1989

A study of variables affecting public relations power and roles in hospitals

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A study of variables affecting public relations power and roles in hospitals

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A STUDY OF VARIABLES AFFECTING PUBLIC RELATIONS
POWER AND ROLES IN HOSPITALS

A Thesis

Presented To

The Faculty of the Department of Journalism and
Mass Communications
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science

By

Holly Fletcher

December, 1989

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ABSTRACT

A STUDY OF VARIABLES AFFECTING PUBLIC RELATIONS POWER AND ROLES IN HOSPITALS

by Holly Fletcher

This thesis addresses the topic of public relations use by hospitals and particularly looks at which variables directly impact the amount of power and decision-making responsibility practitioners wield in their healthcare workplaces. Based on previous organizational research that did not address hospitals specifically, the study hypothesizes that differences in size and technological sophistication directly impact the public relations practitioner's role. In addition, it hypothesizes that other variables, notably marketplace competition, will also have an impact. Further, the study attempts to provide a baseline for future research into the growing, though relatively unexplored, area of healthcare public relations.

The data, obtained through a questionnaire, did not support the hypotheses relating size and complexity to public relations roles, but a positive correlation was found between the supportive attitude of top management toward public relations and the success of a hospital within its own marketplace to a high-level of public relations power.

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CHAPTER I

INTRODUCTION

Historical View of Public Relations Practice and Research

Public relations, largely a product of this century, appears to have come of age in the 1980s. By 1984, 100,000 individuals made their living in public relations (J. Grunig & Hunt), with that figure increasing throughout the decade. Additionally, many communication managers are reaching higher and higher rungs on the corporate ladder and earning salaries to match (Strenski, 1984), while industries and agencies that never before considered using public relations techniques are now hiring communication specialists (Kurtz, 1980).

The growing emphasis on, and power of, public relations has touched organizations of all types. It has not been ignored by executives in the \$400 billion a year healthcare industry, although it is unclear if this increase in emphasis is a response to the growing prestige and credibility of public relations practitioners or is simply a desperate response to the growing uncertainty of the healthcare arena.

This growing uncertainty in healthcare is following decades of relative stability, where hospital systems were easily profitable and revered by an accepting consumer.

Now, they are facing an uncertain, often hostile, environment fueled by Medicare funding shortfalls, spiraling costs, abrupt changes in funding systems, increased competition, rapid advances in technology, and an informed and demanding client base. These factors have forced hospital managers to alter the way they do business, including, perhaps, the importance they place on public relations (Elder, 1976; Hauser, 1983; Hicks, 1986). Just as hospitals may no longer ignore market pressures or financial reality, so they also are no longer able to rely solely on the gentle art of "ladies guild" public relations, where volunteers were walking ambassadors of good will and the media rarely called a physician for a comment, never mind grilling the chief executive officer.

Statement of the Problem

The growth and diversification in public relations has spurred interest among researchers as to why organizations use public relations in such vastly different ways, and why the roles of public relations practitioners vary so widely. One of the recognized leaders in this area of research, Schneider (also known as L. Grunig in later citations), has attempted to analyze how public relations practitioners are used by dividing organizations into four structural types. Based on her 1985 study of these four organizational types, she asserts that the size and complexity of organizations

are critical variables in determining the amount of power and decision-making input public relations practitioners can exercise. Her study also offered the possibility that marketplace pressures, such as competition, may be an additional influencing factor on public relations functioning in organizations.

Particularly important were Schneider's findings that two of her four organizational types, defined as organic and mixed, differed widely in their treatment of public relations practitioners. To draw on a definition laid out by J. Grunig and Hunt (1985), Schneider found that organic organizations, characterized as being small but having skilled employees, were more likely to relegate public relations practitioners to a technician role. Conversely, she found that mixed organizations, defined as being large, complex, and technologically sophisticated, tended to elevate practitioners to a communication manager category.

Although researchers such as Schneider have struggled repeatedly to develop a useful model for public relations' use, few of the organizational studies previously conducted included healthcare facilities, and virtually none has focused exclusively on the variables that impact public relations use and power in hospitals. The findings in the organizational research done by Schneider, however, can be generalized to hospital organizations, particularly since

the fundamental key to Schneider's differentiation of organizations was size and sophistication, variables that are as easily applied to hospitals as to corporations.

Therefore, it could be argued that small, unsophisticated hospitals would reflect the public relations uses found in the organic organization; while large, sophisticated hospitals may mirror the mixed organizational type. More specifically, the smaller hospitals could be expected to grant comparatively less power to the public relations staff, and to give them duties more in line with J. Grunig and Hunt's public relations technician. It could be anticipated that few powerful communication managers would be found in this type of healthcare facility. By comparison, it could be expected that the larger, more complex hospitals would tend to have high-level communication managers in charge of their public relations operations while also employing practitioners in the technician and liaison roles as well. These differences in the power and duties of public relations practitioners may also be found in hospitals that have comparatively limited or extensive technological sophistication, or which are in highly competitive or noncompetitive market environments.

Schneider's definitions of organizational type were the most clear, and the most easily quantifiable of the many organizational definitions suggested by communications

researchers. Other definitions, such as J. Grunig's problem-solving and fatalistic categories, and, later, Ryan's analysis of participative and authoritative organizational types, rely heavily on subjective views of organizational "personalities." The relatively homogeneous sample of this study, that is, hospitals, somewhat restricts the use of "corporate personality" as a variable. Schneider's use of size and complexity as specific variables, and her use of public relations duties that relate strongly to J. Grunig and Hunt's definitions, make her work most appropriate as the foundation for this study of hospital public relations use.

Using Schneider's models of organizational types and J. Grunig and Hunt's models of public relations uses, four hypotheses have been posed.

Hypothesis 1. Larger hospitals, measured by the number of operating beds, will mirror Schneider's mixed organizational structure and will have more powerful public relations practitioners than smaller hospitals, which will have a structure more parallel with the organic organizations.

Hypothesis 2. Complex hospitals, based on a level of technological equipment and clinical sophistication, will mirror Schneider's mixed organizational structure and will have more powerful public relations staff than less complex

hospitals, which will be more in line with the public relations use found in organic organizations.

Hypothesis 3. Marketplace factors such as competitive environment will have an impact on the level of public relations power in hospital organizations.

Hypothesis 4. Other variables will account for the variety of roles and impact exercised by public relations practitioners operating in different hospital facilities, including demographic variables such as the age of practitioners and variables of "corporate personality," such as the attitude of top management toward public relations.

