

NZ OSTEO

November 2026

The human body is not a machine; it is a living and highly sensitive organism - John Martin Littlejohn

osteopaths
NEW ZEALAND
Ngā Mātanga Wheua o Aotearoa

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Message from the Chair

As we head towards the end of another busy year, I wanted to reflect on a few recent developments and some of the conversations taking place on behalf of our profession.

One of the highlights of the past couple of months was attending the Osteopathy Australia (OA) Conference on the Gold Coast. The conference itself was fantastic, with an excellent range of speakers, some thought-provoking presentations and plenty of opportunities to connect with colleagues from across the Tasman.

Of particular value was the time spent with our counterparts on the OA Board. We had a number of productive discussions about the challenges and opportunities facing our respective professions. In many respects, Osteopathy Australia is around ten years ahead of us in its organisational development, having already navigated many of the issues we are likely to encounter in the years ahead. Being able to draw on that experience, understand what has worked for them and learn from the challenges they have faced is enormously valuable. There is a great deal we can learn from one another, and I look forward to continuing to strengthen that relationship.

The conference also provided an opportunity to build connections with speakers and colleagues as we turn our attention towards our own ONZ Conference in Christchurch in 2027. There is already plenty of enthusiasm around what we might bring together, and some of those conversations on the Gold Coast will hopefully translate into opportunities for our members next year.

Closer to home, I know many of us are wondering what has happened to the ACC Cost of Treatment Review. By now, we would have expected the review to have been completed and, ideally, to have resulted in an increase to treatment payments. Unfortunately, we are still waiting for clarity. Our CEO, Angela Young, has been actively following this up, including through formal requests for information to ACC. We will continue to pursue answers and keep members informed as we learn more. Given the ongoing pressures on practice costs, this is an issue that matters to all of us.

Finally, with Christmas fast approaching, I hope everyone manages to enjoy the run-up to the festive season without things becoming too hectic. It has been another full year for the profession, and I hope you all get the opportunity to take a well-earned break, enjoy some of our New Zealand summer and spend time with family and friends.

Thank you for your continued support of ONZ, and I look forward to what we can achieve together in 2027.

-Morgan Hancock





Osteopathy Australia Conference 2026 – Gold Coast

The Osteopathy Australia Conference was held at the Gold Coast on 16–17 October, bringing together osteopaths from Australia and New Zealand for two days of clinical education, research, workshops and professional discussion at Sea World Resort.

The programme covered a broad range of contemporary practice, including pain, paediatrics, concussion, rehabilitation, women's health, ageing and research. There was also a strong focus on how osteopathy continues to develop within the wider healthcare environment, rather than simply concentrating on new manual techniques.

The conference opened with Dr Jorge Aranda Beltran, founder of the Hands with Heart Foundation, presenting The Regulated Child. Jorge's work combines paediatric osteopathy with extensive experience working with children with disability in communities with limited access to healthcare. This was followed by Elizabeth Howard discussing the application of contemporary pain science to nerve pain, including the sometimes less obvious ways neural sensitivity can present clinically.

Research and professional development featured prominently throughout the conference. A panel on Best Care, Confidence and Credibility looked at the importance of building a stronger research base for osteopathy and, importantly, generating useful data from everyday clinical practice. This theme continued through the research presentations, which covered areas including falls prevention, migraine, perinatal back pain and hospital-based osteopathic research.

New Zealand also had a place within the research programme, with Anj Young presenting the ONZ national PROMs pilot. The project has been exploring how routinely collected patient-reported outcome measures could provide better information about what is happening in osteopathic practices across Aotearoa. It was useful to see this work sitting alongside similar efforts internationally to improve the profession's ability to measure, understand and demonstrate patient outcomes.

