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Chiropractic physicians: toward a select conceptual understanding of bureaucratic structures and functions in the health care institution

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Abstract

Objective: The purpose of this article is to present select concepts and theories of bureaucratic structures and functions so that chiropractic physicians and other health care professionals can use them in their respective practices. The society-culture-personality model can be applied as an organizational instrument for assisting chiropractors in the diagnosis and treatment of their patients irrespective of locality.

Discussion: Society-culture-personality and social meaningful interaction are examined in relationship to the structural and functional aspects of bureaucracy within the health care institution of a society. Implicit in the examination of the health care bureaucratic structures and functions of a society is the focus that chiropractic physicians and chiropractic students learn how to integrate, synthesize, and actualize values and virtues such as empathy, integrity, excellence, diversity, compassion, caring, and understanding with a deep commitment to self-reflection.

Conclusion: It is essential that future and current chiropractic physicians be aware of the structural and functional aspects of an organization so that chiropractic and other health care professionals are able to deliver care that involves the ingredients of quality, affordability, availability, accessibility, and continuity for their patients.

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Introduction

> Our society is an organizational society. We are born in organizations, educated by organizations, and most of us spend much of our lives working for organizations. We spend much of our leisure time paying, playing, and praying in organizations. Most of us will die in an organization, and when the time comes for burial, the largest organization of all—the state must grant official permission.[1]

In many societies, automation is seen as the logical extension of industrialization. Thus, bureaucracy can be viewed as the predictable extension of social organizations within the societies. An *organization* is defined as "a social system of consciously coordinated activities or forces of two or more persons explicitly created to achieve specific ends."[2] Not surprisingly, leading social scientists hold that 3 interrelated social processes, namely, urbanization, industrialization, and bureaucratization, are the most influential factors that have transformed American community life over the generations.[3] Indeed, immigration and globalization are contributing factors for such transformations.

What is true for communities is no less true for their institutions. The institutional complex of major concern to us is health care that exemplifies the structures and functions of the bureaucracy. The structural aspect "seeks to explain a feature of society as the predictable consequence of certain structural characteristics of society."[4] The functional aspect, on the other hand, "seeks to explain a feature of society in terms of the beneficial consequences it has for the larger social system."[4] It is of interest to note that institutions are crescive in nature and have a strain of consistency,[5] which means that institutions build over time and that they are all interrelated. For example, the institutions such as the family and health care are interrelated because the family is the "unit of health because it is the unit of living."[6] In brief, institutions are socially approved patterns of behavior. Health care and the family are viewed as institutions in American society. A medical industrial organization as an institution, therefore, cannot be fully understood unless it is examined in itself as well as in relation to other institutions such as the family, social welfare, government, education, religion, and other organizational structures in the society. A society, from one perspective, can be viewed as falling somewhere between 2 polar pure types, ideal types, or mental constructs as either *gemeinschaft* (G1) or *gesellschaft* (G2) in orientation, or perhaps rural and urban (Fig 1). The society-culture-personality (SCP) model from a macroscopic perspective represents the global village, a nation, a community, an institution, or a group. There are a multitude of subsystems, comparable to subsystems in the human body, operating in any of these aggregates.

Bureaucracy, therefore, is the typical social and cultural milieu in which health care workers carry out their individual and common tasks in a society. Thus, a health care professional does not simply work in a clinic, a hospital, or a department of a medical industrial complex; but he or she works in a bureaucratic setting of a health care institution within a particular community of a specified society located either in a G1 or a G2 type of environment (Fig 1).

Therefore, the purpose of this article is to present select concepts and theories of bureaucratic structures and functions so that chiropractic physicians and other health care professionals can use them in their respective practices. The SCP model can be applied as an organizational instrument for assisting chiropractors in the diagnosis and treatment of their patients irrespective of locality.

Discussion

The structural aspects of bureaucracy and the health care institution

Society-culture-personality forms an interlocking social system (Fig 1). By definition, a *social system* is a pattern relationship of roles; and as these roles become highly complex structures, they are called *institutions* (I), that is, ways of taking care of the basic human needs of a society. As mentioned previously, a society, from one perspective, can be viewed as falling somewhere between 2 polar "pure" types, ideal types, or mental constructs, such as G1 and G2 in orientation.

