

ETHICS & BOUNDARIES FOR MEDICINE CHIRPOGRAPHY 2026

CONVENTION IS NOT THE SAME AS TRUTH

In 18th-century Britain, this was considered good medicine.

When a person was pulled from the river and thought to be drowned, one accepted resuscitation method was to insert a rectal tube and blow tobacco smoke into the body.

It was taught, equipped, and defended as a legitimate intervention by respected physicians.



Resuscitation by tobacco smoke cures, 18th century London (Oxfordshire based on contemporary sources)

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Today it seems absurd. That is the point.
Medicine changes. Evidence changes. Social expectations change. Ethical practice requires the profession to change too.

September 2026 | Michigan for Good | Sources as reported

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ETHICS

Why start here?

Convention, evidence, and ethics do not always move together.

Teaching point
Convention is not truth.
Professional confidence is not evidence.
Accepted practice can later look absurd.
Ethics and standards have to evolve.

Today it seems absurd. That is the point.
Medicine changes. Evidence changes. Social expectations change. Ethical practice requires the profession to change too.

Bridge into the course: accepted practice, social convention, and professional certainty are not the same thing as truth. That is why ethics education must keep changing.

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LAW AS A COMPARISON: ETHICS STARTS AT THE LICENSING GATE

Ethics was part of my 1996 Michigan lawyer-licensing path—and it still is

The testing structure has changed dramatically. The profession's message has not: technical knowledge alone is not enough to earn public trust.



1996
Michigan-specific bar
PBTB developed
Character & fitness review

2002
Michigan adopts UBE
Ethics education required
Ethics exam required
Ethics exam required

2026
Ethics remains layered
PBTB eliminated
Character & fitness review
Michigan Law Ethics required
Professional competence and ethics exam required

2026
Newborn UBE
Michigan Law Ethics required
Professional competence and ethics exam required

Bridge to chiropractic
If law treats ethics as part of entry, fitness, professionalization, and ongoing discipline, chiropractic should not treat ethics & boundaries as a box-checking CE topic. We are not being singled-out... we are being treated like a profession.

Professional competence + technical skill + ethical judgment + public trust.

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WHY ETHICS HAS TO BE TAUGHT

Is ethics intuitive?

We — but only partly. Personal moral instinct is real, but professional ethics has to operate under pressure, ambiguity, power, and [ethical reasoning and decision-making skills](#).

Moral intuition tells us we should do the right thing. Professional ethics helps us determine what "the right thing" is when the situation becomes complicated.

Personal morality
What kind of person are you?
Shapes our judgments, values, culture, experience, conditioning, temperament, and character.

Professional ethics
What does my entrusted role require?
Adds power, resources, confidentiality, competence, boundaries, referral, records, and conflict of interest duties.

Law and regulation
What minimum standards has society imposed?
Enforced rules, licensure, discipline, reporting duties, privacy rules, and enforceable consequences.

Character gives you the compass. Ethics education gives you the map.

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WHY INTUITION ALONE IS NOT ENOUGH

Good values can collide with each other

A clinician can be trying to do the right thing and still face a situation where duties compete.



1. Competing duties
Confidentiality may collide with safety.
Patient autonomy may collide with non-maleficence.
Loyalty to the patient may collide with truthful documentation and reporting duties.

2. Professional role problems
Ordinary life does not prepare you for potential conflicts: infinite right care, patient goals, social media complexity, confidentiality, or when a patient's social situation undermines treatment.

3. Power changes the equation
The clinician controls recommendations, records, discipline, billing, revenue, and clinical representation.
Even decent people can underestimate how much influence that creates.

Ethics helps good clinicians recognize when ordinary moral instinct is being asked to solve a professional problem.

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WHY INTUITION ALONE IS NOT ENOUGH

Blind spots can look like good reasons

The hardest ethical risks often do not feel unethical at the moment they begin.



1. Rationalization
Humans are very good at explaining why the right thing benefits us and happens to be the right thing.
"This patient needs it." "Everyone does it." "It's only defending myself."

2. Different moral intuitions
Culture, modesty, family authority, gender equity, trust, discrimination, gifts, and disclosure can vary.
Professional ethics creates a common floor beneath these differences.

3. Delayed and system harms
Creating dependency, oversteering, closed-door inspections, bad faith culture, and creating or eroding support systems may feel perfect until the consequences surface later.

Ethical drift rarely announces itself. It often begins as convenience, kindness, habit, revenue pressure, or "that's how we've always done it."

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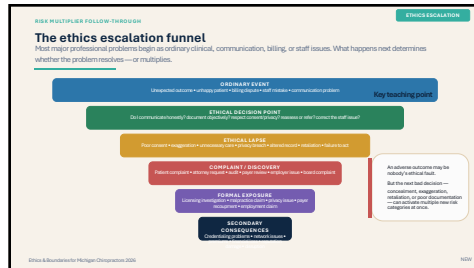
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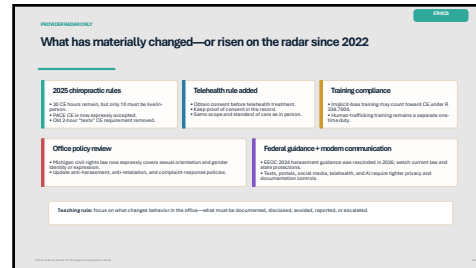
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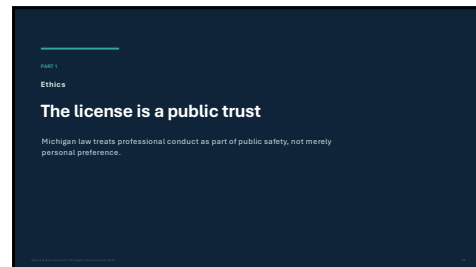
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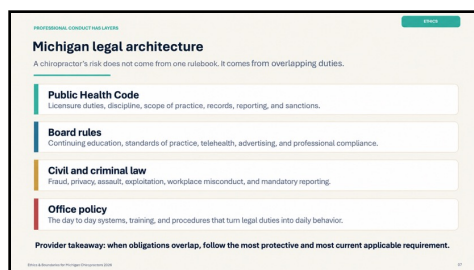
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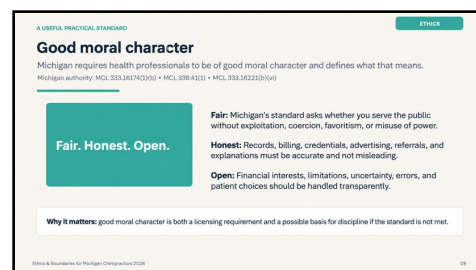
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WHEN THE RULEBOOK RUNS OUT

Not every ethical duty fits in a statute
The absence of a specific rule is not the absence of responsibility. Professional judgment still has to protect trust, dignity, safety, and fairness.