The practical programme provided plenty for clinicians to take back into practice. Paul Hermann explored lumbar multifidus dysfunction and rehabilitation in mechanical lower back pain, while Zac Lewis provided a structured approach to concussion assessment, including vestibular, oculomotor and cervical components and decision-making around management, co-management and referral. Other workshops addressed patient-led treatment planning, shockwave therapy, paediatric hip conditions and healthy ageing. Amy Lawton and Jack Feehan's ageing workshop in particular extended beyond treatment to include frailty, falls risk, validated screening and the role osteopaths can play within coordinated healthcare for older adults.



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Day two also included some less traditional areas of osteopathic practice. Luke McCarney introduced myotonometry as an objective way of measuring superficial muscle stiffness, while Dr Nick Penny presented Mendable, his digital self-management app for people with persistent low back pain, offering the kind of patient data government healthcare systems are increasingly looking for, alongside an alternative to prescription-based management. Notably, the app also encourages users to "see your osteopath" if their pain persists.

Max Hopes presented qualitative research into the lived experience of lower-limb tendinopathy, Andrea Robertson addressed the interaction between menopause, inflammation and musculoskeletal health, and Toby Barker closed the clinical presentations by considering what complex patients can teach us about keeping management simple.

Perhaps the broader takeaway from the conference was the diversity of where osteopathy is heading. Manual therapy remains a central part of our identity, but the programme increasingly placed it alongside rehabilitation, pain science, outcome measurement, multidisciplinary care and research.

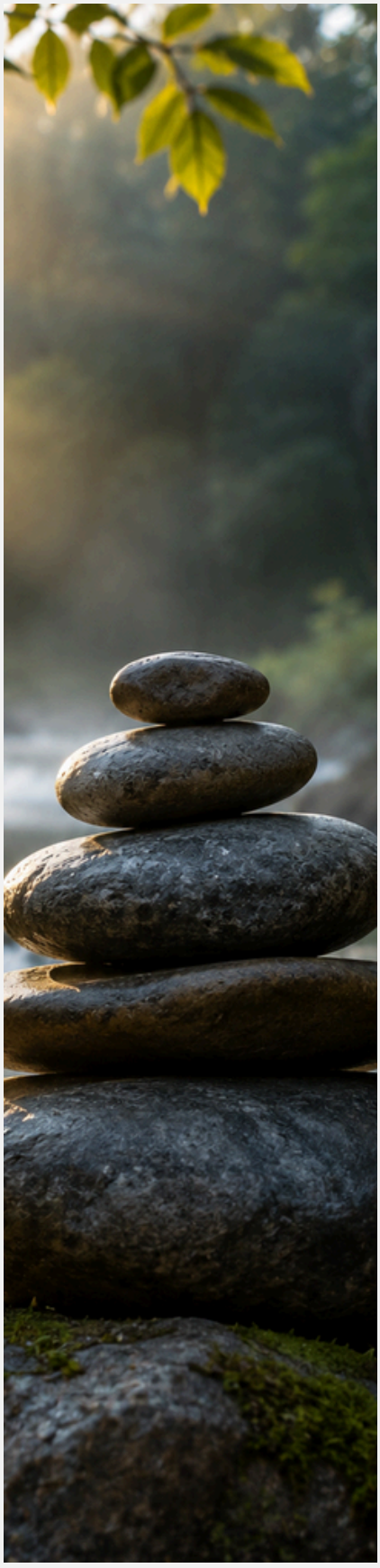
That feels important. The profession is continuing to widen its view of what good osteopathic care can look like, with less emphasis on a single intervention and more on how treatment fits within the wider clinical picture. For many patients, that may mean combining hands-on care with exercise, education, self-management, screening, referral or collaboration with other health professionals.

The conference also reinforced the value of being able to demonstrate what we do, not just describe it. PROMs, clinical data and research all help the profession better understand its outcomes and communicate its role within healthcare. At the same time, sessions on concussion, ageing, tendinopathy and paediatrics showed how broad the osteopathic skill set can be when applied thoughtfully.

Rather than moving away from osteopathy's roots, the programme suggested a profession becoming more confident in placing those roots within a broader, more evidence-informed and collaborative model of care.