Bureaucracy is a pyramiding of unit organizations of the social system in any complex society. Bureaucracy contains several subsystems within the larger social system: the authority system, the power system, the status system, the organizational system, the security system, and the role system (Fig 1). However, bureaucracy does involve a number of related characteristics. These are as follows (Fig 1): Freedom—The employee is bound by contract to perform various functions during the day's work, but is free to do what he/she wants after hours. Hierarchy—The structure of a bureaucracy is in the form of a hierarchy, with each

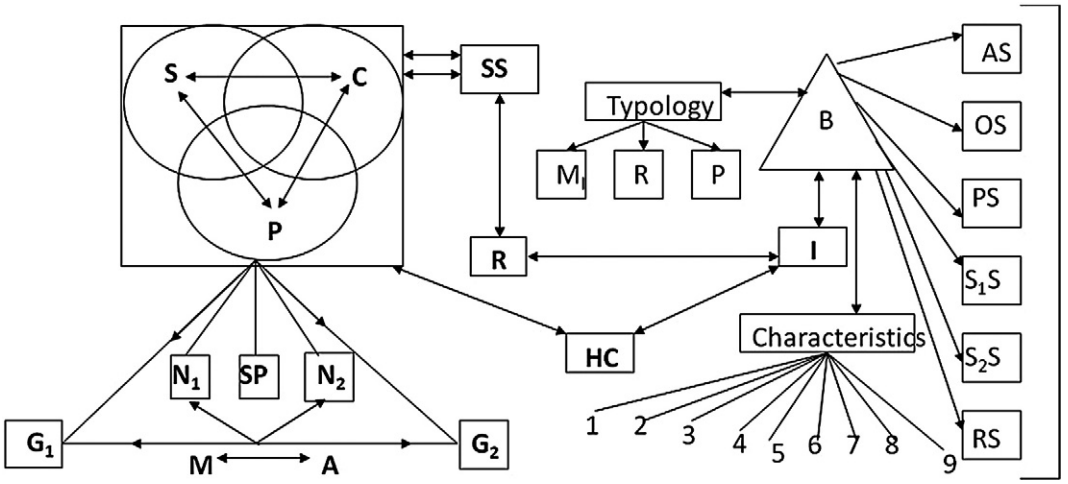

Fig 1. Select structural aspects of bureaucracy, health care, and SCP. S, society; C, culture; P, personality; N_1, nature or heredity; N_2, nurture or environment; G_1, *gemeinschaft*; SP, socialization process; G_2, *gesellschaft*; M, marginality; A, anomie; SS, social systems; R, role; I, institution; B, bureaucracy; AS, authority system; OS, organizational system; PS, power system; S_1S, status system; S_2S, security system; RS, role system; 1, freedom; 2, hierarchy; 3, competence; 4, contract; 5, qualification; 6, salary; 7, promotion; 8, procedure; 9, discipline; M1, mock bureaucracy; R, representative bureaucracy; P, punishment centered bureaucracy.

member answerable to a higher authority or authorities. Competence—There is a high degree of specialization. The members have defined spheres of competence and authority, and the duties and obligations of each group are specifically stated. Contract—Positions are filled by a contract, and both the organization and the individual are bound by its terms. Qualifications—The various levels are based upon technical competence, often following competitive examinations. Salary—The salary is fixed for each grade of the hierarchy. Promotion—Promotion is slow but reasonably sure. Procedure—The procedure in a bureaucratic setting is highly regularized; communication takes place through channels and according to established forms. Discipline—A bureaucracy is subject to strict discipline. The members are supposed to carry out the work of their office, keep the "secrets" of the organization, and maintain an in-group feeling against outsiders.[7] Bureaucracy, therefore, is a "hierarchical form of social organization rationally geared to the achievement of precisely specified objectives by means of a division of labor based on demonstrated competence."[7]

As bureaucracy has come to define and to regulate important functions of other institutions within this society, health care has increasingly adopted such bureaucratic characteristics as positions and official record keeping.[8] Indeed, the appearance of bureaucratic administration in almost every sphere of life has not left the health care professions untouched. Bureaucracy influences relations between chiropractic physicians and patients, between physicians and nurses, and other health-related professionals, permeating and influencing the whole structure of health services and the community as a whole.[9] The structural aspects of bureaucracy in relation to the health care institution (Fig 1) can be analyzed from the viewpoint of typologies.

