Submission on Consultation: Scope of Practice - Needling Techniques in Osteopathic Practice Review

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15 July 2026

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Tēnā koe Tim,

Osteopaths New Zealand (ONZ) welcomes the opportunity to respond to the Osteopathic Council of New Zealand's consultation on the proposed Scope of Practice: Needling Techniques in Osteopathic Practice, the proposed competencies and the proposed accreditation standards.

ONZ supports the direction of the review in principle. We support a modernised, modality-neutral framework that protects the public and enables appropriately trained osteopaths to use needling techniques as adjuncts within osteopathic care. Our feedback is directed primarily to ensuring that the framework is clear, proportionate, accessible and workable when implemented.

Overall, ONZ supports the proposals in principle, subject to clarification of implementation, qualification recognition, clinical assessment, technique-specific competence, dual-practice boundaries, titles, costs and ongoing competence requirements.

1. Do you have feedback on the revised scope of practice wording?

Yes. ONZ supports the move from a Western Medical Acupuncture-specific scope to a modality-neutral Needling Techniques in Osteopathic Practice scope. We also support retaining needling within an extended scope, rather than creating separate scopes for dry needling and other needling modalities. Many of the principal risks arise from skin penetration and needle use and are not confined to one technique.

ONZ also supports the automatic transfer of practitioners who currently hold the Western Medical Acupuncture and Related Needling Techniques scope into the new scope. This transition should occur without additional qualification assessment, unnecessary transitional education or avoidable application costs.

Areas requiring clarification or amendment

a. The listed clinical uses should be illustrative, not exhaustive. The proposed scope describes needling techniques as primarily supporting musculoskeletal care, including myofascial trigger points, postoperative pain and nausea. ONZ asks Council to clarify that these examples do not define the complete permitted boundaries of practice or prevent future evidence-informed applications, provided the practitioner is appropriately trained and competent.

> *Suggested wording: "Needling techniques may be used as adjunctive modalities within osteopathic practice where their use is supported by appropriate clinical reasoning, practitioner competence, the best available evidence and the patient's informed consent."*

b. The meaning of "biomedical framework" should be clarified. ONZ understands this wording is intended to distinguish osteopathic needling from acupuncture practised within traditional Chinese medicine. It should not be interpreted as reducing osteopathic practice to an isolated technical or narrowly biomedical procedure. Needling remains part of a holistic, person-centred osteopathic consultation in which psychosocial, cultural and wider clinical factors continue to apply.

> *Alternative wording: "These techniques are grounded in contemporary anatomical, physiological and pathological knowledge and evidence-informed healthcare, and are incorporated within a holistic, person-centred osteopathic consultation."*

c. Scope registration should not imply competence in every needling technique. The proposal allows practitioners to use specific recognised technique titles where they have undertaken appropriate training. ONZ asks Council to make clear whether registration is technique-specific and how a practitioner's assessed techniques will be recorded. A practitioner trained only in a limited dry needling approach should not be assumed competent to perform every technique or anatomical application that may sit within the broader scope.

- Clarify whether registration permits all recognised needling techniques or only those included in the practitioner's education and assessment.
- Explain how technique-specific competence will appear on the public register or in Council records.
- Publish a transparent process for recognising, adding, amending or removing named techniques.

d. Dual-qualified practitioners require clear dual-practice guidance. The exclusion of traditional Chinese medicine acupuncture from osteopathic practice is understood. However, some practitioners may separately hold registration or qualifications in osteopathy, Chinese medicine or acupuncture. Council should provide practical guidance, developed with relevant regulatory bodies where appropriate, covering professional role, advertising, appointment designation, consent, clinical records, invoicing, and whether the two professional roles may be exercised within one appointment.

e. The proposed public-facing titles should be reconsidered. “Osteopathic Practitioner of Needling Techniques” and “Osteopathic Needling Technique Practitioner” are cumbersome and may be mistaken for a separate profession or specialist credential. ONZ recommends retaining the primacy of the protected title osteopath and using a clear register endorsement, such as:

> *“Osteopath - registered in the Needling Techniques scope.”*

Council should also clarify whether the use of an extended-scope title is optional and undertake plain-language testing before finalising the titles.

2. Do you support the proposed education requirements?

ONZ supports the proposed education and accreditation framework in principle. We agree that programmes should include anatomy, clean needle technique and infection control, safe needling technique, contraindications, adverse-event management, evidence-informed practice, clinical reasoning, communication, informed consent and cultural safety. We also support formal quality assurance and assessment rather than relying on informal attendance-based training.

Conditions required for a workable framework

a. Implementation should be linked to an accessible pathway. The consultation recognises that there is currently limited opportunity for osteopaths in New Zealand to undertake recognised needling education. The revised requirements should not commence for new applicants until at least one accredited programme or published assessment or qualification equivalence pathway is practically available.