-Morgan Hancock





The Quiet Skill

Not every problem needs our hands

As osteopaths, we spend a great deal of time learning a wide range of treatment approaches. We learn treatment models, techniques, and ways of modifying them for different patients. Less attention is given to another clinical skill because it develops more quietly with experience: knowing when not to treat.

That doesnt mean doing nothing. Sometimes the most appropriate consultation involves reassurance, advice, movement, referral, further investigation, or simply allowing time for a problem to settle. At other times it means recognising that although we could treat something we have found, there may be little reason to do so.

There can be a subtle pressure in manual practice to provide treatment simply because the patient has booked an appointment. They have come expecting something to happen, and we have a large toolbox available to us. Finding an area of stiffness or tenderness can easily become justification for treating it. But the ability to perform a treatment is not, by itself, an indication to use it.

Not every finding needs correcting

Examination rarely produces a completely unremarkable patient. If we look closely enough, we will almost always find asymmetry, tenderness, reduced movement, altered tone or some other variation that could potentially be treated. The more important question is whether it matters.

If a patient is improving, functioning well and returning comfortably to normal activity, does a remaining restriction require another appointment? If we find an asymmetry that is not painful and does not appear to affect function, are we helping by drawing attention to it?

Modern musculoskeletal guidance increasingly reflects this distinction. Good care is not simply about providing more intervention. It involves identifying serious pathology when present, understanding the individual patient, supporting activity and self-management, monitoring progress, and using treatment in a way that contributes to a broader clinical plan. Manual therapy can be useful within that plan, but it need not be the centre of every consultation.





When "Abnormal" Is Part of Performance

This becomes particularly important when working with athletes. A finding that looks abnormal in the general population may be an entirely appropriate adaptation to a particular sport. Baseball pitchers are a good example. Studies of healthy pitchers have demonstrated characteristic side-to-side differences in thoracolumbar rotation, reflecting the highly repetitive rotational demands of throwing. Those differences are not necessarily dysfunctions waiting to be corrected; they may form part of the movement strategy that allows the athlete to perform at a high level.

Imagine finding reduced rotation in one direction through the thoracic or thoracolumbar region. In an office worker with pain and a clear functional limitation, improving that movement may be entirely reasonable.

Find the same asymmetry in a professional pitcher, however, and the significance may be very different. Pitching relies on precisely coordinated rotation through the pelvis, trunk, shoulder and arm to transfer force into the ball. Changing one part of that established pattern simply because it appears asymmetrical on the treatment table may alter a movement strategy the athlete has spent years developing.

That does not mean we should never address restrictions in athletes. It means the question changes from "Can I make this more symmetrical?" to "Is this actually limiting performance, contributing to symptoms, or increasing risk?" For clinicians working around elite sport, this distinction quickly becomes obvious: changing an athlete for the sake of producing a more textbook examination can be considerably less helpful than understanding why their body has adapted the way it has.

The same principle applies well beyond professional sport. The recreational golfer, tennis player, swimmer, cyclist or weekend runner may also develop asymmetries that reflect what they repeatedly ask their body to do. Normal for that individual may not look particularly symmetrical, and our job is not automatically to make it so.

A common trap for new graduates

This can be especially difficult early in practice. New graduates have spent years learning how to assess, diagnose and treat, so there can be a strong internal pressure to do something with every finding.



If an area feels restricted, change it. If something is tender, treat it. If the patient has paid for the appointment, make sure they leave feeling that something tangible has happened.

There is also the understandable desire to prove your value. When confidence is still developing, it can feel safer to provide more treatment than less. A longer session, more techniques, more areas addressed and more explanation can all feel like evidence that the patient has received their money's worth.

But value is not measured by how many things we change during an appointment. Sometimes the more experienced decision is to leave something alone. A finding may be real but irrelevant. A patient may already be progressing well. Another treatment may add little beyond reinforcing the idea that recovery depends on us continuing to intervene.

