • In contrast, global standards (International Confederation of Midwives) prioritise competency over fixed hour requirements • Introduction of Master's pathway shows flexibility in hours (1500 clinical) when prior experience is recognised
Midwifery	New Zealand College of Midwives	Not available	Website article	https://tinyurl.com/adna5u38	• Degree is 4800 hours equivalent • Programme includes clinical placements across hospital, community, urban and rural settings • Curriculum is nationally consistent and meets international regulatory standards • Minimum clinical requirements include pregnancy assessments, births, postnatal care, newborn • assessments, and continuity of care
Physio- therapy	Maree Grbin	2013	Peer-reviewed journal article	https://tinyurl.com/26phadey	• Early NZ regulation focused on training duration rather than clinical hours • Masseurs Registration Act 1920 required 12 months of training • 1935 amendment extended minimum training to 21 months • Regulation emphasised competence, character, and Board approved training institutions • No minimum clinical hour requirement existed in early legislation
Physio- therapy	Physiotherapy Board of New Zealand's Professional Advisor for Accreditation	Acquired through Email (personal communication) on January 28, 2026	PDF – File document	Not available – Acquired throughpersonal communication (email)	• NZ required 1000 hours of supervised clinical practice from 1949–2007 • 2008 review found no evidence supporting 1000 hours as a minimum • World Confederation of physiotherapy had already removed its 1000hour recommendation in 1991 • Australian Physiotherapy Council (ACOPRA) also did not require 1000 hours

Profession	Author/s; Organisation/s	Date or year	Type of document	Website Link*	Key Summary
					• NZ shifted to a competency-based model • Reference to 1000 hours later removed entirely to stop • perpetuating the “myth”
Physio- therapy	Joan McMeeken from University of Melbourne & University of Otago	2014	Editorial article from New Zealand Journal of Physiotherapy	McMeeken, J. M. (2014). Celebrating a shared past, planning a shared future: physiotherapy in Australia and New Zealand. New Zealand Journal of Physiotherapy, 42(1), 1–8.	• Early physiotherapy education in NZ and Australia based on 2year hospital/university programmes • Training emphasised anatomy, physiology, massage, and medical gymnastics • No reference to minimum clinical hours • Education strengthened during polio epidemics and world wars • Professionalisation grew through increased autonomy and integration with universities
Physio- therapy	Physiotherapy Board of New Zealand	2026	Website article with attached files within	https://tinyurl.com/4vxfut98	• Physiotherapy Practice Thresholds define the competence required for initial registration • Thresholds cover professional behaviour, communication, assessment, intervention, cultural safety, and lifelong learning • No minimum clinical hour requirement • Competency based framework shared by NZ and Australia
Physio- therapy	Physiotherapy Board of New Zealand	Updated January 14, 2026	Website article with attached files within	https://tinyurl.com/5xhhc2wh	• Accreditation Standard V2 2025 does not prescribe minimum clinical hours • Students must achieve relevant competencies before supervised patient care • Emphasis on public safety and competence rather than time-based thresholds • Programmes must demonstrate graduates meet Physiotherapy Practice Threshold
P Physio- therapy	Physiotherapy Board of New Zealand	n.d.	Website article	https://tinyurl.com/4zm99w7y	• Clinical Hours Profile used for international applicants to describe supervised practice • Not a minimum requirement for NZ programmes • Helps assess scope, depth, and relevance of overseas training • Supports competency-based assessment rather than hour based
Physio- therapy	Grant, R.	2024	Peer-reviewed journal article	https://doi.org/10.1016/s0004-9514(14)60116-1	• ACOPRA does not require 1000 hours for accreditation • Focus is on quality, comprehensiveness, and depth of clinical education • Confirms 1000 hours was never an Australian requirement • Influenced NZ’s move away from hour-based regulation Australian Physiotherapy Council – Letter to the Editor (Australia)