Non-coiffed duties Use professional judgment when no rule gives a precise answer. Accommodate vulnerability, dependence, power imbalance, and authority. Accommodate dependency, dependency, dependency, dependency, and dependency. Remember: "Not just doing" does not always mean "not doing".	Culture changes how ethics is carried out Patients may differ in respect, gender, profession, faith, culture, sex, values, language, family involvement, or authority relationships. Do not assume based on identity or background. Ask what the patient needs for consent, dignity, and communication to be meaningful.	Professional floor remains Cultural professions do not cross law, safety, autonomy, privacy, informed consent, health care, or other, or appropriate clinical care. Accommodate when reasonable and safe. Expect professional or regulatory when accommodation is not possible.
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Ask + Accommodate + Explain + Document
Ask rather than assume. Accommodate when reasonable and safe. Explain limits clearly. Document when the issue changes consent, privacy, communication, treatment, or health.

When the rulebook ends, professional judgment begins.

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COMMUNICATION IS A CLINICAL INTERVENTION

The doctor's words are part of the treatment
Expectation, reassurance, and framing can help patients — or harm them. The ethical issue is not whether words matter. It is whether they are used truthfully and proportionately. "Visit Neuman Get Well Sooner?"

Trustful optimism INFORMED EXPECTANCY Unencumbered and confident, expectantly. Simplify. There is no right or wrong in planning, what's not possible and "probably". Contextualize benefits and legitimate risks.	Calibrated uncertainty INFORMED CONSENT Talk the talk with appropriate nuance. Example: "This is the best we can do, but I'm not sure about the long-term results." "I'm not sure about the long-term results." "I'm not sure about the long-term results."	Exaggerated threat SCARED + CONFUSION Words can threaten, frighten, excite, and intimidate. Example: "The worst thing that could happen to you is that you will be in pain for the rest of your life." "The worst thing that could happen to you is that you will be in pain for the rest of your life."	Unsupported pathology DISEASE FOMENTING Only one condition or widely expected outcome is being addressed, leaving the patient with a sense of helplessness. Example: "You have a serious condition, and it's going to get worse if you don't do something about it." "You have a serious condition, and it's going to get worse if you don't do something about it."
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Harness expectancy. Don't manufacture belief. Communicate risk without manufacturing fear.

Practical note: Tell the truth optimistically. Let the contextual effect amplify evidence-based care — not expectations for it.

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GOOD INTENT IS NOT ENOUGH

Ethical decisions have second-order effects
A clinician can be trying to help and still create a foreseeable boundary, billing, privacy, or dependency problem.

Issue → Action → Consequence → New expectation → Ethical exposure

Well-intended accommodation After hours visit to help a stressed patient. Personal call number for an anxious patient. Special schedule access for a favorite patient.	Well-intended kindness The value that creates billing or insurance claims. Example: "I'm sorry you're not getting better, but I'm not sure about the long-term results." "I'm not sure about the long-term results."	Well-intended defense Online response meant to clear your name. Example: "I'm sorry you're not getting better, but I'm not sure about the long-term results." "I'm not sure about the long-term results."
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Second-order ethical thinking asks: What relationship, expectation, precedent, dependency, or risk does this action create next?

Tracking rules: good intent helps explain the decision, but it does not end the ethical analysis.

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THE BOARD COMPLAINS

Disciplinary risk: MCL 333.16221 in plain English
The exact statutory words matter, but providers need the pattern.

Care below standard Negligence, failure to exercise due care, negligent delegation or supervision, or any conduct or condition that impairs safe practice.	Personal disqualifications Incompetence, substance use disorder, mental or physical inability affecting safe practice, certain criminal convictions, lack of good moral character, or treating while intoxicated or impaired.
Prohibited acts Fraud or deception in obtaining or renewing a license, allowing unauthorized use of a license, practice outside scope, or unlawful controlled substance activity.	Unethical business practices Offer or misleading advertising, fee splitting or kickbacks, and fraud or deceit in obtaining or attempting to obtain third-party reimbursement.
Unprofessional conduct Misrepresentation, breach of professional confidence, unnecessary services for personal gain, improper financial interest steering, and sexual conduct with a patient.	

Takeaway: most board cases trace back to unsafe care, impairment, dishonesty, scope problems, business misconduct, or boundary violations.

Understand how good intentions can go wrong. "Not just doing" does not always mean "not doing".

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CONSEQUENCES

What can happen when ethics becomes discipline
The consequences are broader than "fixing a license."

Investigation, interview requests, subpoenas, expert review, and administrative complaint process.
Probation, limitation, reprimand, fines, continuing education, monitoring, suspension, revocation, or denial.
Collateral effects: payer termination, malpractice exposure, employment claims, social media/public reputation, and family/relationship harm.
A poor response can make an underlying mistake worse: alteration of records, intimidation, retaliation, concealment, or inconsistent explanations.

The cover up is often easier to prove than the original error.

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SAFETY: YOU ARE AND SHOULD BE WELL-DEFINED

Scope, titles, and holding out
Say what you are. Do what you are authorized to do.

Title clarity When using "doctor" or "Dr." in written, printed, or displayed materials, clearly identify the chiropractor's professional credentials and specialty claims must be accurate and must not imply authority the provider does not possess.	Scope & delegation Staff may perform appropriately delegated tasks when qualified and supervised. Critical decisions requiring the chiropractor's professional education, skill, and judgment remain with the chiropractor.	Marketing is not scope Staff may perform appropriately delegated tasks when qualified and supervised. Critical decisions requiring the chiropractor's professional education, skill, and judgment remain with the chiropractor.
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Takeaway: the test is not "Can I use this word?" The test is: "What am I representing, what am I actually doing, and does my Michigan chiropractic license authorize it?"

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INTERPROFESSIONAL ETHICS

Altering another provider's treatment plan

Independent clinical judgment is appropriate. Unilateral, out-of-scope, or uncoordinated interference is not.

Appropriate diagnosis

Offer a different approach within your scope. Identify red flags, contraindications, or lack of progress. Request referral and opinion or co-management when justified. Explain rationale, uncertainty, risks, and alternatives.