This study, while exploratory and descriptive in nature, sheds light on how public relations is developed and managed specifically within hospital organizations. Further, the study tests the viability of J. Grunig and Hunt's public relations roles in the hospital environment, and tests the viability of Schneider's findings that quantifiable organizational variables have a significant impact on public relations functioning. Lastly, the study is a baseline for future research on the growth of public relations as a communications profession both generally and within the healthcare arena.

CHAPTER II

SURVEY OF SELECTED LITERATURE

Organizational Models and Theories

Definitions of public relations have changed through the years. In 1975, public relations researcher J. Grunig defined organizational communication as "behavior through which individuals and organizations disseminate (give or publicize) information or acquire (seek or listen to) information" (p. 13). He also defined information, writing:

(It is) any piece of a picture of reality that a person or organization gives to or gets from another person or organization. The role of the public relations person, then, is to facilitate communication between organization and public so that they better understand each other's picture of reality (p. 13).

Later, in his geneology of the field, Harlow (1977), writes that public relations was born in the early 1900s to defend businesses against muckraking journalists and interfering politicians. From there, definitions of public relations fluctuated. By the 1940s, most agreed public relations practitioners' primary functions were to help management stay informed and to influence opinion, and to plan and engage in activities that brought goodwill to the organization. By 1947, when the Public Relations Society of America was formed, the emphasis was on promoting and maintaining high standards of public service. By the late 1960s, public relations practitioners were seen as fostering

company prestige, helping preserve corporate tradition and using creativity to solve problems. Harlow ended his geneology with a modern, lofty new definition:

Public relations is a philosophy and policy-influencing adjunct to the management process; a function of reconciliation; a catalytic agent; an ongoing preventive; an active initiator of policy (p. 62).

This latter definition, though supported and cheered by many practitioners, has proven to be perhaps more of an ideal than a universal description. Additionally, it has proved difficult for researchers to quantify. Possibly even more elusive has been an explanation of why application of this new definition is found in some organizations and not in others. Researchers have only met with limited success in agreeing on what impacts public relations power and roles and which models most accurately describe organizational communication goals and/or their practitioners. J. Grunig (1975) writes: "Organizational communication is much like the oasis in the middle of the desert through which many travelers pass, but in which few linger long enough to meet one another" (p. 99).

Although some researchers look at the practitioners themselves, more attention has been directed at defining public relations uses through the characteristics of the organization in which they work. In 1976, J. Grunig undertook an elaborate study in an attempt to use a "general systems approach in an effort to expand a theory of

communication behavior . . . to explain the communication behavior of individuals and publics" (p. 3). He was particularly interested in how communication flows within an organization and the constraints an organization puts on the public relations staff's effort to communicate. He also attempted to measure practitioners' professionalism, and looked at organizations grouped more by their organizational behavior and what can be described as a organizational work ethic, than by Schneider's more easily quantifiable factors of simple size and sophistication. J. Grunig divided organizations into either problem-solving or fatalistic categories. He defined the former as organizations having high levels of complexity, less centralization, and an emphasis on employee efficiency and compliance rather than coercion. He defined the latter category as organizations focusing on programmed behavior, code rigidity, and the importance of tradition. The fatalistic organizations also were highly impacted by such constraints as routine technology, a stagnant level of knowledge, and a great deal of competition.

In this study, of 216 organizations ranging in size and complexity from "a Chamber of Commerce to some of the largest corporations in the nation" (p. 35), J. Grunig found "a clear relationship between the behavioral type of an organization, the professionalism of its public relations

practitioners and the types of communication procedures it utilizes" (p. 49). He found that organizations utilizing problem-facing behavior employed larger public relations staffs and granted more power to their public relations personnel. However, J. Grunig also found that as these organizations became older, larger, and more formalized, they tended to institutionalize the public relations function as one that gave information about decisions, but did not help reach those decisions.

The fatalistic organizations, J. Grunig found, used their public relations staff primarily to react to the mass media in time of crisis and to maintain interpersonal contacts needed for the organizations' survival. He advised public relations practitioners in the job market to seek out problem-solving organizations by asking questions about centralization, mobility, and programmed behavior. He advocated avoidance of fatalistic organizations, which he said "cannot truly be said to be engaging in public relations" (p. 50).

J. Grunig and Hunt (1984) later categorized public relations use by the type and flow of communication. They divided public relations into four models: press agency/publicity, public information, two-way asymmetric, and two-way symmetric. In the press agency/publicity model, communication is one-way, from the business to the

public, with truth a nonessential component. This model, practiced by 15% of public relations personnel, is found most frequently in sports and theater. In the public information model, information also flows two ways, but truth is considered important. This model, most often found in government and non-profit agencies, includes 50% of public relations practitioners. Two-way asymmetric communication is a more modern form of public relations. Its purpose is scientific persuasion with feedback from the public making the communication flow two ways. Used in competitive business and public relations agencies, this model makes up 20% of the public relations field. The two-way symmetric model is the newest model for public relations, and is the only one that allows public relations practitioners into the decision-making process. This model, practiced by 15% of practitioners, focuses on mutual understanding and mediation with changes made both in the attitude of the public and in the actions of top management.

Later, J. Grunig and Hunt (1984) divided public relations use into categories not by the action of the organization or the flow of communication, but by the duties of the practitioner. Using this method, they developed two categories: communication technician and communication manager. The former is an individual who uses writing, editing, audiovisual skills, and graphic skills to send a

message, but does not make the organizational decisions behind the message. The communication managers, meanwhile, systematically plan and manage the public relations programs and are involved in all segments of public relations decision making. J. Grunig and Hunt believe these managers frequently fill one or more subroles: the expert prescriber, who takes responsibility for implementing programs; the communication facilitator, who serves as a go-between to keep information flowing between the organization and its "publics"; and the problem-solving process facilitators, who work across organizational lines to solve the public relations problems of organizational subsystems. J. Grunig and Hunt also expressed support for the middle-level liaison roles proposed by Dozier, which are defined as media relations and communication liaison roles. In these roles, practitioners are involved in two-way communication between the media and other external publics, but are not solely responsible for the message content.

Although these categories could be considered parallel to more traditional organizational titles usually associated with various degree of power, that is, a vice president would be a communication manager, J. Grunig and Hunt looked at duties rather than titles; they drew no parallels with traditional public relations hierarchies. Nevertheless, these categories are the clearest and most easily

quantifiable way to define public relations roles and power, and, therefore, were adapted for use in this study.