Profession	Author/s; Organisation/s	Date or year	Type of document	Website Link*	Key Summary
Physio- therapy	Chipchase, L., Dalton, M., Williams, M., & Scutter, S.	2024	Peer-reviewed journal article	https://doi.org/10.1016/S0004-9514(14)60150-1	• Physiotherapy education is largely tradition based, not evidence based • “1000 hours” requirement is based on opinion, not research • Clinical education varies widely across universities • Education research is underfunded and undervalued • Evidence-basededucationrequiresintegrating research, educator expertise, and student needs • Current model is “experience based” or “exposure based,” not evidence based
Occupational Therapy	New Zealand Gazette	2024	Website article	https://tinyurl.com/mwtrfmf5	• Gazette defines scopes of practice and prescribed qualifications for physiotherapists • Physiotherapists must provide evidence informed, autonomous care • No mention of minimum clinical hours • Registration based on holding an approved qualification
Occupational Therapy	OccupationalTherapy Board of New Zealand	2022	PDF–File document	https://tinyurl.com/bdd8cjy3	• Public safety is the primary principle guiding OT programme design • Students must achieve prerequisite OT knowledge, skills, and behaviours before any client contact • Fitness-to-practise processes must be effective • Practice education must meet quality and safety standards • No minimum number of hours is stated, but programmes must ensure quality, quantity, duration, and diversity of fieldwork sufficient for competence • Assessment must ensure graduates are safe, ethical, and competent • Supervision must be competent and sufficient
Occupational Therapy	World of Federation of Occupational Therapists	2020	Website article with files attached within	https://tinyurl.com/yfp42s2k	• WFOT sets the international minimum requirement of 1000 hours of fieldwork for OT programmes • Minimum Standards aim to ensure global consistency and mobility of OT graduates • Standards emphasise human rights, social inclusion, and global health needs • Practice education is a core component of OT identity and competence

Profession	Author/s; Organisation/s	Date or year	Type of document	Website Link*	Key Summary
					• World of Federation of Occupational Therapists' approval is required for international recognition of OT qualification
Occupational Therapy	Karen Stagnitti & Narelle Robertson	2012	Discussion paper for ANZCOTE meeting	https://tinyurl.com/4wp8khd7	• OT students are required to complete 1000 hours based on World of Federation of Occupational Therapists' standards • Evidence supporting 1000 hours is limited; requirement is largely historical • Literature shows little empirical evidence for minimum hours in occupational therapy, nursing, speech pathology, or social work • Only one study evaluated 1000 hours and found competence was almost achieved but evidence was limited • Significant challenges exist in securing placements: shortage of sites, supervisor workload, inconsistent supervision quality • Some argue quality of placement matters more than quantity • Alternative models (e.g., GRACE programme, 2:1 supervision) show promise
Occupational Therapy	Policy Administrator, Occupational Therapy Board	2026	Acquired through email – PDF File	Not available – Acquired through personal communication (email)	• Occupational Therapy Board of New Zealand confirms New Zealand Occupational Therapy programmes must meet World of Federation of Occupational Therapists' minimum 1000 hours • Both NZ programmes (AUT & Otago) publicly state they meet the 1000-hour requirement • HPCA Act mandates Occupational Therapy Board of New Zealand to prescribe qualifications and accredit programmes • World of Federation of Occupational Therapists' • approval ensures international recognition and mobility • Occupational Therapy Board of New Zealand emphasises alignment with World of Federation of Occupational Therapists as the basis for the 1000-hour requirement
Occupational Therapy	OccupationalTherapy Council of Australia	December 2018	PDF–File document	https://tinyurl.com/2rjkywc9	• Australian Occupational Therapy accreditation standards require sufficient quality, quantity, duration, and diversity of practice education • Standards incorporate World of Federation of Occupational Therapists 2016 Minimum Standards • No explicit hour requirement stated in OTC standards, but programmes must meet World of Federation of Occupational

Profession	Author/s; Organisation/s	Date or year	Type of document	Website Link*	Key Summary
					Therapists expectations (1000 hours) for international approval • Emphasis on competence, cultural capability, interprofessional learning, and evidence-informed teaching • Practice education must prepare graduates for diverse and emerging contexts

Table 3 presents the CRAAP evaluation, comparing each selected source across the five domains of currency, relevance, authority, accuracy, and purpose. For each domain, the results indicate the number of guiding questions satisfied according to the evaluation criteria as described by Blakeslee (17). Despite, most of the evidence scoring highly across most domains, the 'Currency' domain (timeliness of information) showed the lowest scores across the included evidence. Further detail on responses to each CRAAP domain, based on guiding questions, is provided in Appendix A.