Before commencement, Council should publish an implementation plan addressing:

- anticipated implementation and accreditation dates;
- the pathway if no programme is accredited by the intended commencement date;
- expected course frequency and delivery formats, including part-time and blended options;
- supervisor and clinical placement capacity;
- application, qualification assessment and registration fees;
- transitional arrangements for practitioners who are already undertaking relevant education; and
- the process by which the wider education-provider market will be informed of accreditation opportunities.

b. The model should be provider-neutral and open to a wider range of appropriately governed education providers. Council should allow more than one pathway to the same competency outcome, provided that safety and assessment standards are met. Possible pathways could include accredited qualifications, modular or micro-credentialled programmes, equivalent overseas programmes, recognition of prior learning with bridging education, and direct competence assessment where documentary evidence is incomplete.

c. Qualification equivalence, recognition of prior learning and competence assessment processes should be published before implementation. The consultation provides automatic transfer for existing WMA scope holders, but does not explain how the following groups will be assessed:

- osteopaths holding New Zealand or overseas dry needling qualifications;
- practitioners with older or non-NZQCF courses;
- practitioners with mixed CPD and supervised practical education;
- holders of acupuncture-related qualifications, to the extent that their education maps to the proposed competencies;
- applicants whose documentary evidence identifies some, but not all, required competencies.

Council should publish eligibility criteria, required evidence, likely fees and timeframes, bridging options, direct assessment pathways and review or appeal arrangements. Any transitional pathway should preserve public safety and should not be understood as retrospectively authorising practice undertaken without the required scope.

d. Entry and teaching requirements should be clearer. The proposed 80-hour minimum is justified on the basis that osteopaths already possess foundational anatomical and clinical knowledge. The accreditation standards should therefore specify who may enter the programme and what prerequisite knowledge is required. Council should also clarify whether the programme head and clinical supervisors must personally hold recognised needling qualifications, the Needling Techniques scope, recent clinical experience and training in supervision and assessment.

e. Accreditation requirements should be applied proportionately. ONZ supports robust governance, Te Tiriti responsibilities, public safety, quality assurance and valid assessment. However, the standards should remain realistic for a focused Level 5 programme and should not inadvertently exclude credible collaborative, multidisciplinary or private-provider models that can demonstrate equivalent governance, educational quality and clinical safety.

3. Are the competencies and training topics sufficient?

The proposed domains and core training topics are broadly appropriate. ONZ supports the inclusion of Te Tiriti responsibilities, culturally safe communication, informed consent, clinical reasoning, contraindications, record keeping, safe needle use and disposal, adverse-event management, continuing professional learning and multidisciplinary practice.

The competencies are intentionally high-level. That approach can provide flexibility, but terms such as “appropriate level”, “range of clinical skills” and “appropriate management” do not, by themselves, tell practitioners, education providers or assessors what minimum observable performance is required. ONZ recommends retaining the high-level competencies while developing supporting practice guidance and assessment indicators.

Additional or more explicit content

- patient selection, screening and contraindications;
- anticoagulant and antiplatelet use, bleeding disorders and other bleeding risks;
- pregnancy, infection risk and immunocompromised patients;
- anatomical danger zones, including the thoracic, cervical regions and other higher-risk anatomical areas;
- needle selection, insertion depth and direction, patient positioning and needle accountability;
- clean needle technique, sharps disposal, needle-stick injury and blood-borne exposure management;
- vasovagal episodes, unexpected pain, suspected pneumothorax and other serious adverse events;
- criteria for emergency services, urgent medical assessment, referral and follow-up;
- informed consent and documentation for materially different procedures or anatomical regions;
- needling in sensitive areas and with paediatric or otherwise vulnerable patients;
- incident reporting, open disclosure and post-event review;
- electrical stimulation through needles, should this be included as a recognised technique; and
- the interaction of needling with other clinical interventions and medicines.

ONZ also supports directly observed practical assessment. The accreditation standards already require comprehensive theoretical and clinical assessment, multiple validated assessment tools and direct observation in a clinical setting. Council should clarify the minimum performance thresholds and clinical exposure expected so these requirements are applied consistently across providers.

Ongoing competence should be addressed before implementation. The proposed competencies require continuing professional learning, but do not specify whether there will be needling-specific CPD, recency requirements, refresher education, practice audits or return-to-practice requirements. Any ongoing competence requirements should, where possible, be integrated into the existing Continuing Competence Programme unless evidence supports a separate process.

4. Is the proposed academic level and minimum hours appropriate?

ONZ supports Level 5 and 80 hours as reasonable minimum educational inputs, recognising that registered osteopaths already possess substantial foundational education in anatomy, pathology, clinical reasoning, consent and patient management. We also support Council's willingness to consider programmes that demonstrate an equivalent academic level without necessarily being formally listed on the NZQCF.