Ethical danger zone

Stealing from the patient's rightful resolution or a co-professional team. Co-managing another plan without consulting or informing. Changing another clinician instead of clarifying the clinical question. Creating confusion about who is managing what.

Out-of-scope interference

Exercising another provider's role in a way outside your competence. Using an otherwise authorized/unauthorized clinical device. Example: telling a patient not to follow RGP instructions after having no training or experience. Addressing complex medical questions in the qualified clinician.

Use the interprofessional rule
Understand + Stay in scope + Communicate + Explain + Document

Don't ask, "Whose treatment plan wins?" Ask, "What does the patient need to make a safe, informed decision?"

Chiropractic & Biomechanics Michigan Chiropractors 2020

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ETHICS

Advertising after the old Rule 14 era

The time for encouraging advertising use is receded. But here is advertising advertising with some disciplinary risk.

Do not imply guaranteed cures, unjustified expectations, unsupported superiority, or "secret" diagnoses.

Patient testimonials and before/after claims need context, accuracy, consent, and a reasonable evidence basis.

Avoid bait-and-switch offers, undisclosed financial relationships, pressure language, and inaccurate insurance statements.

Online directories and websites should identify chiropractic status clearly and avoid specialty claims that overstate licensure.

Marketing is charting in public.

If it would be misleading in the chart, it is risky in an ad.

Chiropractic & Biomechanics Michigan Chiropractors 2020

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ETHICS

What changed: old Rule 14 advertising rule

Rule 14 was rescinded effective January 7, 2019. Truthful advertising still matters.

Before 2019

Rule 14 required chiropractors identify on right, interested, and business cards. It also stated certain claims, such as "chiropractic adjustment," and "effective treatment or cure" were prohibited as misleading.

After the 2019 rescission

Rule 14 isn't in force. Michigan no longer uses a separate chiropractic advertising checklist. Advertising is judged under broader rules on "truthfulness, professional ethics, honesty, and, and scope of practice."

What still applies

False or misleading advertising remains prohibited. Do not imply connections, specializations, or scope you do not have, and avoid misrepresentation of government licensure claims.

Practical teaching point

"Michigan moved away from a chiropractic-specific checklist telling you exactly what would have to appear on every sign and business card. Take the larger questions and ask yourself: identifying yourself? Are you staying within scope? Are your credentials and specialty claims accurate? Could a reasonable patient be misled?"

Source: former Michigan Administrative Code R 320.1300 (Rescinded) R 320.1301 (R 320.1302) R 320.1303 (R 320.1304) R 320.1305 (R 320.1306) R 320.1307 (R 320.1308) R 320.1309 (R 320.1310) R 320.1311 (R 320.1312) R 320.1313 (R 320.1314) R 320.1315 (R 320.1316) R 320.1317 (R 320.1318) R 320.1319 (R 320.1320) R 320.1321 (R 320.1322) R 320.1323 (R 320.1324) R 320.1325 (R 320.1326) R 320.1327 (R 320.1328) R 320.1329 (R 320.1330) R 320.1331 (R 320.1332) R 320.1333 (R 320.1334) R 320.1335 (R 320.1336) R 320.1337 (R 320.1338) R 320.1339 (R 320.1340) R 320.1341 (R 320.1342) R 320.1343 (R 320.1344) R 320.1345 (R 320.1346) R 320.1347 (R 320.1348) R 320.1349 (R 320.1350) R 320.1351 (R 320.1352) R 320.1353 (R 320.1354) R 320.1355 (R 320.1356) R 320.1357 (R 320.1358) R 320.1359 (R 320.1360) R 320.1361 (R 320.1362) R 320.1363 (R 320.1364) R 320.1365 (R 320.1366) R 320.1367 (R 320.1368) R 320.1369 (R 320.1370) R 320.1371 (R 320.1372) R 320.1373 (R 320.1374) R 320.1375 (R 320.1376) R 320.1377 (R 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A SIMPLE WAY TO TEACH STAFF AND DOCTORS

The three boundary zones

Most serious boundary problems begin with smaller warning signs that were not recognized or corrected.

GREEN CLEAR / PROFESSIONAL	YELLOW PAUSE / CLARIFY	RED STOP / ACT
- Clear clinical purpose - Explanation before contact - Meaningful consent - Privacy and appropriate draping - Documentation when appropriate - Chaperone when warranted	- Increasing informality - Unclear or unexpected touch - Special access or favoritism - Private teasing / social-media contact - Patient discomfort or frustration - Blurring personal and professional roles	- Sexualized conduct - Coercion or intimidation - Ignoring/refusal or withdrawal of consent - Sexuality or concealment - Retaliation - Clinically unjustified intimate contact

Yellow is the warning zone: pause, clarify, document when appropriate, and reset the professional boundary before proceeding.

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EXPLAIN BEFORE YOU TOUCH

Consent is an ongoing process, not just a signature

Good boundary practice turns consent into a conversation before and during care.

Explain the purpose—what you are going to do and why it is clinically relevant.

Explain the contact—body area, hand placement, positioning, and what the patient may feel.

Offer meaningful choice—proceed, modify, request a chaperone, ask questions, or stop.

Watch for hesitation—nonverbal discomfort should prompt clarification.

Document when it matters—sensitive area, unusual technique, concern, chaperone issue, or change in consent.

How to document it

Check the clinically significant elements: what was explained, patient agreement/questions, options offered, chaperone offered/accepted/declined and who was present, patient response, and any modifications, stop, or withdrawal of consent.

Consent can be modified or withdrawn during the encounter.

Phrase to use

"Before I do this, I want to explain what I'm going to do and why, if anything is going to hurt, or if you want me to change or stop, tell me and I will stop."

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THIS CHAPERONE IS PART OF THE SYSTEM

Chaperones, assistants, and room protocols

A chaperone can protect patient comfort and reduce ambiguity—but only when the role, choice, and documentation are clear.

When to consider / offer	What to document	The chaperone's role
- Sensitive or intimate anatomical areas - Patient request or expressed discomfort - Minor or vulnerable patient - Threats to safety or communication difficulty - Unusual positioning or technique - Prior boundary concern or complaint	- Chaperone offered when appropriate - Accepted or declined - Role / role of person present - Reason patient consent - Procedure or anatomical area involved - Any concern, interruption, or modification	- Understand why they are present - Position patient privacy and dignity - Be positioned so presence is meaningful - Recognize and respond to discomfort - Know how to role and report a concern

A chaperone does not create consent, clinical necessity, or appropriate conduct. Those obligations remain with the clinician.