Alvin Gouldner suggested that 3 patterns of bureaucracy are clearly distinguishable: mock, representative, and punishment centered. In mock bureaucracy, the informal organization of personnel circumvents the formal organization; nonenforcement and nonobedience of rules are informally arranged by superordinates and subordinates with little tension or conflict ensuring. Representative bureaucracy is marked by the endorsement and support of the rules by both groups; tension and conflict are relatively absent. Punishment-centered bureaucracy involves insistence on enforcement of the rules by one group and evasion of rules by the other (either pattern can be adopted by the superordinate or subordinate groups); consequently, tension and conflict are common in this type of work situation. Every organization, therefore, of any significant size is bureaucratized to some degree. Stable patterns of behavior based on structural roles and specialized tasks are apparent. As a general rule, any organization large enough inhibits face-to-face relationships in a bureaucracy.

When large numbers of people are added to an organization so that its goals may be accomplished, a

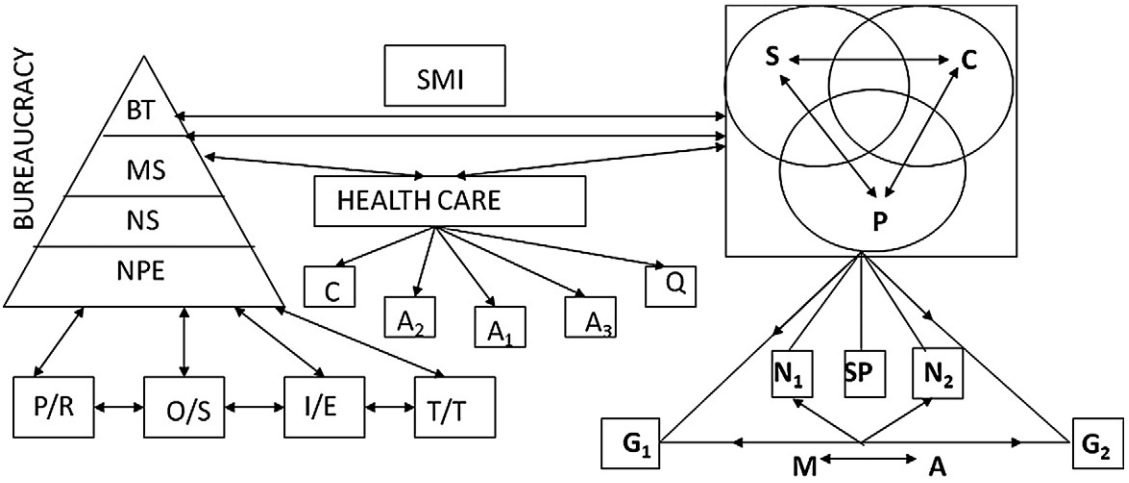

Fig 2. Select interactional aspects of bureaucracy and health care within the SCP model. S, society; C, culture; P, personality; N_1, nature or heredity; N_2, nurture or environment; G_1, *gemeinschaft*; SP, socialization process; NPE, non-professional employees; G_2, *gesellschaft*; M, marginality; A, anomie; BT, board of trustees; MS, medical staff; NS, nursing staff; SMI, social meaningful interaction; Q, quality; A_3, availability; A_1, accessibility; A_2, affordability; C, continuity; P/R, proactive/reactive; O/S, operational/strategic; I/E, intramural/extramural; T/T, transactional/transformational.

hierarchy of authority emerges as a line-ranking of positions from top to bottom. Tensions and frequent conflict arise between specialists and administrative persons in authority. Each considers his or her function indispensable to the organization and expects his or her point of view to take precedence, especially in allocating funds for example in a medical industrial complex.[10]