In a similar but somewhat less precise model, Acharya (1985) also analyzed the function of public relations practitioners and proposed five professional roles ranging from a mere communication technician to the top-of-the-line public relations professional. In his model, a public relations practitioner described as an expert prescriber is responsible for diagnosing public relations problems and prescribing solutions. A second, though similar role, is that of problem-solving process facilitator, which features a public relations practitioner who confronts, identifies, and then solves problems throughout the organization. A communication facilitator is essentially a spokesperson's role, with the public relations practitioner having liaison duties and responsibility for mediating information between the organization and the public, but having no real decision-making opportunity. The communication technician, like the similar role set out by J. Grunig and Hunt, also has no decision-making role, and serves merely to use skills such as writing or photography to carry out the public relations program. Acharya's last role is that of acceptant legitimizer, also called, without need for further description, the yes-man role.

Like the earlier J. Grunig study, Schneider (1985) attempted to evaluate public relations power and roles by examining the environment in which practitioners operate. She set out four definitions determined by an organization's structure: traditional or craft, mechanical, organic, and mixed mechanical/organic. The traditional or craft organizations are small-scale operations with few employees and a low knowledge base. Mechanical organizations are usually large scale with many employees, but with low complexity and a limited knowledge base. Organic organizations are small in scale though complex, with skilled professionals as employees. Mixed mechanical/organic organizations are large-scale and highly complex, with many employees and shifting competitors.

In her study, Schneider examined data from an earlier J. Grunig study, which involved 216 organizations of all kinds, to find out how each of these four organizational types used public relations. She found that public relations practitioners in traditional organizations had little power, indeed the least power and authority of the four types, and public relations was most often a staff function. Organic organizations also relegated little power to the public relations department, which was typically fairly small. Mechanical and mixed organizations, the two organizational types with the largest size, granted the most

power to their public relations departments. In mixed organizations, public relations was more apt to be part of top management and given power and authority. This type of organization put more emphasis on public relations than any of the other three. In mixed organizations, the public relations professional spent the most time counseling management, writing speeches, or holding press conferences and the least amount of time writing press releases. These findings suggest that as organizations grow in size and complexity so does the public relations function grow in status. Schneider believed this may occur because larger organizations are operating in more complex environments and therefore are more in need of the support of public relations to succeed.

L. Grunig, referred to as Schneider in previous citations, looked again at organizational public relations use in 1987. This time, she studied how public relations practitioners in the four organizational types communicated with their external constituencies. Her study of 48 organizations located in Washington D.C. found that mechanical organizations were autonomous from their stockholders, suppliers, unions, and competitors, but were significantly constrained by government. The public relations practitioners in these organizations, however, failed to devote sufficient attention to this area in order

to overcome these constraints. She also found that public relations practitioners in organic organizations were not sufficiently knowledgeable about the needs of their publics. Once again, the mixed organization's public relations practitioner seemed to meet the challenge the best, reporting cooperative relationships with narrowly defined target audiences, unions, competitors, and journalists.

Ryan (1987) looked at public relations roles by organizational type in a way reminiscent of J. Grunig's problem-solving and fatalistic organizational definitions. Ryan divided organizations into participative or authoritative types and focused on the organizational constraints on practitioners rather than on their specific functions. Authoritative organizations were characterized by extreme controls on employees, an atmosphere of listening to then ignoring opinions of workers, and a top management that sought worker input but had little confidence in its soundness. Participative organizations, by contrast, encouraged workers to participate fully in setting goals and making decisions and relied on worker feedback to operate the organization.

Like the earlier J. Grunig categories, Ryan's definitions rely heavily on a subjective view of organizational personality, rather than Schneider's more objective criteria, such as size. Ryan, who sampled 240

public relations practitioners, divided them into the two categories based on how they responded to five attitude statements. He found that practitioners who worked in participative environments viewed themselves as less constrained than did their counterparts in authoritative organizations. Based on the results of his study, Ryan suggested that practitioners in authoritative organizations should educate management about the advantages of involving public relations practitioners in the highest level of the organization's decision-making hierarchy and to remove from them constraints on their freedom to act professionally. Ryan also said practitioners should work to change attitudes, writing:

(Practitioners must) change the common management views that public relations persons should tell the public what management wants the public to know, rather than what the public needs to know, and that practitioners are mere advocates for management, rather than representatives of various publics to management . . . (p. 855).

In 1988, J. Grunig and L. Grunig said that none of the variables previously offered by researchers truly explained the public relations behavior of organizations. They said previous research data seemed to indicate that organizations rarely practiced the type of public relations that was best suited for their specific environment. They even suggested that the reason for public relations use may be that organizations simply practice it in a historical way: They

do it the way they have always done it. They argue that organizations should practice strategic communication, developing programs to communicate with the internal and external publics that are the greatest threat to the organization's goals or opportunities.

Public Relations Studies

In addition to numerous public relations theories and models, a number of quantitative studies of the field have been conducted to determine the status, job responsibility, and reporting hierarchy of public relations practitioners in their organizations. Many of the studies have looked, at least in part, at practitioners' ability, perceived or real, to participate in the organizational decision-making process.

Broom and Dozier conducted two studies, in 1979 and 1985, which showed that public relations practitioners are reportedly doing more activities within the communication manager role and fewer activities that would be considered as falling in the lower-level technician role. In addition, more practitioners reported performing activities that fell within the expert prescriber, communication facilitator, and problem-solving facilitator roles, with the most dramatic increase in the latter. In 1979, 71% of the practitioners polled were predominantly performing a public relations manager role. In 1985, 81% of those polled were in such a

role. During the same time, those confined to relatively powerless public relations technician roles dropped from 29% to 19%, although there was no indication the incidence of the products of a public relations technician, such as written publications, had also decreased. Importantly, Broom and Dozier's studies show that J. Grunig and Hunt's categories can be realistically applied to survey data and used to help monitor the realities of public relations use.

Another survey, by Lindenmann and Lapetina (1981), appeared to show that public relations practitioners were placed high in the organizational hierarchy. They found that public relations employees reported to the CEO, president, or chairman of small companies, and to the vice president of marketing, communications, or special projects in medium to large-sized companies. In their study of 74 senior executives, Lindenmann and Lapetina found that top managers regarded public relations as an integral part of corporate planning. They noted one of the top five job characteristics of public relations practitioners, as stated by the survey respondents, was helping top management develop and execute a constructive response to important issues affecting the organization, one of the key definitions for J. Grunig and Hunt's communication manager role.