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CLINICAL PRECISION REDUCES AMBIGUITY

Draping, positioning, and sensitive contact

Good boundaries are operational. They show up in how the patient is prepared, positioned, exposed, touched, and responded to.

Prepare before positioning	Use minimum necessary exposure	Respond to patient cues
- Explain what clothing stays on. - Explain what areas need access or exposure. - Describe how the patient will be positioned. - Explain why it is clinically relevant.	- Expose only the anatomical area reasonably needed. - Preserve privacy and drape appropriately. - Explain sensitive contact before it occurs. - Avoid vague, unexpected, or sudden touch.	- If the patient says stop, stop. - If the patient sighs, puts away, becomes tense, or appears confused, pause. - Clarify and obtain renewed agreement before proceeding.

Document when sensitive contact, unusual positioning, patient concern, or a change in consent occurs.

Ambiguity is the enemy of trust.

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MICHIGAN'S STANDARD IS BROAD

Sexual conduct with a patient

Patient initiation or consent does not make sexual conduct permissible within the professional relationship.

Michigan disciplinary law reaches	Clinical distinction
- Sexual intercourse or sexual kissing - Sexualized teasing - Teasing that is suggestive of sexual harassment, intimidation, or coercion - Conduct that may reasonably be interpreted as sexual - Conduct initiated by the patient or conduct to which the patient consents	- Appropriate clinical contact is not prohibited merely because it involves a sensitive anatomical area - Ask: Was there a legitimate clinical purpose? - Was the contact appropriate to assessment, treatment, or comfort? - Was it expected, consented to, and professional in context?

Patient consent is not a defense to sexual conduct within the professional relationship.

Michigan Public Health Code MCL 333.162(2)(b)(i)
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THE HARD CASES STILL REQUIRE BOUNDARIES

Mutual attraction, former patients, and staff

Attraction does not eliminate the power differential. Establish the rule before feelings complicate judgment.

Current patient	Former patient	Employee / staff
- Do not pursue a romantic or sexual relationship while the clinical relationship is active. - Relevant conduct or conduct stops not only sexual contact within the professional relationship. - Separate clinical care from personal attraction immediately.	- Ending care is not an automatic safe harbor - Consider timing, treatment intensity, vulnerability, dependence, and whether transition was graceful. - Also consider exploitation or the appearance of exploitation.	- Consent can be complicated by power over including pay, vacation, discipline, and continued employment. - Other rules, boundaries, retaliation risk, and harassment duties must be considered. - Use policy, disclosure, and role separation.

Changing the label—from patient to former patient, or employee to romantic partner—does not automatically erase the underlying power relationship.

When the relationship creates doubt: maintain the boundary, separate the roles, and obtain independent advice before acting.
Activity code: Michigan Public Health Code MCL 333.162(2)(b)(i); Michigan Public Health Code
Michigan Public Health Code MCL 333.162(2)(b)(i); Michigan Public Health Code
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YOU STILL OWN THE PROFESSIONAL RESPONSE

When the patient crosses a boundary

The patient may relate inappropriate conduct, but the clinician remains responsible for maintaining the professional frame.

- 1 Name the boundary**
Respond calmly: "I want to keep our relationship professional and focused on your care."
- 2 Do not participate**
Do not feel forced, lose energy, escalate the interaction, privately message, retaliate, shame, or ignore repeated conduct.
- 3 Reset the encounter**
Bring to a halt for a moment, change positioning or room setup, modify the visit, or end the encounter if necessary.
- 4 Document objectively**
Record what was said or done, who was present, your response, any modification or discontinuation of care, and so on.
- 5 Escalate when needed**
For threatening, coercive, repeated, or unsafe behavior, follow the office safety plan and consider whether additional care is appropriate.

Chart language

Document behavior, not beliefs.
Avoid "Patient was inappropriate."
Use "Patient stated, ... , attempted ... , and ..."
Avoid the question of intent and avoid using "I" statements.
Avoid "I" statements. Staff member ... asked the question. The patient ... modified the question. Follow-up plan ..."

If terminating care
Follow reporting, contractual, legal, and continuity-of-care requirements.

Patient behavior may explain what happened. It does not excuse the clinician from maintaining the boundary.

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BOUNDARY ANALYSIS EXERCISE

The after-hours adjustment

Use the green / yellow / red model. Do not decide from one fact alone.

Scenario
Along time patient texts the doctor at 8:45 PM: "My back is killing me. Can you meet me at the office quickly? I trust only you."

The office is closed. No staff are present. The patient has previously made flirtatious comments.

What should the doctor do next?

Identify yellow flags
After hours contact
Closed office, no staff
Trust without evidence
Trust only your appearance

Not automatically wrong
After hours contact
Legitimate patient care
Established prior treatment
Clinical concern regarding triage

Seeker information
Chief complaint
Chief concern along after hours
Patient in urgent/emergent care if
Exacerbated
Patient's safety/health if care is necessary

Ask the reason
After hours message
What causes this to happen?
What causes this to stop?
What should be documented?

The goal is not "never provide after-hours care." The goal is to remove avoidable ambiguity while still meeting legitimate clinical needs.

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Part 3

Office culture

Boundaries are a system, not a personality trait

A practice gets safer when the rules are clear, trained, followed, and enforced.

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DIGITAL, EVENT, PERSONAL, VIOLENCE, AND VIOLENCE

The office is part of the professional relationship

A chiropractor can be accountable for what the office permits, ignores, or fails to correct.

Staff + patient
Jokes, comments, casual touching, group, social media contact, records, social media, etc.

Patient + staff
Staff need authority to stop abusive, sexualized, threatening, discriminatory, or manipulative patient conduct and escalate if abuse becomes the office norm.

Doctor + staff
The employment power imbalance makes "consent," jokes, dating, discipline, scheduling, favoritism, and retaliation more legally and ethically complex.

Practice rule: write it down, train to it, give staff authority to act, investigate concerns, correct promptly, document what happened, and prohibit retaliation.

Provider takeaway: the owner's tolerated standard becomes the office standard.

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THE OFFICE EXTENDS THE DOCTOR'S ETHICAL FOOTPRINT

Staff conduct can become practice conduct

You benefit from the halo of excellent staff. You also inherit risk from the culture, training, and systems you allow.

What staff can create
Boundary problems with patients
Gossip, resentment, or FUD discourse
Biting pressure or coercive information
Revealed jokes, violations, or testing patient feeling culture.