The concepts of individual initiative, team work, along with authority are additional structural and functional factors that need to be taken into consideration within the medical industrial organization. A. Earl Swift asserts that "all organizational behavior is ultimately founded upon human nature."[11] Human nature, according to Swift, allows for 3 distinct decision-making systems, namely, individualism, collaboration, along with authority and power. Individual initiative, also known as *liberty*, is a crucial aspect for an effective and successful organization. Collaboration, commonly referred to as *teamwork*, is another significant factor in organizational relationships. Teamwork does not allow any individual to manipulate and to dominate other employees because "the group provides a check against individuals with bad motives, denying them the power to tyrannically dominate or exploit other people."[11] When group decisions based upon consensus are established, a democratic approach to organizational relationships is fostered. Authority and power are additional factors that should be taken into consideration if an organization is to continue to fulfill its mission and objectives. The board of trustees, as the chief policy-making group of a medical industrial organization, is there "to enforce the mission and culture to ensure a proper balance of individualism, community, and authority."[11] By establishing homeostasis, it allows for a diverse workforce to work together, as a professional community, to achieve the goals of the organization. "Under most circumstances, however, organizations work most effectively when all three types of decision making are balanced relatively equally, and it is the authoritarian aspect of the organization that controls this balance."[11]

Given the above statements on the health care enterprise, the structural aspects of bureaucracy (Fig 1) are indeed linked to their functional dimensions as they relate to the health care institution (Fig 2). Thus, the structure and function of bureaucratic organizations are essential ingredients of analysis to bring about optimum levels of quality, affordability, availability, accessibility, and continuity in a health care institution irrespective of location whether G1 (rural) or G2 (urban) in orientation (Fig 3).

Select functional aspects of bureaucracy and the role of the family in the health care institution

The functional aspect of bureaucracy in relation to the health care institution of a community or a society is closely linked to the interactional changes within a health care organizational setting such as a clinic or a hospital. These institutional changes can occur both intramurally and/or extramurally (Fig 2). Furthermore,

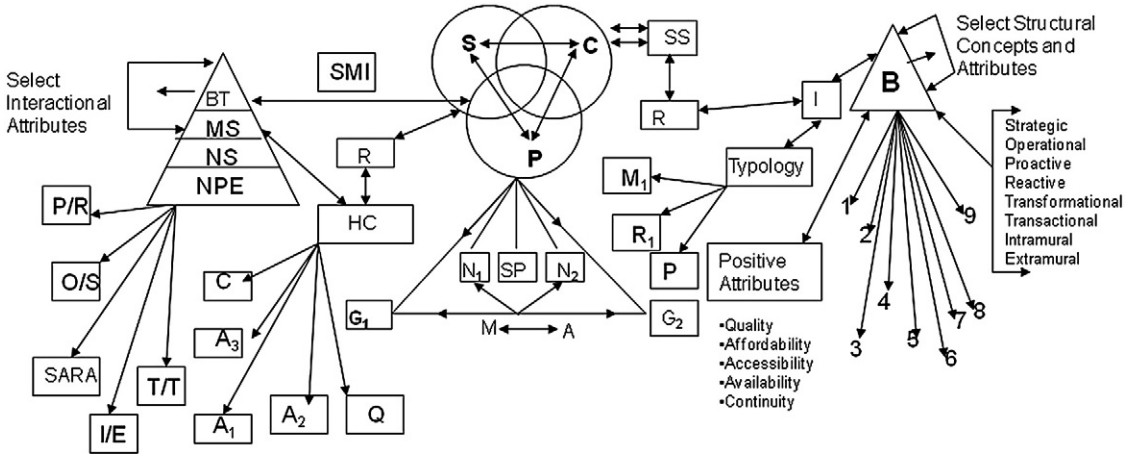

Fig 3. Select attributes and concepts of bureaucracy and health care. SARA, surprise, anxiety, rejection, acceptance; SMI, social meaningful interaction; G_2, *gesellschaft*; M, marginality; A, anomie; R, role; S, society; C, culture; P, personality; N_1, nature or heredity; N_2, nurture or environment; G_1, *gemeinschaft*; B, bureaucracy; SP, socialization process; SS, social systems; 1, freedom; 2, hierarchy; 3, competence; 4, contact; 5, qualification; 6, salary; 7, promotion; 8, procedure; 9, discipline; M_1, mock bureaucracy; HC, health care; R_1, representative bureaucracy; P, punishment centered bureaucracy; Q, quality; A_3, availability; A_1, accessibility; A_2, affordability; C, continuity; P/R, proactive/reactive; O/S, operational/strategic; I/E, intramural/extramural; T/T, transactional/transformational.