This is one of the harder transitions from student to clinician: learning that your role is not to fix everything you can find. It is to decide what matters, what is likely to help, and what can safely be left alone.

Patients are not paying for a certain number of techniques. They are paying for clinical judgement. Sometimes that judgement leads to treatment. Sometimes it leads to advice, reassurance, referral, or simply saying, "I think you're doing well enough now that we should leave this alone and see how you go."

That can initially feel like providing less. In reality, it is often a sign that you are beginning to provide something more valuable than treatment alone.

Reassurance is important

There are consultations where one of the most valuable things we can provide is an informed explanation that the patient is safe to move. Someone experiencing an acute episode of uncomplicated back pain, for example, may arrive concerned that they have damaged something badly. A careful history and examination may give us confidence that there is no indication of serious pathology and that a period of sensible activity and self-management is appropriate.

In that situation, the consultation has already achieved something important. The patient understands what is happening, knows what to watch for, and has a plan for returning to normal activity. The stories we tell patients about their bodies can outlast the treatment itself.

Telling someone that their pelvis is "out", their spine is unstable, or that they require repeated correction can unintentionally create dependence on care. By contrast, explaining that pain can be significant without necessarily representing serious structural damage may help restore confidence and encourage appropriate movement.

Our language is a major part of the treatment, whether we intend it to be or not.

Knowing when the problem is no longer ours

There is also a very different reason not to treat: when the presentation requires something else.

Every clinician eventually encounters the patient whose symptoms do not quite fit. Perhaps the pain is behaving unusually, neurological findings are progressing, the history raises concern about systemic illness, or the patient simply is not progressing as expected. The temptation can be to try one more treatment and see what happens. Sometimes that is reasonable. Sometimes it is exactly the wrong decision.

Knowing when to stop, reconsider and refer is an important part of clinical practice. Red flags are rarely a simple checklist where the presence of a single feature automatically determines the outcome. They need to be considered within the broader history and examination. What matters is recognising when the overall presentation has moved beyond what we can reasonably manage in isolation. Referral is not an admission that treatment has failed. It is often evidence that clinical reasoning has worked.

Knowing when not to treat is not passive. It still requires assessment, judgement and responsibility. It means being confident enough in our examination to reassure when reassurance is appropriate, cautious enough to refer when something does not fit, and disciplined enough to stop treating when treatment is no longer adding meaningful value.

Perhaps the quietest marker of clinical maturity is recognizing that a full toolbox does not require us to use every tool. Sometimes good care is what we do with our hands. Sometimes it is knowing when to take them away.



Seven Days, Six Flights and 30 Minutes with the Dalai Lama

An unexpected invitation, a forgotten passport and a rather memorable journey to the Himalayas for the Chair of ONZ.



Sometimes opportunities come along that you simply can't turn down, even when common sense suggests you probably should.
During the recent Osteopathy Australia conference on the Gold Coast, Dr Jorge Aranda, founder of the Hands with Heart Foundation, mentioned an opportunity for me to join a small international group of osteopaths and university leaders for an audience with His Holiness the Dalai Lama in Dharamshala, India.

Naturally, I jumped at it.

Before anyone reaches for the ONZ financial statements, I should point out that not a cent of ONZ funds was used in this adventure. This was an entirely personal trip, although it did turn into a rather remarkable opportunity for international osteopathic networking.

Getting there was something of an endurance event. Three days and nights of flights, airport lounges and questionable sleep eventually brought me to Dharamshala, a mountain town nestled in the foothills of the Himalayas and home to the Tibetan government-in-exile.

Our group included osteopaths and educational leaders from the United States, Italy, Australia and Spain, people who have given time over the years to help Hands with Hearts, an NGO that treats children with disabilities in various countries around the world.

Among them were Dr Rebecca Giusti, Chair of the Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine Department at Western University of Health Sciences in California; Australian paediatric osteopath and International lecturer Julie Fendall; and Claudia Luisa, the director of Fulcro Academy's university pediatrics course and who is also involved in Hands with Heart's adaptive surfing programs.