However, hours alone should not determine competence. The key safeguards should be valid competency-based assessment, sufficient supervised practical learning and direct observation of clinical performance. Programmes teaching broader techniques, higher-risk

anatomical regions or more complex applications may need to exceed the proposed minimum.

Clarification required regarding the 16-hour practical component

The proposed accreditation standard refers to a minimum of 16 hours of face-to-face clinical learning experience, while the consultation document describes 16 hours of face-to-face instruction. These terms may not mean the same thing. Council should clarify:

- whether all 16 hours must involve supervised practical needling;
- whether the requirement includes direct patient care, simulated practice or peer-to-peer practice;
- whether assessment time is included within the 16 hours;
- whether there is a minimum number or range of supervised needling procedures or clinical encounters;
- how competence in high-risk anatomical areas will be assessed; and
- whether a learner may practise independently before all practical competencies have been demonstrated.

ONZ does not seek an excessive training burden. The purpose of this clarification is to ensure that the accessible 80-hour framework remains clinically meaningful and that graduates are assessed on what they can safely do, rather than merely on time attended.

5. Are there additional cultural safety or partnership considerations?

ONZ supports the inclusion of Te Tiriti o Waitangi partnership responsibilities and cultural safety throughout the scope, competencies and accreditation standards. Needling is not merely a technical act; it occurs within a patient and whānau context and may involve blood, touch, sensitive areas, fear, prior experiences of healthcare and differing understandings of treatment.

Council could further support culturally safe practice by developing practical guidance in partnership with Māori rather than leaving individual providers and practitioners to interpret the high-level competencies independently. Guidance could include:

- culturally safe explanations and consent for needling;
- appropriate discussion and management of blood and tapu;
- whānau involvement and patient preferences;
- communication about pain, adverse events and follow-up;
- needling of culturally or personally sensitive areas;
- application of Māori models of health within the wider osteopathic consultation;
- examples of culturally safe documentation and incident management; and
- access to consistent, endorsed learning resources for practitioners and education providers.

The accreditation standard requiring opportunities for clinical learning experiences with Māori should be implemented meaningfully and ethically. Council should clarify how providers can meet this requirement without tokenising Māori patients, students or communities, particularly within a short programme. Co-design, appropriate partnership and evaluation of the learner experience will be important.

6. Do you have any other comments or suggestions?

Implementation and transition

Council should publish the final implementation and transition arrangements before the revised scope takes effect. Existing WMA scope holders, new applicants, practitioners with prior training, dual-qualified practitioners, education providers and the public should be able to understand exactly what will occur, from what date, and what evidence or action is required.

Costs

Council should explain the likely costs of programme accreditation, qualification or prior-learning assessment, scope applications, ongoing registration and competence monitoring. It should also explain how those costs will be allocated, whether any cross-subsidy from the wider profession is anticipated and how the approach has been assessed as fair and proportionate to the risk being regulated.

Public communication and enforcement

Before the revised scope and associated requirements take effect, Council should publish clear practitioner and public guidance addressing the new scope boundaries, permitted titles, technique-specific competence, advertising, record keeping, dual practice and transitional arrangements. A reasonable education and implementation period will reduce inadvertent non-compliance and improve public understanding.

Priority recommendations

- Confirm automatic and low-burden transfer of existing WMA scope holders.
- Do not commence the revised pathway for new applicants until at least one viable, accessible education or assessment route is available.
- Publish qualification equivalence, recognition of prior learning, bridging and direct competence assessment pathways before implementation.
- Clarify that practitioners may use only the techniques and anatomical applications for which they have been appropriately trained and assessed.
- Clarify the 16-hour face-to-face clinical learning requirement and the minimum practical assessment expectations.
- Develop dual-practice guidance for practitioners who also practise Chinese medicine or acupuncture in another professional capacity.
- Retain “osteopath” as the primary public-facing title and use a clear scope endorsement.

- Provide practical cultural-safety guidance co-designed with Māori.
- Publish expected fees, ongoing competence requirements and the full implementation plan before commencement.

Conclusion

ONZ supports the development of a modern, modality-neutral Needling Techniques in Osteopathic Practice scope and recognises the public-safety rationale for regulating skin-penetrating needling techniques within one extended framework. The proposed Level 5 and 80-hour model is a more accessible basis for education, provided it is supported by meaningful clinical assessment and an actual pathway into the scope.

The remaining issues are principally operational rather than objections to the direction of reform. Clear transition arrangements, accessible education, fair recognition of existing learning, technique-specific competence, practical cultural-safety guidance and transparent costs will be essential to a successful implementation.

ONZ welcomes the opportunity to discuss any aspect of this submission further with OCNZ.

Ngā mihi,



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