functional changes within the health care bureaucracy are affected when transactional and transformational changes are initiated in the system (Fig 2). Before SCP can become functional as an interlocking system, a catalyst or agent is necessary. That catalyst is social meaningful interaction (SMI) (Fig 2). As a person internalizes the culture of a society into his or her own personality, he or she develops a personality that is at once unique and distinctive and more or less adjusted to the demands of a society. In the development of SMI, the actor enters society and establishes rapport. After this has been accomplished, social contact, the simplest unit of relationship between 2 or more persons, is possible. Communication, which is involved in social contact, is the basis of SMI. In a sense, it is SMI. Communication is a thoroughly social activity that involves socialized persons as actors and reactors.

Social contact plus communication results in social interaction, which is a sustained, reciprocal, purposeful, meaningful, and (within limits) predictable series of relationships between 2 or more socialized human beings. In the SMI process, each actor takes the other(s) into account, is aware of the other(s), and appraises the other(s). However, SMI can occur on various levels. For example, interaction can take place between 2 individuals, between the individual and the group, between the individual and culture, and between the individual and mass communication.[12] The SMI is linked to socialization, a learning process in a social environment where the value-attitude system of a culture is internalized.[13]

It is important that chiropractic and other health care professionals recognize the implication of SMI in terms of both quality and quantity to gain an understanding of the health care enterprise. For example, a chiropractic physician and chiropractic student should recognize the fact that patients, although presently in seeming isolation, are family members, and their reactions and behaviors demonstrate their family's influence on their level of understanding and their attitude about the meaning and purpose of health care.[14] The family, conversely, socializes the patient into a system of health care expectations that has been developed by the bureaucratic model. In the socialization process, other agencies, peer groups, and community pressure groups influence the patients view concerning health and illness. As previously stated, health care as an institution, therefore, cannot be fully understood unless it is examined in itself as well as in relation to other institutions such as the family, social welfare, government, education, religion, and other organizational structures in the society.

Every social institution has some sort of structure or framework that helps to put concepts or purposes of the institution into the world of action so that it can serve the interest of society and the members who compose it. The family as a social institution has its framework or structure within which it can carry out the purposes for which it exists. Most individuals are members of 2

families during their lives. The first is the family of origin (orientation) in which our earliest experiences take place. The second is the family of marriage (or procreation) in which we may enact the role of parent. It is within the network of familial relationships that we develop our attitudes and values toward health and illness. Attitudes are tendencies to feel and act in certain ways. Values, on the other hand, are measures of desirability.

The family is the most universal of all human institutions. It varies widely in structure from the consanguineal type (ie, extended kin groups that include a wide variety of related persons) to conjugal families consisting simply of an adult pair (male and female) and their children. The conjugal family acts as a source of "refuge" in mass society—a place where the individual may engage in genuinely personal relationships in a world that is largely impersonal.

In the past, many authors have given us a description of different types of families. Sorokin, for example, presents 3 types: the compulsive, the contractual, and the familistic. In the compulsive family, the bond holding members together is not love but force; and the relationship is based on exploitation, cruelty, and deprivation. The contractual type brings profit and advancement to the participants but is devoid of love and hatred. The familistic type is based on mutual love between the spouses; and it is characterized by devotion, sacrifice, solidarity, sharing, permanence, and stability. Sorokin feels that the 3 types of families have been present regardless of one's society but have changed in proportion with time. The contractual family, however, is the largest one in today's Western world.[15]

The type of family a person comes from can help us understand the behaviors of the patient and members of the family toward the sick person. For example, in severe coronary cases, increasing demands are made on the family to adjust their customary routines to the patient's needs. One can expect, therefore, that if the family type was close (familistic) in which each member was concerned about the others before the illness, then there could be a greater willingness for members of the family to adjust their roles to help the sick person. On the contrary, if the family type was contractual and/or compulsive, then the family members would be less willing to make the sacrifices to aid the sick individual.