The opportunity to spend time with such a diverse and experienced group was valuable in itself. Conversations about osteopathic education, international collaboration and humanitarian work continued throughout our brief stay.

Of course, the highlight was meeting the Dalai Lama himself.
Now 91 years old, His Holiness is clearly an older man, but what struck me most was the strength of his voice. When he greeted us, there was a power and conviction that seemed entirely at odds with his physical age. It was one of those moments where you suddenly appreciate that you're standing in front of someone who has lived through, and influenced, an extraordinary period of world history.

I nearly missed it.

Despite travelling halfway around the world for this one meeting, I managed to leave my passport at our small hotel. Unfortunately, passports were essential for getting through security to meet his Holiness.



What followed was a rather undignified sprint uphill through the steep streets of Dharamshala, followed by a desperate search for transport back down. A wonderfully helpful local scooter driver came to my rescue, carrying a somewhat breathless and considerably less-fit-than-he-thought osteopath back towards the temple.

Not quite the peaceful, contemplative arrival I'd imagined. The meeting itself lasted approximately 30 minutes. After all the anticipation and travel, it was over remarkably quickly, but the experience will stay with me for a lifetime.

To understand how we had ended up with the invite it's worth noting that Dr Aranda had spent a month treating His Holiness the previous year, becoming the first Osteopath invited to treat him in his own home, rather than having the Dalai Lama travel for treatment. On the surface, this sounds like an extraordinary privilege, but it came with an unusual challenge. For each of the 20 treatment days, His Holiness required Dr Aranda to prepare three questions for them to discuss. Finding 60 worthwhile questions to engage one of the world's great spiritual thinkers is no small task! One gets the impression that the Dalai Lama was rather enjoying putting his visiting osteopath through his philosophical paces, and ensuring Jorge left each session having exercised his mind as thoroughly as his hands.

And just like that it was over, with another three days of flying to get home.

Seven days away, six days largely spent travelling, all for a half-hour audience. Not exactly an efficient itinerary, even by ONZ conference standards.



But between meeting an extraordinary spiritual leader, strengthening friendships with international colleagues and experiencing a little of Tibetan culture in the Himalayas, it was worth every minute.

And I can now confidently recommend checking your passport before visiting one of the world's most recognisable religious leaders.
-Morgan Hancock





The Institute of Osteopathy's mentoring platform

Mentoring can be hugely satisfying, can legitimately be classed as CPD and can help you to advance your own career, whether you are the mentor or mentee. Bringing the profession together by developing an effective professional support network for osteopaths will also retain valuable expertise within the profession and help to ensure that osteopathy remains a growing, thriving profession that is fit for the 21st century.

The iO mentoring platform is designed to make it easier for osteopaths who are looking for this sort of support to find a suitable mentor, and includes tools and guidance to support you, whether you want to be a mentor, a mentee, or both.

The iO has always held the view that osteopaths can only benefit from working and sharing with other osteopaths. This goes for observations too. To facilitate this, we are calling for osteopaths who are interested in providing observation/shadowing opportunities to add their details to the iO mentoring platform!

The iO wants you to get the most out of this platform so if you have any enquiries about this initiative, please contact Mentoring@iOsteopathy.org



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Victorian Remedies: A Journey through 1896 Medical Advice

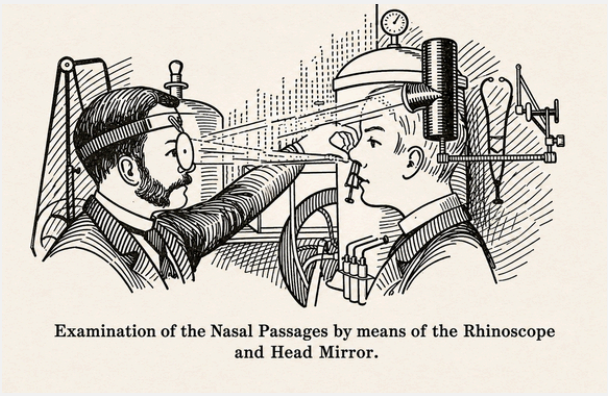
EXCERPTS FROM
"THE PEOPLES COMMON SENSE MEDICAL ADVISOR IN PLAIN ENGLISH"