In Strenski's survey of public relations executives in the nation's leading companies (1984), 64% of respondents said their top management is demonstrating an increased respect for the public relations function. Indeed, one-third had direct input to top management, with 14% of respondents holding the title of vice president and 17% reporting directly to the chairman and CEO. The remainder of those polled reported to a vice president with top management responsibilities. A survey of Public Relations Society of America members (Ryan & Martinson, 1985) does not directly address the public relations decision-making role in organizations, but it does address the way public relations practitioners view the role of public relations in management. For example, 96% of those surveyed disagree that public interest for a public relations person is what management says it is, demonstrating autonomy from the top administration. Furthermore, 99% of respondents said that if they believed management policies were not in the best interest of the public they should work with management to change the policies. This autonomy can be taken as a signal that practitioners are seeking and exercising additional power, according to Ryan and Martinson, who wrote:

Practitioners typically are not satisfied with acting as management representatives (or as mere technicians), implementing policies decided by others. They want to be involved in the making of those decisions . . . (p. 199).

In another study of Public Relations Society of America members, Sullivan, Dozier, and Hellweg (1985), looked at the aspirations of practitioners within a role hierarchy of communication manager, communication liaison, media relations specialist, and communication technician. The researchers found that practitioners do perceive a career ladder of ideal roles within public relations staffs. The practitioners indicated they preferred to perform duties normally associated with the higher level organizational roles. This hierarchy of roles can be, at least in part, attributed to the role-sending message that practitioners received from management, with some roles being more highly rewarded than others.

A recent survey of the 328 public relations practitioners in the United States and Canada (Pollock & Winkleman, 1987), found 54% of respondents reporting directly to corporate management or the board of directors. Ryan (1987) found that public relations practitioners believed they were able to speak out against proposals because they were adequately protected from reprisals. The respondents also did not agree that public relations practitioners were given inadequate opportunities to argue against policies perceived to be damaging to the organization. In addition, they indicated that management does not insist that all important communication to the

public be approved in advance. These findings relate positively with J. Grunig and Hunt's communication manager roles, and again show that these roles can be at least partially quantified.

Anecdotal evidence also suggests an increased corporate status for public relations. Steinberg (1976) said it is a waste of valuable resources to utilize public relations practitioners only to implement policy and as a simple conduit for publicity. He said public relations practitioners can collect and analyze information for both internal and external publics, and he believes that all facets of the organizational structure have public relations overtones. Ehling (1975), in an examination of the behavior of public relations practitioners, also agreed that public relations issues permeate organizations. He wrote:

. . . (I)n theory and practice the public relations manager is placed in the center of debates over issues, or is made a part of controversies (or impending controversies) involving his organization. In short, he is by virtue of his position in management and his role in an organization considered a party to . . . any and all conflicts involving his institution (p.15).

Close (1980) said that public relations is a function of management and must make a contribution to an organization's objectives and long-term prosperity. Close encouraged public relations practitioners to use their broader perspective to identify the issues of greatest importance to the organization, then recommend to management

what should be done. Lilly (1983) said the public relations director helps the CEO set policy and calls their relationship an important partnership. He wrote:

Public relations in at least some corporations, has undergone a major evolution. No longer are practitioners merely technical wordsmiths, editing the jargon supplied by management. . . . Instead (they) have become integral cogs in the management machinery (p. 14).

Howard (1985) said a growing number of CEOs are giving public relations practitioners status comparable to the legal and financial staffs, and that they are functioning as early warning signals for trends and change. Howard also said public relations has evolved because practitioners responding to a media inquiry are now not merely supplying management excuses, but asking themselves, "Why indeed?" Public relations practitioners have gone from "articulating organizational policy to actually framing it" (p. 22), she said. She added that all company problems are public relations issues in the broadest sense of the term. "Instead of . . . criticizing the media for inaccurate reporting, you should help . . . address the policies and practices that prompt investigative reporting" (p.23), she said. Additionally, Howard believed public relations people can take random sequences of events and help translate them into a coherent agenda for management, and can assure that those making decisions in the organization have access to public opinion and attitudes. Ryan said an increasing

number of practitioners directly participate in corporate decision making (1987).

However, although Ryan generally believed public relations practitioners were becoming more independent and powerful, he pointed out (1987) that some practitioners were denied access to management by not being invited to meetings where major decisions were made, or by not being given adequate opportunities to argue against pending policy decisions. Some were not free to voice objections because they were not adequately protected from possible reprisal, and he said management can further disrupt the public relations function by reducing its access to information or by not granting practitioners necessary authority. He believed these constraints may lead some public relations practitioners to act inappropriately. He wrote, "(P)ractitioners sometimes work for organizations that encourage or mandate, through systems of internal constraints, actions that are irresponsible or ineffective" (p. 473). Bitter (1986) said that too many top managers have little grasp of what public relations is and what its role is within the organization. He said the craft "holds a low place in the corporate pecking order" (p. 13). Rogers (1982) said that while many public relations practitioners were involved in corporate policy making, some still

remained relegated to a cubbyhole pumping out press releases.

The healthcare environment

As mentioned earlier, hospitals are suffering from an unprecedented decline in public support. The public is feeling increasingly negative against hospitals, and exhibiting growing concern over such issues as malpractice and healthcare costs. In addition, the amount of negative media scrutiny received by hospitals is on the rise, and there is a general air of suspicion and distrust on the part of consumers (Elder, 1976; Friedman, 1985). These challenges are making public relations an important tool for hospitals. Indeed, by the early part of the decade, there had been a 30% increase in the number of hospital-based public relations departments (Hauser, 1983). Now, even small hospitals with less than 100 beds commonly have a public relations person, he said.

These changes have boosted hospital public relations opportunities. In one nationwide public relations employment newsletter, 30% of the jobs offered were in healthcare (Hauser, 1983). Even a popular daytime soap opera features a public relations character (Kurtz, 1980). J. Grunig and L. Grunig (1988) quote a 1985 unpublished study by Fabiszak that says "as competition increased in the health-care industry, hospitals . . . moved from informal

public relations activities to organized public relations and marketing programs" (p. 116). In 1972, only about 30% of hospitals had formal public relations programs. However, only 54 hospitals of the 244 hospitals that returned questionnaires in Fabiszak's 1985 national sample lacked a public relations department.