What the doctor controls
Hiring expectations
Training and office policies
Supervision and role clarity
Complaint pathways
Physical investigation, correction, and documentation.

Where exposure grows
The conduct was tolerated or ignored.
The office knew or should have known.
No training, policy, or reporting path existed.
The response was defensive, retaliatory, or undocumented.

Practical translation
You may not control every act of every employee, but you are responsible for the system you create, the conduct you authorize, and what you do once a problem is known or foreseeable.

Delegating the task does not delegate responsibility for the office system.

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PROVIDER LIVES - FEDERAL FLOOR

Harassment and discrimination: the practical 2026 posture

The safest approach is not to chase headlines. It is to run a fair, prompt, documented workplace process.

Michigan Elliott-Larsen Civil Rights Act, now
Michigan law explicitly covers sexual orientation and gender identity/expression. It applies to employment and fair housing. Discrimination - both can happen in a chiropractic office.

CRDWW Act update (Creating a Respectful and Open World for Natural Hair)
Michigan race protections now include hair texture and protective hairstyles based on braids, twists, and more. Review dress, grooming, and appearance policies.

Federal floor
Federal harassment standards focus on unwelcome conduct that is discriminatory based on protected characteristics and that prevents and/or creates a hostile work environment.

Office process
Train staff, receive concerns seriously, stop retaliation, investigate thoroughly, respond behavior, document each step, and provide external advice before the situation is resolved or settled.

Takeaway: respectful conduct, prompt response, no retaliation, and consistent documentation reduce office risk.

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NEUTRAL STANDARD, CONSISTENT ENFORCEMENT OFFICE

Dress and appearance are part of the clinical environment

A dress code should support safety, hygiene, patient comfort, and clear professional boundaries—not modesty policing or bias.

Clinical function

Clothing should protect safety, hygiene, and function in work. Monitor requests coverage during movement and treatment. Footwear, jewelry, hair, nails, and accessories should fit patient care and safety needs.

Boundary clarity

Attire should reduce unnecessary ambiguity in a health-based clinical setting. Avoid clothing, signage, or presentation that identifies, glorifies, stigmatizes, or undermines professional care. Apply the same functional standards to doctors, CNAs, staff, trainees, and visitors.

Policy ethics

Address concerns privately and respectfully. Do not humiliate, stereotype, or selectively enforce. Focus on religion, disability, pregnancy, culture, or other legally protected accommodation issues. Document the policy-based reason and apply the accommodation.

Professional appearance should reduce ambiguity—not create it, and not become a vehicle for bias.

Practical rule: write functional standards tied to patient care, safety, infection control, privacy, and respectful workplace expectations.

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ONLY USEFUL IF TRAINED AND ENFORCED OFFICE

Employee handbook and office policies

A policy written in a vacuum is not a culture. It has to guide daily conduct and create proof of response.

Required workplace conduct

Professional conduct, with harassment, non-discrimination, anti-retaliation, confidentiality, and respectful patient-facing behavior.

Clinical boundaries

Boundaries: chaperones, mismanagement, sensitive context, patient behavior, managing a crisis, and incident reporting.

Digital conduct

Texting, photos, photos/videos, portal messages, social media, online reviews, AI tools, and PHI handling.

Operational proof

Training done, signed acknowledgments, complaint workflow, investigation notes, corrective action, and annual review.

Update trigger: legal change, new service line, new technology, patient/staff complaint, role change, staff turnover, or payer/regulatory audit.

Best practice: keep policies written, train staff, document acknowledgments, and show a prompt response when concerns arise.

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THE OFFICE "BIBLE" SHOULD SHOW PRIORITIES, NOT JUST ACCUMULATE PAPERS OFFICE

What belongs in the office "Bible"?

Use one master checklist to govern the handbook, then print the content. These tiers show what a small office must have, should have, and may build over time.

Must have

Employee handbook / HR rules
Clinical care, consent, and documentation standards
Privacy, records, and HIPAA procedures
Billing, coding, and money controls
Safety, incidents, and emergency response

Should have

Digital communications, telehealth, and AI rules
Complaints, investigations, and escalation process
Training log, acknowledgments, and annual review
Boundaries policies: chaperones, misman, sensitive contact

Nice to have

Vendor and business associate oversight
Quality improvement, internal audits, and dashboards
Risk-based SDOH, checklists, and case tracking
Business continuity and downtime planning

Simple architecture: People • Clinical Care • Compliance • Money • Data • Safety • Response • Proof

Practical tip: keep one master manual, but give staff role-based access to the sections that apply to them.

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REVIEW AND POST OFFICE

Social media, reviews, and online familiarity

Online communication can collapse the wall between professional and personal roles—and create privacy, advertising, and boundary risk.

Online reviews

Respond without confirming patient status or disclosing PHI. Use a neutral public reply and move the issue to a private, controlled process.

Social connection

Avoid friending, following, private messaging, or connecting from personal accounts when it creates perceived favoritism.

Testimonials & images

Do not use patient photos, stories, success stories, or testimonials without a compliant authorization and careful context. Avoid false, paid, or unbalanced reviews.

Staff rule: no screenshots, gossip, "funny patient stories," or private patient details in texts, group chats, or social media.
Marketing rule: a patient's own post is not permission for the practice to confirm, reuse, or amplify it.
Office rule: nurse complaints, reviews, and social posts through one trained person or approved script.

Boundary rule: do not let convenience, praise, frustration, or marketing pressure override confidentiality and professional distance.

The internet does not forget—and neither does an investigator.

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REPUTATION DEFENSE WITHOUT A PRIVACY VIOLATION OFFICE

If you need to clear your name online

You can defend your reputation—but do it without confirming, discussing, or disproving an individual patient encounter in public.

Preserve the evidence: screenshot the post, date, URL, comments, and related messages.
Do not argue the case publicly: do not confirm the person was a patient or disclose facts from the chart.
Respond once, briefly, and generally: invite the person to contact the office through a private resolution process.
Move the dispute offline: have a designated person handle it and document the follow-up.
Escalate when needed: if the statement is false, threatening, or materially damaging, involve counsel and preserve all evidence.

Helpful tools / services

Platform reporting / appeals (Google, Meta, Facebook, Instagram, etc.)
Reputation management or online monitoring service
Practice compliance audit, privacy officer, or office manager
Helpdesk service and legal counsel for service alignment

Sample public response

"We take concerns seriously. Privacy rules prevent us from discussing any individual's care in a public forum. Please contact our office so we can review your concern directly."