Table 3
CRAAP tool evaluation of included evidence

Included evidence	Currency	Relevance	Authority	Accuracy	Purpose
	Timeliness of information	Alignment with research topic	Source credibility	Reliability of content	Intent of the source
Ministry of Health New Zealand (2026)	4/4	5/5	5/5	5/6	4/5
Coyle, G. (2007)	2/4	4/5	4/5	4/6	4/5
Nursing Council of New Zealand (2023)	3/4	5/5	5/5	5/6	5/5
Nursing Council of New Zealand (2025)	3/4	5/5	5/5	5/6	4/5
Midwifery Council (2024)	3/4	4/5	5/5	5/6	4/5
Paine, J (2026)	1/4	5/5	5/5	5/6	4/5
New Zealand College of Midwives (n.d.)	2/4	5/5	5/5	5/6	4/5
Grbin, M. (2013)	2/4	4/5	5/5	6/6	5/5
Physiotherapy Board of New Zealand. (2026)	4/4	5/5	5/5	5/6	5/5
McMeeken, J. (2014)	2/4	5/5	5/5	5/6	5/5
Physiotherapy Board of New Zealand (2024)	3/4	5/5	5/5	5/6	5/5
Physiotherapy Board of New Zealand (2025)	3/4	5/5	5/5	5/6	5/5
Physiotherapy Board of New Zealand (n.d.)	2/4	5/5	5/5	5/6	5/5
Grant, R. (2024)	2/4	4/5	5/5	5/6	5/5
Chipchase et al. (2024)	2/4	4/5	4/5	4/6	4/5
New Zealand Gazette (2024)	4/4	5/5	5/5	6/6	5/5
Occupational Therapy Board of New Zealand (2022)	3/4	5/5	5/5	5/6	5/5
World of Federation of Occupational Therapists (2016)	3/4	5/5	5/5	5/6	5/5
Stagnitti et al. (2012)	2/4	5/5	5/5	5/6	5/5
Occupational Therapy Council of Australia. (2026)	4/4	5/5	5/5	6/6	5/5
Occupational Therapy Council of Australia (2020)	3/4	5/5	5/5	5/6	5/5

Qualitative document analysis identified three key themes: 1) the historical development of minimum clinical hour requirements, 2) the regulatory and legislative frameworks governing clinical hours, and 3) the factors influencing decisions about clinical hour requirements. These will be presented in

more detail below.

Theme 1: The historical development of minimum clinical hour requirements

Sources revealed that the minimum clinical hour requirements across all the four professions had been developed over time rather than introduced based on research evidence. None of the sources identified a clear empirical origin for specific hour thresholds. Instead, hour-based requirements reflect the history of apprenticeship traditions and hospital-based training models, where extended exposure to practice was assumed to produce competence (21).

In nursing, clinical hour-based requirements (1000 hours) have been retained through successive reviews despite limited empirical support. Consultation material showed that proposed changes, including reduction in hours, were not adopted due to strong stakeholder support for existing requirements (24, 25). Midwifery followed a similar path, although with higher hour expectations (2400 clinical hours). The historical transition from nursing-based education to an autonomous profession, and the introduction of direct-entry programmes and degree-level qualifications, included the establishment of substantial clinical requirements (J. Paine, (personal communication, 23/01/2026); (26, 27).

Physiotherapy shows a different pattern. Earlier frameworks specified an expectation of approximately 1000 clinical hours, but later reviews identified no evidence supporting this figure (22); Professional Advisor, Physiotherapy Board of New Zealand (personal communication 28/01/2026)). As such, references to minimum clinical hours were removed, with regulatory focus shifting toward competency outcomes. Occupational therapy does not specify mandated clinical hours within Aotearoa New Zealand but aligns with international expectation of 1000 fieldwork hours to support professional recognition, despite limited evidence to support that threshold (8, 23, 28); (Chief Executive and Registrar OT, (personal communication 27/01/2026)).

Theme 2: The regulatory and legislative frameworks governing clinical hours

All four professions are regulated under the HPCAA 2003 which requires practitioners to be competent but does not prescribe how competence should be achieved (2, 29, 30). Within this shared framework, responsible RAs adopt profession-specific approaches.

Nursing and midwifery use prescriptive standards that specify clinical hour requirements as part of programme approval. In nursing, these are expressed as minimum hours across practice settings (24, 25). Midwifery pre-registration standards define broader programme expectations, including numbers of continuity of care experiences and clinical exposure, as additional competency elements to explicit clinical hours (5, 26).

Physiotherapy standards do not mandate a minimum number of clinical hours. Instead, they require programmes to demonstrate that graduates meet defined practice competencies (31); (Professional Advisor, Physiotherapy Board of New Zealand (personal communication 28/01/2026)). Clinical hours are recorded but not used as a regulatory measure. Occupational therapy standards similarly emphasise competence across domains and require sufficient fieldwork exposure, with international alignment shaping expectations rather than national regulation (28, 32); (Chief Executive and Registrar Occupational Therapy Board of New Zealand, (personal communication 27/01/2026)).