Despite its growing importance, few quantitative studies of the role of public relations in hospitals appear to exist. One study, which looked at the impact of a hospital's image on patients, looked solely at the relationship between the patients and the care providers, although the study did show the importance of a hospital's public image -- presumably created by a variety of factors including public relations -- by linking it to a reduction in patient anxiety (Zeev, 1983). "Patient's belief in the quality of the hospital may further their confidence that the utmost will be done to promote recovery" (p. 943), Zeev wrote. J. Grunig (1978) researched one area of healthcare by conducting a study on hospitals and their publics. The study, however, only looked at the facilities in terms of their patients, which he divided into such categories as older white collar, low income, younger white collar, and blue collar. J. Grunig did not look at the effect a public relations program, or lack thereof, had on these individuals.

J. Grunig and L. Grunig (1988) refer to Fabiszak's unpublished 1985 study where 244 hospitals were studied to see into which four models of public relations the facilities belonged, that is, the press agency, public information, two-way asymmetrical, and two-way symmetrical models. The study found that both two-way asymmetrical and symmetrical models showed a growing sophistication toward public relations use. The study also found a negative correlation between the frequency of marketing activities in the hospitals studied and the press agency and the public information model. These results indicated that an increase in sophistication may occur because of the increased attention to marketing in healthcare organizations. J. Grunig and L. Grunig, looking at public relations and marketing in healthcare organizations in a theoretical way. They determined that, like many other organizations, hospitals failed to practice public relations in an ideal fashion, that is, a strategic way, which emphasizes symmetrical communication and is based on research and management of conflict.

Although the quantitative studies are limited, there is a significant amount of anecdotal evidence that suggests the public relations practitioners in hospitals are mirroring their corporate counterparts and also gaining in power and status. Hicks (1986) said that healthcare public relations

is growing in professional status within its own field, noting that students are seeking internships in hospitals to prepare for public relations careers specifically in healthcare, and a children's hospital in New England is offering a six-figure salary to their new public relations person. "Healthcare public relations has come of age. Practitioners are commanding higher salaries, have more staff support and are reporting directly to the CEO" (p. 30), she wrote. As more evidence of progress, Perry (1983), said that some hospitals have changed their organizational structure in order to have public relations practitioners reporting directly to the CEO rather than to an assistant administrator.

Kurtz (1980) said public relations is following the path of the financial managers who have grown from mere bookkeepers to key members of the hospital management staff. He wrote:

(I)n more and more hospitals, the public relations director reports to the chief executive officer of the hospital, attends board of trustee's meetings and is a part of the management team. Tomorrow this will become the rule (p. 4).

Quane said (1973) the key to survival for hospital public relations is the word counsel. "They must participate in the decision-making process if they are to function as true professionals" (p. 20). He also warned that "departments

practicing the ladies auxiliary form of PR are of no help in dealing with community demonstrations" (p. 20).

CHAPTER III

METHODOLOGY

Subjects

The frame for this study was hospitals appearing on the membership lists for the Hospital Council of Northern California (HCNC) and the Society for Healthcare Public Relations and Marketing of Northern California (HPRM), as these two organizations combined make up the bulk of hospitals located in Northern California. The lists were combined, and duplicate listings and listings for healthcare organizations other than hospitals were eliminated.

HCNC, comprised of chief executive officers from approximately 120 hospitals from the Oregon border to Monterey County, has been in existence since 1962. It provides a regional forum for hospital CEOs to meet, communicate, and exchange information. It also serves as a forum for joint problem solving and policy making in the healthcare industry, and acts as a focal point for educational sessions. Virtually all of the hospitals in Northern California, approximately 80%, are members of HCNC. Those hospitals not registered as members appear simply to be disinterested in the organization and do not appear to be significantly different than member hospitals. HCNC members include hospitals ranging in bed size from less than

100 to more than 1,000. These hospitals may or may not have a defined public relations practitioner. HPRM has a membership of public relations and marketing professionals from approximately 120 hospitals and health-related agencies. The organization's goals include education, professional enhancement, and heightening the awareness of the public and top management of the role of public relations and marketing in healthcare. Hospitals that are members of HPRM may or may not also be members of HCNC.

The name of the highest ranking public relations professional, or the individual who had responsibility for public relations, was identified either through the membership list information or obtained by calling the facility. The initial mailing included 157 hospitals. Practitioners from 76 facilities completed and returned the surveys for a return rate of 48%. A second mailing was sent one month later to 95 individual hospitals. This second mailing consisted of 84 hospitals that were on the first mailing and 11 additional hospitals that were added to the HCNC membership in a newly issued updated membership listing. Two hospitals from the first list were eliminated from the second mailing list as they had recently merged with hospitals already included on the mailing list. The second mailing included 17 hospitals that had returned the survey but had failed to include the name of their hospital,

or had included it in such a way as to make it difficult to pinpoint the exact hospital. For example, some of the returned surveys included the name Kaiser Permanente Medical Center, but did not specify the city, making it impossible to positively track the respondents. In order to reduce the chance of practitioners sending in more than one survey, explicit instructions were included in the second mailing. In addition, since so many of the original responses were from unidentifiable Kaiser Permanente medical centers, they were not included in the second mailing to reduce the chance of more than one survey being returned from a facility. This decision reduced the second mailing by 12.

Twenty-five completed surveys from the second mailing of 95 were returned for a return rate of 26%; one hospital on the mailing list returned the survey but did not fill it out as the facility had not yet opened. In all, 166 surveys were mailed to appropriate facilities, with 101 useable surveys returned, for an overall return rate of 61%.

Data Collection/Analysis

In order to obtain the information necessary to answer the four hypotheses offered in the introduction, it was necessary to create a written questionnaire that would allow statistical calculation of relative power within the organization as compared to a variety of variables, as well as to facilitate grouping by J. Grunig and Hunt's public

relations definitions. The instrument was also designed to obtain descriptive information that may provide framework for future studies, and to obtain data on the general state of public relations in the healthcare marketplace. A copy of the original cover letter, written per instructions from the Human Subjects Committee of San Jose State University, is included in Appendix A. The questionnaire is included in Appendix B.

Thirteen statements were developed and put in a Likert scaling format allowing respondents five choices of response ranging from strongly agree to strongly disagree. The 13 statements were designed to test the amount of power public relations practitioners believed they had within the organization, concentrating on such areas as adequate funding, management support, and autonomy. The statements were developed using past literature as a guide for previously used quantifiers of power, including support of top management and problem-solving duties. Also used were statements included in a questionnaire posed by Ryan in a 1987 survey of public relations and organizational constraints. Ryan's survey, for example, attempted to quantify public relations power with questions relating to such areas as management's prior approval of communications and management support of practitioners arguing against proposed policies.