Bottom line: HIPAA may keep you from telling your side publicly, but it does not leave you defenseless.

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CLINICAL JUDGMENT MUST NOT LOOK PURCHASED OFFICE

Financial boundaries and care recommendations

Ethical care keeps patient need, billing incentives, packages, and referral relationships visibly separate.

Treatment plans

Individualize recommendations. Explain and document the clinical reason. Avoid high-revenue product packages, inflated marketing, or one-size-fits-all care driven by collection goals.

Referrals & ownership

Disclose financial interests. Avoid fee splitting, kickbacks, and referral patterns that make care appear commercially motivated or ownership.

Billing & payer proof

Before billing, confirm the service was performed, verify steps, and identify resources for the patient. Disclose fees, identify codes, and financially disclose.

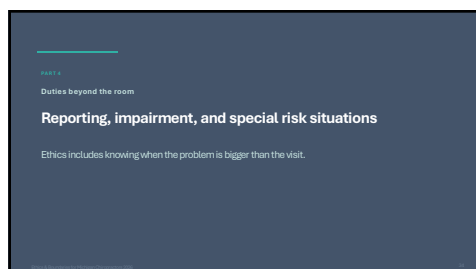
Practical test: would the same recommendation make clinical sense if the payment source, package sale, referral relationship, or ownership interest disappeared?

Provider takeaway: patient trust erodes quickly when the doctor appears to be selling rather than caring.

Legal warning: unnecessary services, reimbursement fraud, fee splitting/kickbacks, financial interest steering, and other financial issues when applicable.

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CASE ROUNDS

CASES

The testimonial

Use for discussion: identify the yellow flags, the missing facts, the applicable law/policy, and what should be documented.

Scenario A patient posts a glowing review and asks to be featured in a "science miracle" video. What must you consider before saying yes?	Yellow flags Advertising claim risk Patient authorization / privacy Typical results implications Incentives or material connections	Facilitator prompts Could this be misleading even if the patient truly improved? What written authorization would be needed before using the patient's image or story? How should "miracle" language be handled? What would the practice need to keep in its file?
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Key point: A patient may speak positively, but the practice should not publish or amplify claims it cannot substantiate, and any use of patient identity or health information requires a valid authorization.

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CASE ROUNDS

CASES

The staff joke

Use for discussion: identify the yellow flags, the missing facts, the applicable law/policy, and what should be documented.

Scenario A CA repeatedly makes sexual jokes in an open treatment area. No one has filed a formal complaint. Does the owner have a duty to act, and what should happen next?	Yellow flags Open treatment setting Repeated sexualized comments Staff discomfort / retaliation risk Patient professionalism concerns	Facilitator prompts Does the practice have to wait for a written complaint? What immediate steps should the supervisor take? What should be documented about the concern and response? What follow-up would be appropriate?
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Key point: The duty is to address inappropriate conduct early, protect staff and patients, document the concern, and take corrective action rather than waiting for the situation to worsen.

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CASE ROUNDS

CASES

The minor patient

Use for discussion: identify the yellow flags, the missing facts, the applicable law/policy, and what should be documented.

Scenario A minor arrives with a significantly older partner who answers every question and refuses to leave the room. What do you assess first, and when does this become a safety or reporting issue?	Yellow flags Possible coercion or control Minor cannot speak privately Relationship / age uncertainty Potential abuse, neglect, or exploitation	Facilitator prompts How can the office create a safe chance to speak with the patient alone? What facts are missing before deciding what duty applied? When would law enforcement or a reporting pathway become appropriate? What observations should be documented objectively?
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Key point: Do not jump to conclusions, but do not ignore the warning signs. Focus first on safety, private assessment, objective documentation, and the correct reporting or referral pathway if concern rises to suspicion.

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CASE ROUNDS

CASES

The AI note

Use for discussion: identify the yellow flags, the missing facts, the applicable law/policy, and what should be documented.

Scenario A doctor pastes an entire patient chart into an online AI tool to "clean it up." What questions must be answered before any PHI is entered?	Yellow flags Protected health information Vendor approval / governance Business associate issues Data retention or reuse risk	Facilitator prompts Is the tool approved by the practice for PHI use? Is a business associate agreement needed? What is the minimum necessary information? What should the office policy say about AI tools?
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Key point: Before using AI with patient information, the practice must decide whether the tool is authorized for PHI, what legal/contractual protections are in place, and how to limit data exposure.

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CLOSING

CLOSING

Final takeaway: protect trust before you defend conduct

The best ethical system is simple enough to use on the busiest day in the office.

Explain before touching Describe what you are going to do, why, and obtain meaningful consent.	Keep clean records Document context, clinical judgment, unusual events, exceptions, and your response. Review after the record after the fact.
Use chaperones and staff protocols wisely Reduce ambiguity about decisions, patient preferences, or the nature of the encounter with care.	Recognize when reporting duties apply Know when safety concerns, suspected abuse, reproductive equipment, or other statutory obligations require escalation or reporting.
Fix the system Find every vulnerability, near miss, or uncomfortable event as information about policy, training, expectations, or culture.	

Ethics is what you do when no one is watching—and what your systems and records demonstrate afterward.

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APPENDIX

Citations, statutory anchors, and update references

These slides are intended to support course approval, presenter preparation, and follow-up questions. They are not intended as individualized legal advice.

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APPENDIX

A1. Michigan Chiropractic CE requirements

Content not subject for future approval and review, contribution

A1.1. Michigan Board of Chiropractic: Licensing authority and rule links
Michigan Department of Licensing, Regulation and Consumer Services, Board of Chiropractic, General Rules

A1.2. R 336.13021: license renewal CE hours
Required license CE for every practitioner renewing license, required license compliance and standards documentation for four years

A1.3. R 336.13041: required topics and delivery limits
Required over 1 hour per year and by presentation type, three annual hours, three ethics, three physical measures, one 15 hours CE hours, at least 10 hours by person hours

A1.4. R 336.13041: course approval and documentation
Approval process includes Board approval and required course must be approved by the Board, certificate of completion, certificate of completion, certificate of completion

A1.5. R 336.13041: CE program approval application
Course, presentation, delivery method, electronic training, and sample certificate of completion template

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APPENDIX

A2. Material 2025 chiropractic rule updates

Practitioner-facing changes within amendments to the rules state

A2.1. Michigan Chiropractic: General Rules update history
Michigan Department of Licensing, Regulation and Consumer Services, Board of Chiropractic, General Rules, 2025 CE requirements, 2025