Structure within the institution of the family plays an essential role in the way stress is handled during a sudden crisis. The outcome of such a crisis will depend upon the type of familial relationship before the episode. For example, stress within a family may lead to infectious illness. Research done at the Family Medicine Unit at Harvard Medical School have demonstrated rather clearly that:

> Common crises such as death of grandparents, change of residence, a loss of a father's job, and a child's being subjected to unusual pressure, occur four times more frequently in the two week period prior to the appearance of streptococcal infection than in the 2 weeks afterward.[16]

The same studies have shown that:

> Age, intimacy of contact, and family organization influenced the susceptibility to streptococcal infection. Children of school age were most susceptible, and a spread of infection to other family members sharing the same bedroom was likely. Chronic family disorganization also was correlated with susceptibility to infection.[16]

Additional research demonstrates that "streptococcal and staphylococcal infections are family disorders, and successful management responses requires consideration of the family group."[17]

Another kind of crisis in which the type of family plays an important role is the biological inheritance factor. If one learns that he or she is a cause of disease that affects children, or learns that he or she is a recipient of a disease of a familiar nature, this knowledge can bring about complicated emotional problems in family interaction. For example, the birth of a deformed infant may be accompanied by a guilt reaction on the part of both parents. One can speculate about the emotional disturbances of the family in the specific case of muscular dystrophy that is carried by the female and attacks the male. The need of a parent to deny knowledge about such discomforting facts is understandable; however, there is a tendency for the parent to believe that the facts must be disproved and to continually seek out advice to get different answers. At this stage of the crisis, there is a great need to see the family as a unit of treatment. Whether or not the family is viewed as such will depend partially upon the type of familial relationships before the episode.

Another important role of the family is the patient-physician relationship concerning the care at the end of life. Although many health care professionals are often uncomfortable discussing death and dying with their patients and families and feel that such discussion would be too difficult emotionally and thus ineffective for the patient and family, a recent study has shown that the reverse is true. Almost 90% of caregivers (ie, the

family) feel that such collaboration was not stressful, whereas 20% found it beneficial.[18] The burden of caregiving on the family is often substantial. Family members who are themselves elderly, ill, and disabled often perform caregiving. It can be the equivalent of a full-time job for 20% of caregivers and result in further financial burden. The average annual costs for caregiving in the United States can range from $3 billion to $6 billion.[19]

These stressors often lead families to seek long-term care (LTC) placement. Several patient and caregiver characteristics are predictors of future placement. Caregivers who are older (>65 years of age) and who feel a greater sense of burden are more likely to have their loved one in an LTC facility.[20] Although many caregivers experience symptoms of anxiety and depression (15%-20%) before placement in an LTC facility, these symptoms did not change after placement, which is particularly true for spouses.[21] Two recent studies found that caregivers often experience a sense of relief after the passing of a loved one when it was preceded by ongoing suffering and significant burden to the caregiver.[22,23] One study suggests that, in addition to the known risk of psychiatric morbidity of caregiving, there is a 60% higher risk of caregiver's death when compared with noncaregiver's controls.[24] In recognizing the burden of caregiving, Rabow et al recently proposed 5 areas of opportunities for caregivers to be of service to the family. These are (*a*) promote communication, (*b*) promote advanced care planning and decision making, (*c*) support home care, (*d*) demonstrate empathy for patients and their family, and (*e*) participate in family grief and bereavement. In providing compassion and empathy, caregivers have much to offer to patients and their families.