In order to study the impact of the major variables of bed size, technological sophistication and marketplace environment on the perceived power wielded by public relations practitioners in hospitals, a composite "power score" was calculated for each respondent based on their mean responses to the first 13 statements in the survey. The more positively a respondent felt about a statement, the lower the points they received. Point values ranged from 1 for strongly agree to 5 for strongly disagree. The lower the score a respondent received for each individual statement and the lower the overall power score they earned, the more power the public relations practitioners felt they had within their hospital organizations. The decision to assign the lowest points to the most powerful responses became, ultimately, problematic, as it is more typical that higher numbers represent the more desirable outcome.

The survey instrument also included a ranking of duties that approximately corresponded to duties likely to be found in J. Grunig and Hunt's three public relations roles: technician, liaison and manager. It was hypothesized that the top public relations practitioner at the larger, more complex hospitals would fall into J. Grunig and Hunt's manager role, while those practitioners at small, less sophisticated facilities would fall into the liaison or technician roles only. In addition, there were a

significant number of descriptive and demographic questions to provide overall information about the respondents and their hospital settings. Demographic questions, such as age and educational level, were phrased as open ended.

One close-ended question was used to determine the level of technological sophistication of the hospitals. Six determinants of sophistication were offered, with respondents checking off all that applied. These determinants, such as the availability of transplant surgery or a neonatal intensive care unit, were checked for validity with public relation practitioners, hospital administrators, and physicians to ensure they were adequate monitors of technological refinement. The entire survey instrument was subjected to a pilot-test by public relations practitioners from 10 hospitals in Southern California, which was outside the survey's sampling population but otherwise matched the population.

Data was analyzed using a variety of statistical methods including computation of means, t tests, chi-square, and regression. In several instances, data was collapsed to give it more meaning, as in the case of grouping hospitals into small or large categories according to their bed size, or considering hospitals sophisticated or unsophisticated depending on the presence or absence of a certain number of sophisticated clinical services.

Coding of data was straightforward, and no attempt was made to decipher data that was inconsistent with the survey's directions. In some instances, for example, respondents ranked more than one duty by the same number in the question asking for information on job responsibilities. These responses were not in accordance with the survey's intentions and could not appropriately be quantified. These responses were simply considered missing data. More explicit instructions and a prohibition from using one number for more than one duty may have prevented this problem.

Although the instructions specified that respondents should circle the number that best corresponded to their feelings about the 13 statements that made up the power score, some respondents circled two adjoining responses, indicating, for example, indecision between strongly agree and somewhat agree. In these instances, it was felt the answer was pulling away from the midpoint, considered to be the neither agree nor disagree response, and therefore was coded as if the answer farthest away from the midpoint had been solely selected. Therefore, when both neither agree nor disagree and somewhat disagree were both circled, the answer would be coded as if somewhat disagree had been the sole response. This was necessary in only a very few surveys. Although subject to criticism, it was done

consistently for answers pulling both positively and negatively from the midpoint and was done with no prior knowledge of the data results.

A number of limitations in the methodology must be noted. There was a vast diversity among the respondents. Because the hospitals ranged so widely in size, geographic distribution, and clinical mission, the individual most responsible for the public relations program varied from the hospital administrator to an executive secretary. In some instances, the additional duties of the respondents ranged from nursing to personnel. It also was extremely difficult, in many instances, to separate public relations and marketing duties. Some respondents included marketing and advertising responsibilities in their list of duties, and sometimes these responses were ranked quite high, indicating they spent more time on marketing responsibilities than those more usually considered public relations. In addition, although the 13 power score statements specifically applied to public relations, those respondents with large marketing responsibilities may not have differentiated their responses for public relations and marketing. For example, questions about top management, CEO and physician support was intended to determine support for public relations, but a respondent with marketing duties may have answered considering the overall support for their

function. Despite acknowledgement that there may be such overlap in the responses, no attempt was made to pull these respondents from the survey or to reject their responses.

In addition, although the survey strived to provide an accurate reflection of power, the results may suffer to some extent from the inflated responses of the practitioners, who may believe they have more power and decision-making input than, in fact, they do. With this in mind, the relatively strong power scores may not be an accurate reflection of the practitioners' organizational level. No attempt was made to verify the statements of the practitioners with others in their organizations, but such a follow-up study, perhaps with the CEOs of the hospitals, may prove to be an appropriate way to test the relative accuracy of the power score and the practitioners' perception of their own organizational strength.

CHAPTER IV

RESULTS

Descriptive Statistics

There is limited information available on the general state of hospital public relations in any locale, and virtually nothing has been done using Northern California specifically. The descriptive statistics available from this survey's data, therefore, presents one of the first pictures of public relations functioning in one of the most important geographic areas in the nation.

The survey's respondents worked in a wide variety of facilities ranging from quite small to some of the largest in the country. The hospitals also ran the gamut from sophisticated, urban facilities to very small rural sites. Some were part of fairly large hospital chains, such as Kaiser Permanente, while others were county or federal government institutions. According to the data in this survey, most practitioners come from relatively small to medium sized hospitals, with a mean bed size of 213, though sizes ranged from 30 to 1,200 beds. Thirty-four hospitals were quite small, having 100 beds or fewer; while 16 hospitals were quite large, having 400 or more beds. Almost half of the hospitals, 48 out of 101, had little or no high technology, with respondents marking none of the services

used in the survey as indicators of clinical sophistication; while 83 hospitals had limited technology, with respondents marking two or fewer services. Almost exactly half of the respondents, 53 out of 101, said they worked in hospitals that were in an extremely or very competitive market, while nearly as many, 46 of 101, said their facilities were doing extremely well or very well in their marketplace.

The respondents were mostly women, with 69 female practitioners and 30 males returning the survey. The age of respondents ranged from 25 to 64 years, with an average age of 39. The mean size of the hospitals' full-time public relations staff was 1.7, with the range from 12 to 0. The latter response was recorded for some hospitals where the individual responsible for public relations apparently did not consider it a primary or full-time duty. It was included as an answer and not considered missing data in the analysis. The majority of respondents, 54%, considered themselves to be in a staff position within their organizational hierarchy and therefore to have limited supervisory responsibility, while 28% said they were a line function, indicating they had other departments reporting to them. The remainder did not know or did not answer. The respondents' mean salary was \$41,556 per year, and the median annual salary was \$48,000. Respondents reported a salary low of \$16,000 per year and a high of

\$80,000. Perhaps because the survey also asked for practitioners' names, 22% of respondents failed to answer the question on salary, while others provided a range that was not used in calculations. The respondents' number of years in public relations ranged from 1 to 30, with 9 years the mean amount of time spent in the field. The majority of the high-level public relations practitioners responding to the survey were well educated, with 48% holding a bachelor's degree and 35% having a master's degree.