A2.2. R 336.13016: telehealth
Required license compliance and standards documentation, required license compliance, required license compliance

A2.3. CE delivery changes summarized by MAC
Michigan Department of Licensing, Regulation and Consumer Services, Board of Chiropractic, General Rules, 2025 CE requirements, required license compliance, required license compliance, required license compliance

A2.4. Curation on summaries
Required license compliance and standards documentation, required license compliance, required license compliance

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APPENDIX

A3. Michigan Public Health Code anchors

Content not subject for future approval and review, contribution

A3.1. MCL 333.1621: good moral character
Content not subject for future approval and review, contribution

A3.2. MCL 333.1621: grounds for disciplinary action
Content not subject for future approval and review, contribution

A3.3. MCL 333.1622: sanctions
Content not subject for future approval and review, contribution

A3.4. MCL 333.1621 and 333.1622: holding out and use of "doctor"
Content not subject for future approval and review, contribution

A3.5. MCL 333.1621: practice of chiropractic
Content not subject for future approval and review, contribution

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APPENDIX

A4. Sexual boundaries and professional conduct sources

Content not subject for future approval and review, contribution

A4.1. MCL 333.1621(1): unprofessional conduct
Content not subject for future approval and review, contribution

A4.2. Michigan Public Health Code sexual conduct language
Content not subject for future approval and review, contribution

A4.3. Federation of State Medical Boards: concepts
Content not subject for future approval and review, contribution

A4.4. Legacy course material
Content not subject for future approval and review, contribution

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APPENDIX

A5. Records, privacy, telehealth, and communications

Content not subject for future approval and review, contribution

A5.1. Medical Records Access Act, MCL 333.2621 et seq.
Michigan Department of Licensing, Regulation and Consumer Services, Board of Chiropractic, General Rules

A5.2. MDHHS 2026 Medical Records Access Fee
Michigan Department of Health and Human Services, Michigan Department of Health and Human Services

A5.3. HIPAA Privacy/Security Breach Notification Rules
Michigan Department of Health and Human Services, Michigan Department of Health and Human Services

A5.4. HHS OCR 2019 reproductive health privacy update
Michigan Department of Health and Human Services, Michigan Department of Health and Human Services

A5.5. R 336.13016 and MCL 333.1621: telehealth
Michigan Department of Licensing, Regulation and Consumer Services, Board of Chiropractic, General Rules

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APPENDIX

A6. Mandatory reporting and training sources

Content not subject for future approval and review, contribution

A6.1. Child Protection Law, MCL 722.623
Michigan Department of Licensing, Regulation and Consumer Services, Board of Chiropractic, General Rules

A6.2. MDHHS Mandatory Reporter guidance
Michigan Department of Health and Human Services, Michigan Department of Health and Human Services

A6.3. Social Welfare Act, MCL 400.11a and MDHHS APS guidance
Michigan Department of Health and Human Services, Michigan Department of Health and Human Services

A6.4. Human Trafficking training, MCL 333.1616 and Michigan Admin Code R 336.1616
Michigan Department of Licensing, Regulation and Consumer Services, Board of Chiropractic, General Rules

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APPENDIX

A7. Impairment and HPRP sources

Provider wellness, patient safety, and discipline provisions

A7.1. Michigan Health Professional Recovery Program
 A link to the Michigan Health Professional Recovery Program (HPRP) website, which provides information on the HPRP process and resources for providers who are struggling with substance use or mental health concerns.

A7.2. HPRP participant resources
 A link to the HPRP participant resources page, which includes information on the HPRP process, resources, and support.

A7.3. Public Health Code discipline interaction
 A link to the Michigan Public Health Code, which includes information on the discipline process and resources.

A7.4. Practical teaching point
 Providers should be aware of the HPRP process and resources, and should be able to identify the appropriate resources for providers who are struggling with substance use or mental health.

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APPENDIX

A8. Employment, harassment, and civil rights sources

Office culture and workplace issues

A8.1. Elliott-Larsen Civil Rights Act amendments, 2023 PA 6
 A link to the Elliott-Larsen Civil Rights Act amendments, 2023 PA 6, which includes information on the amendments and resources.

A8.2. Michigan CROWN Act, 2023 PA 48
 A link to the Michigan CROWN Act, 2023 PA 48, which includes information on the Act and resources.

A8.3. EEOC harassment resources and 2018 resolution notice
 A link to the EEOC harassment resources and 2018 resolution notice, which includes information on the EEOC process and resources.

A8.4. Michigan Earned Sick Time Act, effective 2023
 A link to the Michigan Earned Sick Time Act, effective 2023, which includes information on the Act and resources.

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APPENDIX

A9. Fraud, abuse, referrals, and federal overlay

State and federal entities, and the state health authority's role in fraud, abuse, referrals, and federal overlay

A9.1. Federal criminal statutes
 A link to the Federal criminal statutes, which includes information on the statutes and resources.

A9.2. Anti-Kickback Statute and False Claims Act
 A link to the Anti-Kickback Statute and False Claims Act, which includes information on the statutes and resources.

A9.3. Stark law and Michigan adoption by reference
 A link to the Stark law and Michigan adoption by reference, which includes information on the law and resources.

A9.4. Provider teaching point
 Providers should be aware of the federal criminal statutes, the Anti-Kickback Statute, the False Claims Act, the Stark law, and the Michigan adoption by reference, and should be able to identify the appropriate resources for providers who are struggling with fraud, abuse, referrals, and federal overlay.

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APPENDIX

A10. Source decks and presenter disclaimer

Legal disclaimer and source decks

A10.1. Ethics & Boundaries 2022 source deck
 A link to the Ethics & Boundaries 2022 source deck, which includes information on the source deck and resources.

A10.2. Adult Ethics & Boundaries 2019 source deck
 A link to the Adult Ethics & Boundaries 2019 source deck, which includes information on the source deck and resources.

A10.3. Presenter disclaimer
 A link to the Presenter disclaimer, which includes information on the disclaimer and resources.

A10.4. Revision control
 A link to the Revision control, which includes information on the revision control and resources.

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APPENDIX

A11. Expanded-deck source anchors: opening and risk framing

Sources added for the new opening, consent/informed consent, and risk exposure slides.