Select attributes and concepts of bureaucracy in the health care institution

Health care, an institution within American society, is like other institutions whereby structural subsystems and functional components are intertwined (Fig 3). Using a medical industrial complex, for example, one could identify certain organizational and functional goals such as education, research, and health care services. The organizational structure and functional components of the medical industrial bureaucracy are composed of a hierarchy of offices and positions.[25] The board of trustees is the chief policy-making group within the medical industrial complex. It is made up partially of community representatives who safeguard the interests of the community within the organization. The administration translates the policies of the board into practice. Every department and service within the medical industrial complex have a hierarchy. Within the hierarchy, the title and office that one holds confer status upon one, which varies depending upon the position in the organization.[25]

From the functional perspective, a professional person in a health care organization is exposed to the laws of authority, professional and bureaucratic; both are essential for the functioning of the intricate health care enterprise. Professional authority rightly has the freedom to act on the basis of professional skill and judgment on behalf of the individual patient in the particular situation regardless of bureaucratic rules.[26] Skipper and Mumford[8] asserted that "the professional person derives his or her basic authority from outside the bureaucracy." For example, the health care professionals come to work in a hospital (or a clinic) with their own professional license to practice.[8] On the other hand, the bureaucratic authority of the organization rightly demands regularity and conformity to regulations that make for dependability and predictability within the organizational network.[8] Thus, the medical staff usually defines the "line" in its activities, whereas the management authority is often restricted to matters of providing the means by which the doctor's orders may be successfully carried out.[27-30]

From the viewpoints of the functions of bureaucracy in the health care institution, it is important to note that Max Weber's approach is "essentially formal, outlining the blueprint character of bureaucracy—the rule of rules rather than of men, the role of hierarchy, specialization, and experience, the development of the office as a career."[31] The functions of bureaucracy (Fig 2) are also linked to 5 factors that are directly related to the positive outcomes in any health care organization. These variables are quality, availability, accessibility, affordability, and continuity.[32] In the functioning of the health care bureaucracy, the factors noted above may bring about sociopsychological pressures to the professionals within the organization. The acronym "SARA" (surprise-anxiety-rejection-acceptance) is most relevant in analyzing the functional changes of personality within the system. Thus, it may be hypothesized that the interaction between the various units in a health care bureaucratic system will either be associative, tending toward a mutual sharing of responsibility, power, and authority, or disassociative, tending toward the tension and conflict situations (Fig 2).

If one takes the variable of power into consideration, certain associative and dissassociative patterns are

possible. One of the significant patterns today is the relationship between and among health care professionals. As the recipients of the chiropractic physician's orders for his or her patterns, the nurse is obligated to carry out these orders in a professional competent manner; but at the same time, he or she is a hired employee of the hospital, clinic, or doctor's office and consequently subject to all the rules and regulations of the administrative organization.[33,*] Corwin[34] has indicated that "the tension is severest between professionally oriented employees and employee-oriented administrators." Furthermore, the demands of patient care, especially those of an emergency nature, cannot be accomplished within the framework of administrative rules. Thus, the nurse can be in a conflict situation between the expectations of the chiropractic physician that his or her orders be carried out and the expectations of the administration that administrative procedures will be complied with.[16,17,35] The dysfunctions of bureaucracy were pointed out by men like Veblen, Dewey, and Warnotte who documented concepts of "trained incapacity," "occupational psychosis," and "professional deformation" respectively.[26,36]

Veblen's "trained incapacity" refers to that condition in which one's abilities function as inadequacies or blind spots, preventing one from adjusting correctly to the changed situation. Thus, skills and training that have been successfully applied in the past may under changed conditions result in inappropriate responses.[35] Dewey's concept of "occupational psychosis" is founded upon some observations from the humdrum activities of life in which people develop certain preferences, antipathies, discriminations, and points of interest. By psychosis, Dewey means "a profound character of the mind." These psychoses originate from demands put upon the individual by the organizing of his occupation role.[35] However, there are forces at work that tend to lessen the severity of the potential problems resulting from the social structure of a medical industrial complex. Coe asserts that:

> One of these is the ideology of service, an historical legacy of the Middle Ages, expressed in modern terms as commitment to a job. A second force is the development of informal groups within the formal organization which permit certain activities to be accomplished regardless of the potential blocks of the social structure.[25]

Insofar as the chiropractic physician and nurse are concerned, the relationship shifts from time to time and from place to place. It varies according to the generation each belongs to, to the size of the community and the hospital setting, and to the field of specialization in nursing and medicine.[37]