It was extremely difficult to assess where within the organizational hierarchy the respondents fell. The survey was intentionally mailed to the individuals who identified themselves as the highest ranking public relations practitioner in the organization, regardless of the other tasks to which they were assigned. Titles relating to public relations function were many, including: director of communications, director of community relations, public relations manager, director of public affairs, and public relations/marketing director. There appeared to be extensive overlapping of duties, with some respondents having marketing as part of their duties and title. There were also a number of respondents who had responsibilities far outside of public relations. Titles included: assistant administrator for nursing, director of pharmacy and purchasing, foundation executive director, vice president

for development, and administrative assistant to the chief of staff.

The titles of the individuals to whom these public relations practitioners reported were also numerous, although most appeared to report to top management, with 52 out of 94 reporting to a CEO, president or administrator. The respondents appeared to be placed high in the facility's communication and information chain of command, regardless to whom they directly reported, with 60% of respondents saying their most common way of learning about top-level decisions was through a personal meeting with management. The second most common way to learn of decisions, ranked second by 29% of the respondents, was a general management meeting.

The survey attempted to obtain data that would allow comparison of public relations impact by grouping respondents into J. Grunig and Hunt's manager, liaison or technician roles through a ranking duties in order of time spent. This proved impossible due to a blurring of the duties reported by the respondents. In too many instances, an individual respondent would report spending large amounts of time on writing, which is largely a technician function, media relations, usually considered a liaison function, and advising management, which is a manager function. Such responses essentially defied classification of respondents

either into these three categories, or into two more broader categories of manager and technician. This inability to adequately categorize respondents may lie in the survey's request that duties be listed by amount of time spent, rather than importance. It is arguable that most practitioners spend large amounts of time writing whether they are managers or technicians. What is more important, perhaps, is that they also have management responsibilities regardless of how little time such duties actually involve.

Although it proved impossible to use the ranking of job duties to group public relations roles in the J. Grunig and Hunt categories, the descriptive data from this ranking of duties showed that most hospital public relations practitioners are responsible for duties traditionally considered part of public relations functioning and that which fall primarily in the technician or liaison categories. For example, 27% of the respondents ranked writing/editing as the duty to which they devoted the most time; 15% of respondents ranked it as their second most time-consuming responsibility. A large number of respondents, 22%, reported community relations as their primary job duty, while another 28% ranked it as their second or third most time-consuming responsibility. A significant number of respondents also ranked media relations/spokesperson duties as high on their list of

responsibilities, with 10% listing it as their second highest duty, and 12% listing it as third. Also frequently marked was employee relations responsibilities, which were cited as one of their top three duties by 30% of respondents; an additional 15% of respondents listed it as their fourth most time-consuming responsibility.

Perhaps more indicative of modern public relations roles were the number of respondents, 13%, who said setting public relations goals/objectives was their single most time-consuming duty. Also reflective of higher status was the relatively large number of practitioners citing representing management to the public as a time-consuming duty, with 20% of respondents listing it as one of their top three responsibilities. Although only 6% of the respondents said advising management was their top duty, 13% and 15% respectively listed it as their second or third most time-consuming responsibility.

Few respondents held press conferences with any frequency and more than half of the respondents, 52%, did not do any graphic design or layout work at all. Only 9% of respondents listed it as their fourth most time-consuming responsibility. Table 1 presents specific percentages for how respondents listed their top five most time-consuming job responsibilities.

Table 1

Top Five Job Duties Reported by Respondents by Percentage

	<u>Ranking</u>				
	No. 1	No. 2	No. 3	No. 4	No. 5
<u>Duties</u>					
1. <u>Writing/editing</u>	27	16	8	7	8
2. <u>Holding press conferences</u>	1	0	0	0	3
3. <u>Acting as hospital spokesperson</u>	0	10	12	13	14
4. <u>Advising management</u>	6	13	15	8	10
5. <u>Setting PR goals/objectives</u>	13	7	7	10	10
6. <u>Doing graphic design or layout</u>	1	6	2	9	3
7. <u>Doing employee relations activities</u>	4	12	14	15	8
8. <u>Doing community relations activities</u>	22	14	14	14	10
9. <u>Doing crisis response counseling</u>	1	3	5	2	7
10. <u>Representing management to the public</u>	5	4	10	4	8

Questionnaire Findings

The power score, based on the mean of responses for the first 13 statements, was used as the main quantifier to study the impact of the major variables on public relations power. The power scores ranged from 1.154 to 4.077, with the smaller scores representing comparatively more power. The best power score was earned by two different practitioners. They worked in relatively large nonprofit hospitals with bed sizes of more than 200. The practitioner with the poorest power score worked in a very small, nonprofit hospital with fewer than 100 beds.

Overall, the respondents reported feeling somewhat powerful within organizations, with practitioners recording a mean power score slightly better than midpoint, at 2.235. In all, 68 of the 101 respondents received a power score at the midpoint or lower, and 41 respondents had a power score of less than 2.0. The respondents' power scores were compared to a number of different variables in an effort to determine possible relationships between these variables and the power granted to the public relations staff. The two variables of most interest to Schneider were the size of the organizations and their complexity or sophistication. In this study, size was determined by the number of available beds, and complexity by the availability of technologically advanced services, such as transplant surgery.

Schneider's findings of a direct relationship between public relations power and both size and sophistication, as stated in Hypothesis #1 and Hypothesis #2, were not supported by this study. However, her observations of the impact of marketplace environment, as stated in Hypothesis #3, were largely supported.

Simple regression failed to find a significant relationship between the amount of power a public relations practitioner exercised and the number of beds in the facility, discounting Hypothesis #1, which predicted the practitioners at larger hospitals would have better power scores. Even when hospitals were grouped into two categories, with facilities of 100 beds or fewer characterized as small, and those with 101 beds or more considered to be large, a t test failed to find significance. A second grouping of small to medium hospitals (399 beds and fewer), and large to very large hospitals (400 and more), also failed to find a significant relationship using a t test, although the mean power scores was moving in the direction anticipated by the hypothesis.