R.V Pierce M.D
Sixty sixth edition - 1896

These are direct historical extracts from the above 1896 publication. A short disclaimer; ONZ does not recommend following any of the information. It is purely for interest and amusement

NASAL POLYPS

Having operated with unvarying success upon a very large number and variety of nasal tumors at the Invalids Hotel and Surgical Institute, we are positively assured that the means and methods with which we employ are neither severe nor dangerous. Many forms of injection and local treatment are in use for the removal of nasal polypi, none of which have proven to be curative. Many cases have presented themselves after having been treated by the heroic method of seizing the polypus with a pair of forceps and forcibly tearing it loose, bringing with it segments of healthy tissue, leaving bone exposed and a ragged, uneven surface of diseased membrane. It is much easier to properly treat a case from the beginning than to undertake it in such a condition. The nasal passage, having been thoroughly anesthetized or benumbed by the use of cocaine, the nasal speculum is introduced, and by means of refracted light from the head mirror worn by the operator, the interior of the nostril is brought into view.



Examination of the Nasal Passages by means of the Rhinoscope and Head Mirror.

Many styles and shapes of delicately devised instruments are necessary to completely remove the growth without doing injury to the adjacent structures. Our newly devised operation, the tumor is at once removed without pain and with the loss of only a few drops of blood. Further, because the tumor is entirely removed and the base properly treated, there is not the offensive discharge for a long time afterwards, and the danger from infection and blood poisoning to which the patient is subjected in other forms of treatment.

USING DR SAGES CATARRH REMEDY

To prepare the medicine ready for use, put the whole quantity of powder in the package into a bottle with one pint of cool water. Shake it thoroughly, after which allow it to stand six hours to settle. Without shaking the bottle to roil the fluid, pour out a teaspoonful or more into the hollow of the hand. Hold it there until warmed, first gently and afterwards forcibly, snuff the fluid up one nostril and then the other, until the nose is well filled and it passes back into the throat. No fears need be entertained that it will produce strangling or any unpleasant effect in thus using it.

In a few minutes after thus using the remedy, it should be blown out gently, never forcibly, to clear the nose and throat of all hardened crusts and offensive accumulations, if any such exist. This process should be repeated until the remedy has been thoroughly applied two or three times.



Need support?

ONZ advocacy, advice & support

Is everything going well at work, or do you sometimes wish you had someone outside of work to talk to? Are you dealing with a challenging work environment, issues with your principal or employees, or feeling unsure about how to handle or file a complaint? Perhaps you're feeling isolated or undervalued?
One of the key roles of ONZ is to provide support for members when things start to turn pear-shaped.

Even experienced practitioners encounter problems, and we have successfully supported many of our members through various issues.

If you have a problem, contact ONZ. We provide confidential support to help you address the challenges you're facing.

Online Learning Library & Resource Hub



Have you explored the resources available through the ONZ website recently? The ONZ Member Resources hub brings together a wide range of information and educational material to support osteopaths throughout their careers. From webinars, OsteoTalks and conference recordings to business advice, ACC information, research, professional development opportunities and practical resources for running a clinic, there's plenty to explore.

Whether you're looking to develop your clinical knowledge, manage your practice or simply catch up on what's happening across the profession, it's worth taking some time to browse what's available.

Visit the ONZ Member Resources page and see what's there.

2026/27 ONZ TEAM



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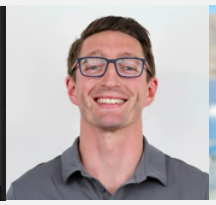

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