The Getzels-Guba model gives us further insight into the structural and functional aspects of organizational bureaucracy. The nomothetic or normative dimension of the model is composed of institutions, roles, and expectations. The idiographic or personal dimension of the model is characterized by the individual, personality, and need-disposition.[38] Social behavior is the result of the interactions between 2 sets of motives: the nomothetic/normative dimension and the idiographic/personal dimension. The Getzels-Guba model asserts that, within an institution, an individual has a purposeful role and is required to meet certain expectations as a member of the organization. Need-disposition and role expectation can be viewed as structural elements in patient/chiropractic physician rapport and in professional and ethical functions. If there is a lack of homeostasis between needs/structures and roles/functions within an organization, it may produce stress, strain, and anxiety that may negatively affect professional relationships and the continuity of health care.

According to W. Edwards Deming's[39] *Out of the Crisis*, principles such as efficiency and effectiveness need to be aligned so that the members of the health care organization take part in shared decision making. If a health care organization lacks these principles, it may lead to identity and role confusion at work (in a hospital or a clinic), creating additional stress and strain that may affect the proper functioning of the organization. The patient, who is the customer in the health care organization, can be affected positively or negatively if such issues within the health care organization remain unsolved.

If stress, strain, and anxiety are created from occupational relationships (and remain unresolved), this could result in what Gregory Bateson et al[40] refer to as the *double bind theory*. Given this theory, the recipient of double bind is given contradictory messages, causing confusion in self-concept that may lead to an element of uncertainty within the personality of the individual. For example, a medical organization may instill in their employees the importance of teamwork and shared decision making; but when employees actually voices their concern, they are greeted with resistance and disapproval. This element of uncertainty along with identity and role confusion

* For a study of conflict between professional and bureaucratic roles of the nurse with respect to dying patients, see Glaser B, Strauss A. Awareness of dying. Chicago: Aldine; 1965.

can lead to what Emile Durkheim[41] called *anomie* (commonly known as a *lack of norms*). This type of behavior within a medical industrial organization can increase the level of stress and strain, leading to neurosis; and if it remains untreated, it can result in psychosis that affects the functioning within the organizational system.[42]

Conclusion

This discussion examined some select concepts of bureaucratic structures and functions so that chiropractic physicians and other health care professionals can use them accordingly. We have focused upon the relationships of SCP and SMI upon the structural and functional aspects of bureaucracy in the health care institution of a society. It is hoped that present and future chiropractic physicians and other health care professionals will internalize and make use of these select concepts and theories in their future roles as health care givers (Figs 1 and 2).

Implicit in our analysis of the health care bureaucratic structures and functions in a society is the focus that future chiropractic and other health care professionals integrate, synthesize, and actualize values and virtues such as empathy, integrity, excellence, diversity, compassion, caring, and understanding with a deep commitment to self-reflection so that they can deliver care that involves the ingredients of quality, affordability, availability, accessibility, and continuity for their patients. If these values are taught constructively in any health care bureaucracy, then future health care professionals will be able to transmit the traditions of excellence, dedication, and creativity within the health care profession.

On balance, it is asserted that chiropractic physicians recognize the implications of the structures and functions of the health care bureaucracy for the prognosis, treatment, and diagnosis of a patient especially because a bureaucracy is a phenomenon of every highly urbanized and industrialized society today. Indeed, it is an environment in which chiropractic physicians and other health care professionals are educated and trained, the organization in which the overwhelming majority will work through their lives.

As bureaucracy has tended to define and to regulate the important functions of all institutions within this society, health care has increasingly been transformed into a bureaucratic activity both structurally and functionally. Every health care organization of any considerable size has become bureaucratized to some degree. Stable patterns of behavior based on structured statuses, roles, and specialized tasks are linked to life or death issues. The explosive growth of scientific knowledge, the rapid increases in technology, and the impact of globalization produce ever more specialization to be incorporated and coordinated in the present health care structures and functions. Such a concern of care epitomizes the statement promulgated by Wilson Hoff, "we must recognize that the adequacy of health services depends as much upon the organization of health personnel and the combinations with other resources as is does upon their numbers alone."[43] Indeed, a concern for care further documented the diction noted by Prof Frances Weld Peabody of Harvard Medical School, namely, "the secret of the care of the patient is in the caring of the patient."[44]

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