Theme 3: The factors influencing decisions about clinical hour requirements

Across professions, four influences on clinical hours were evident: stakeholder consultation, professional expectations, international alignment, and system constraints.

Consultation processes were especially visible in nursing, where feedback from practitioners, educators, and Māori and Pacific respondents supported retaining existing clinical hour thresholds despite limited evidence (24). Professional expectations also influenced decisions. In midwifery, extensive clinical exposure is linked to readiness for autonomous and safe practice at registration (J. Paine, (personal communication, 23/01/2026)) (33, 34).

International alignment shaped requirements in midwifery and occupational therapy. Maintaining comparability with external standards supported workforce mobility and professional recognition (Chief Executive and Registrar Occupational Therapy Board of New Zealand, (personal communication 27/01/2026)) (28). Physiotherapy sources described a shift toward international competency-based models rather than fixed hours (35).

Workforce and system-related considerations were consistently reported across sources. Clinical placement availability, supervision capacity and resource limitations within healthcare settings restricted programmes' flexibility to explore how clinical experiences may look. Mandated clinical hours were described as potentially limiting student numbers and programme scalability, particularly when placement capacity was constrained (21). While these constraints were recognised, they did not lead to reductions in required clinical hours as time-based requirements were considered easier to regulate and justify (21, 23).

Discussion

Overview of findings

This review identified a range of sources that relate to minimum clinical hours requirements across nursing, midwifery, physiotherapy, and occupational therapy, largely drawn from grey literature. Our synthesis highlighted how these clinical hour requirements in Aotearoa New Zealand are shaped by the interplay of their historical precedent, regulatory frameworks, and broader contextual factors.

The findings show a clear tension between time-based and competency-based approaches to clinical education. Regulatory frameworks emphasise competence, yet several professions internationally continue to rely on minimum clinical hours as a proxy for readiness (36–38). These standards are also linked to maintaining public confidence in the professions (39). This reliance reflects practically rather than evidence. There is little indication across the sources that specific hour thresholds are linked to competence outcomes (6, 21, 23). Competency-based education offers an alternative model that focuses on demonstrating ability rather than time spent in training. However, as Reljic et al. (40), have reported, it requires consistent and credible assessment systems, which are difficult to implement across varied clinical environments. For example, there remains an inconsistent definition of what constitutes a "clinical hour", and variability in how clinical hours are documented (Coyle, 2007; Professional Advisor, Physiotherapy Board of New Zealand (personal communication 28/01/2026)). The continued use of counting clinical hours reflects this gap. Time provides a simple measurable construct in the absence of more reliable ways to assess competence at scale. Rather than considering them as opposing models, time-based and competency-based approaches may be better understood as complementary. Achieving this balance requires clearer definitions of competence, more robust and consistent assessment systems, and stronger evidence to support competency-based implementation (41–43). Without these, reliance on minimum clinical hour requirements is likely to persist as a practical response to ongoing uncertainty, variability, and the need to ensure public confidence in health professional education.

Differences between professions reflect regulatory choice rather than differences in evidence. Physiotherapy demonstrates that removal of time-based requirements is feasible when competence frameworks are accepted and embedded in regulation (31). In contrast, nursing and midwifery retain hour-based requirements because they align with professional expectations and public assurance (5). Clinical hours appear to operate as signals of preparedness. In nursing and midwifery, they are linked to perceptions of safety, quality, and readiness for practice, which influence both professional identity and regulatory decision-making (39). Reducing them carries reputational risk, even where evidence is limited. International alignment reinforces these choices. For midwifery and occupational therapy, consistency with external standards supports qualification recognition and workforce mobility. This creates an incentive to retain hour requirements rather than revise them in response to local evidence gaps (44).

Workforce and system constraints shape how clinical education operates in practice. Our findings of how placement shortages, high clinical workloads, and limited supervision capacity affect the quality and consistency of student learning is consistent with others (13, 45–48). These constraints limit the ability of education providers to adjust clinical hours without affecting programme delivery. The findings highlight a mismatch between quantity and quality. Completing a set number of hours does not ensure equivalent learning, as clinical environments vary widely in supervision, workload, and learning opportunities (49, 50). Despite this, minimum clinical hours persist because they are administratively stable and easier to monitor that more complex measures of competence (45). Competency-based models could address these issues by focussing on performance rather than time, but they introduce new demands. These include increased assessment workload, variability in implementation, and the need for system-wide alignment (42, 43, 51). Within these constraints, time-base requirements continue to function as the practical and pragmatic tool.