Historical opening: "good medicine" changes
 • Science/Medicine/Big Data: "Strongly in support of evidence" — evidence-based medicine
 • Medical Science/Big Data: "Evidence-based medicine" — evidence-based medicine
 • The Law, Evidence, "Evidence-based medicine" — historical roots in legal/human sciences

Professional ethics framing
 • HHS, 2017 — professional ethics: law, human, and professional ethics
 • HHS, 2017 — professional ethics: law, human, and professional ethics
 • HHS, 2017 — professional ethics: law, human, and professional ethics

Risk framing: field of risk / ethics multiplier
 • Adaptive Medicine Service, "Evidence-based medicine" — evidence-based medicine
 • Adaptive Medicine Service, "Evidence-based medicine" — evidence-based medicine
 • Adaptive Medicine Service, "Evidence-based medicine" — evidence-based medicine

Mid-note
 • HHS, 2017 — professional ethics: law, human, and professional ethics
 • HHS, 2017 — professional ethics: law, human, and professional ethics
 • HHS, 2017 — professional ethics: law, human, and professional ethics

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APPENDIX

A12. Expanded-deck source anchors: care decisions and communication

Sources added for the new opening, consent/informed consent, and risk exposure slides.

Consent/informed consent / failure to graduate
 • HHS, 2017 — professional ethics: law, human, and professional ethics
 • HHS, 2017 — professional ethics: law, human, and professional ethics
 • HHS, 2017 — professional ethics: law, human, and professional ethics

Mid-note / consent/informed consent / failure to graduate
 • HHS, 2017 — professional ethics: law, human, and professional ethics
 • HHS, 2017 — professional ethics: law, human, and professional ethics
 • HHS, 2017 — professional ethics: law, human, and professional ethics

Professional ethics framing
 • HHS, 2017 — professional ethics: law, human, and professional ethics
 • HHS, 2017 — professional ethics: law, human, and professional ethics
 • HHS, 2017 — professional ethics: law, human, and professional ethics

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APPENDIX

SOURCES

A13. Expanded-deck source anchors: office systems and duties beyond the room

Sources edited for CBO referral, interprofessional conflict, staff conduct, dress/appearance, and complaints.

CBO / social needs referral • CBO Assessment and Connection Hub – screening, referral, and navigation for health-related needs. • CBO Care Coordination – patient outreach, coordination with providers, patient and community resources, and patient navigation. • CBO Care Coordination – patient outreach, coordination with providers, patient and community resources, and patient navigation.	Interprofessional treatment plan conflict • HCL 300.0000 – Interprofessional collaboration, referral coordination, and evidence-based practice. • HCL 300.0000 – Interprofessional collaboration, referral coordination, and evidence-based practice. • HCL 300.0000 – Interprofessional collaboration, referral coordination, and evidence-based practice.
Complaints / staff / vicarious exposure • HCL 300.0000 – Staff conduct, patient safety, and interprofessional collaboration. • HCL 300.0000 – Staff conduct, patient safety, and interprofessional collaboration. • HCL 300.0000 – Staff conduct, patient safety, and interprofessional collaboration.	Dress / appearance / culture • HCL 300.0000 – Staff conduct, patient safety, and interprofessional collaboration. • HCL 300.0000 – Staff conduct, patient safety, and interprofessional collaboration. • HCL 300.0000 – Staff conduct, patient safety, and interprofessional collaboration.

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APPENDIX

SOURCES

A14. Expanded-deck source anchors: impairment and fit-for-duty

Sources edited for the alcohol, medication, and fitness-for-duty state.

Michigan impairment and legal-duty anchors • HCL 300.0000 – Impairment and legal-duty anchors. • HCL 300.0000 – Impairment and legal-duty anchors. • HCL 300.0000 – Impairment and legal-duty anchors.	Medication / alcohol performance anchors • HCL 300.0000 – Medication and alcohol performance anchors. • HCL 300.0000 – Medication and alcohol performance anchors. • HCL 300.0000 – Medication and alcohol performance anchors.
Professional ethics context • HCL 300.0000 – Professional ethics context. • HCL 300.0000 – Professional ethics context. • HCL 300.0000 – Professional ethics context.	Practical teaching boundary • HCL 300.0000 – Practical teaching boundary. • HCL 300.0000 – Practical teaching boundary. • HCL 300.0000 – Practical teaching boundary.

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APPENDIX

A15. Online source URL index, part 1

Source for CBO referral, interprofessional conflict, staff conduct, dress/appearance, and complaints.

Michigan Board of Chiropractic	https://www.michiganboardofchiropractic.com/
Michigan Board of Chiropractic, Public Health Code General Rules	https://www.michiganboardofchiropractic.com/public-health-code-general-rules/
Michigan Board of Chiropractic, Public Health Code General Rules	https://www.michiganboardofchiropractic.com/public-health-code-general-rules/
HCL 300.0000, general medical director	https://www.michiganboardofchiropractic.com/hcl-300-0000-general-medical-director/
HCL 300.0000, chiropractic practice	https://www.michiganboardofchiropractic.com/hcl-300-0000-chiropractic-practice/
HCL 300.0000, licensure	https://www.michiganboardofchiropractic.com/hcl-300-0000-licensure/
HCL 300.0000, malpractice	https://www.michiganboardofchiropractic.com/hcl-300-0000-malpractice/
HCL 300.0000, malpractice	https://www.michiganboardofchiropractic.com/hcl-300-0000-malpractice/
HCL 300.0000, malpractice	https://www.michiganboardofchiropractic.com/hcl-300-0000-malpractice/

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APPENDIX

A16. Online source URL index, part 2

Source for CBO referral, interprofessional conflict, staff conduct, dress/appearance, and complaints.

Michigan Board of Chiropractic	https://www.michiganboardofchiropractic.com/
Michigan Board of Chiropractic, Public Health Code General Rules	https://www.michiganboardofchiropractic.com/public-health-code-general-rules/
Michigan Board of Chiropractic, Public Health Code General Rules	https://www.michiganboardofchiropractic.com/public-health-code-general-rules/
HCL 300.0000, general medical director	https://www.michiganboardofchiropractic.com/hcl-300-0000-general-medical-director/
HCL 300.0000, chiropractic practice	https://www.michiganboardofchiropractic.com/hcl-300-0000-chiropractic-practice/
HCL 300.0000, licensure	https://www.michiganboardofchiropractic.com/hcl-300-0000-licensure/
HCL 300.0000, malpractice	https://www.michiganboardofchiropractic.com/hcl-300-0000-malpractice/
HCL 300.0000, malpractice	https://www.michiganboardofchiropractic.com/hcl-300-0000-malpractice/
HCL 300.0000, malpractice	https://www.michiganboardofchiropractic.com/hcl-300-0000-malpractice/

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