Strengths and Limitations

This study has several strengths. It adopted an international perspective, enabling comparison across diverse regulatory contexts and strengthening the broader relevance of the findings. The inclusion of input from regulatory authorities, alongside in-depth follow-up from the specific professional bodies, provided insight into decision-making processes and enhanced the depth and credibility of the analysis. However, some limitations should be acknowledged. The review was focused on four professions; while this may appear narrow, these disciplines represent a substantial proportion of the regulated health workforce that have well-established roles within healthcare systems, supporting transferability of findings. In addition, although the search was initially framed within the context of Aotearoa New Zealand, it drew on international literature and sources. As a result, the findings are likely to have applicability beyond the Aotearoa New Zealand setting but may not fully capture all contextual nuances of other jurisdictions.

Future Considerations

The findings point to gaps in both evidence and regulatory transparency. Future research should continue to apply document analysis by drawing on a wider range of sources, including archival materials and internal regulatory records where possible. There is also a need to examine competence as a primary measure of readiness for practice with robust, evidence-based assessments, independent of fixed clinical hour thresholds. Regulatory bodies should strengthen the clarity and transparency of publicly available documentation by clearly articulating the rationale, evidence base, and decision-making processes underpinning clinical hour requirements and any subsequent revisions.

Greater consistency in how clinical education requirements are defined and reported, including clearer descriptions of what constitutes a clinical hour, would support future comparison and evaluation. In addition, more detailed and systematic reporting would enhance understanding of policy development processes and improve the quality of evidence in this area.

Conclusion

This study examined the rationale underpinning minimum clinical hour requirements across nursing, midwifery, physiotherapy, and occupational therapy in Aotearoa New Zealand. These requirements are largely historically derived, with limited empirical evidence linking specific hour thresholds to competence. Instead, decisions have been shaped by regulatory obligations to ensure public safety, professional expectations, stakeholder consultation, and alignment with international standards. Variation across professions suggests that clinical hour requirements are not based on a consistent evidence-informed framework but reflect different regulatory approaches and professional priorities. Workforce and system constraints, including placement capacity and supervision, also influence how these requirements are maintained and implemented. Competency-based approaches offer an

alternative, yet time-based requirements persist as practical and widely accepted approaches within complex education and regulatory systems. These findings highlight the need for stronger evidence to inform clinical education, improved approaches to assessing competence, and attention to system-level constraints that shape learning in practice.

Abbreviations

HPCAA	Health Practitioners Competency Assurance Act
CRAAP	Currency, Relevance, Authority, Accuracy, Purpose framework
RA	Regulatory Authorities

Declarations

Ethics approval and consent to participate

Not applicable

Consent for publication

Consent obtained from J Paine to include their name when referring to personal communication.

Consent for using personal communication obtained from J Paine.

Availability of data and materials

All data generated or analysed during this study are included in this published article.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

TF, VS involved in conception and design of the work; CN, TD involved in acquisition, analysis, CN, TD, TF, VS involved in interpretation of data; CN, TD, TF, VS involved in drafting and revising manuscript, TF, VS involved in approving the submitted version.

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Figures

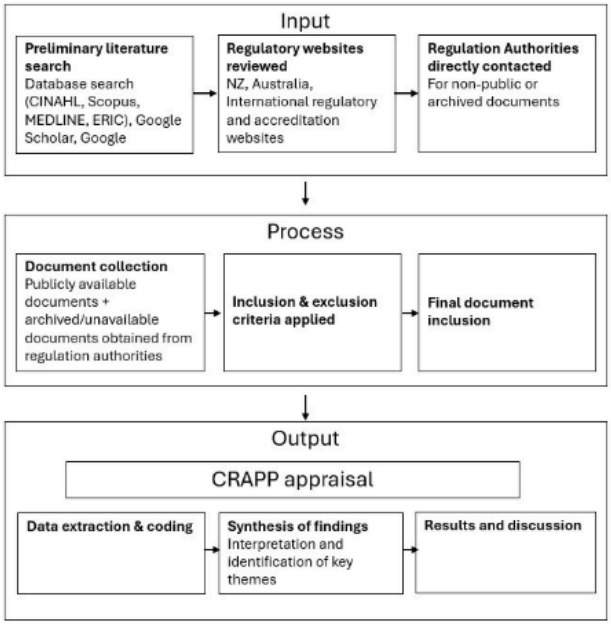


Figure 1

Study Design Process

Supplementary Files

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- AppendixA.docx