In the analysis of the impact of sophistication on the respondents' power scores, hospitals were characterized as unsophisticated if they provided none of the technological services indicated on the survey and sophisticated if the respondents checked even a single item. When power scores

from respondents from hospitals in the two categories were compared no significance was found; rather, the scores were virtually identical, at 2.236 and 2.235. Hypothesis #2 had expected to find more powerful scores recorded by practitioners working in more clinically sophisticated hospitals. The hospitals were then re-grouped, with those hospitals having three or more of the technology markers considered super sophisticated and those with two or fewer categories considered less sophisticated. Again, Schneider's research proved unpredictable as no significance was found between these categories and the power score.

Schneider's research focused largely on the size and complexity of organizations as the two key variables in categorizing organizations, and therefore as key predictors of how much power was granted to the public relations staff. However, her research also considered the variable of marketplace competition as meriting study as a potential critical element in public relations roles and power. Hypothesis #3 stated that marketplace factors would be related to public relations power. This potential was realized in this study, when the respondents' power scores were compared to marketplace success ($p < .001$). In this comparison, hospitals were considered to be good performers within their environment if the respondents answered extremely well or very well to the question regarding

hospital success in the marketplace. Respondents who marked any other response were considered to work in a hospital that was performing less well. The public relations practitioners who believed their hospitals were strong performers had a mean power score reflecting a high amount of power, at 1.972, while those considering their hospitals to be less than excellent performers had mean power scores that were much poorer, at 2.457.

Although the public relations practitioners' perception of their hospitals' marketplace performance proved to be an important variable for predicting public relations power, the amount of competition a hospital faced in its marketplace failed to prove significant. Hospitals were grouped into a high competition category if they reported extremely or very high amounts of competition. Hospitals with respondents reporting other answers to the question on competitive environment were considered to be in a low competitive environment. A t test of the two groups' power scores failed to find a significant relationship, although those practitioners working for hospitals in highly competitive environments had a slightly better mean power score, at 2.15, than those who were not working in such competitive arenas, at 2.30.

Although marketplace success can be due to a variety of factors, including a lack of competition, a well-funded

corporate owner, and strong community support, one factor rises above the others as an essential element: an excellent top management. The importance of top management attitude, although not mentioned in the earlier studies of organizational public relations, may well prove to be an important, if not the most important, variable for public relations power. Although the study did not directly address this issue as a variable, the composite power score includes the statement: The CEO publicly supports PR efforts. This statement was the only one of 13 statements which proved significant when compared to the overall power scores of the respondents ($p < .001$). This finding supports Hypothesis #4, which predicted other variables would impact public relations power.

The attitude of the CEO was found to be statistically significantly related to marketplace success, using an independent t test ($p < .01$). The mean score on the CEO statement for respondents in those hospitals performing well was 1.413, while those practitioners in hospitals performing poorly had a mean score of 1.86 on that statement. As before, however, Schneider's conclusions about bed size and technological sophistication failed to act as predictors, and there was no significant relationship between CEO support of public relations and bed size, or between such support and technology. Also, as before, there was no

relationship between the competitiveness of a hospital's marketplace and CEO attitude towards public relations.

In an attempt to determine if the power of the public relations staff was related to the individual practitioners themselves, in terms of gender, education, or experience, as suggested by Hypothesis #4, the overall power scores were compared to demographic variables. Uniformly, these comparisons were not significant, although in some cases power scores were moving in the direction predicted by previous studies or anecdotal evidence. For example, an independent t test found no significant differences in power by gender, although the mean power scores for males were stronger than for the females, with 2.15 for the former as compared to 2.27 for the latter. Additionally, simple regression failed to find a significant relationship between power and salary or power and age.

Two additional power scores were developed from a factor analysis of statements 1 through 13. Neither showed any significant relationship with size or technology. One scale score, statements 5, 6, and 13, represents autonomy for the public relations practitioners. These statements dealt with management interference, approval of communications, and responsibility for messages to the media. The second scale score, a compilation of statements 7, 8, 9, 11, and 12, represents decision-making ability.

These statements dealt with such areas as practitioners' impact on decisions, ability to argue against policies and participation in top-level meetings.

Although attempts to categorize respondents through their listing of duties failed, one job duty listed in the survey, that of advising management, is unquestionably in the arena of the communication manager. Previous research recognizes this duty as highly reflective of a top level public relations practitioner and a predictor of high status within an organization. Therefore, this one duty was separated from the others and considered the sole requirement for inclusion in the communication manager category. The practitioners of 34 hospitals listed advising management as one of their top three duties. The remaining 67 respondents were grouped as nonmanagers. A statistically significant relationship was found between this grouping by duties and the mean power score ($p < .001$). As predicted, those respondents characterized as managers had a stronger mean power score, at 1.91, than did those considered to be nonmanagers, who had a less powerful mean score, at 2.4.

However, the relationship between the communication manager designation and other major variables failed to be significant. The mean scores for the communication manager as compared to the nonmanager according to bed size using an independent t test found no relationship. There also was a

lack of significance when managers were compared to nonmanagers using a chi-square with low and high technology as variables. However, hospitals with higher technology had a larger percentage of communication managers, 38%, than did low technology hospitals, which had only 29% of their practitioners considered to be high level.

The variables of both marketplace environment and marketplace success also failed to generate a significant correlation when compared to the groupings of respondents according to the duty of advising management. However, a nonsignificant trend could be found, with a larger frequency of public relations practitioners in the communication manager role in the highly successful hospitals than in less successful facilities. The former had 39% of their practitioners falling into the high-level category, while only 29% of the practitioners in the latter designation fell into the group. A similar frequency was found in the comparison between the hospitals in competitive environments and those in relatively uncompetitive arenas. Of the competitive hospitals, 38% employed manager-level practitioners, while only 29% of the hospitals in less competitive environments had such high-level practitioners.

A closer look at the 13 statements comprising the power score is also of interest, as it provides more scrutiny of the attitudes of practitioners toward specific measures of

power. Overall, most practitioners responding to the survey felt public relations was valued by their top management. Many of the respondents also believed public relations was valued by the hospital's top physicians, although this support did not appear as sure as that of top management. Respondents reported being generally pleased with the level of funding awarded to the public relations program, although a sizeable minority of practitioners believed resources were insufficient.

Most of the respondents felt their top management considered public relations ramifications when changing hospital policies, and most reported that management did not interfere in the daily operation of the public relations department. Most respondents also were expected to attend high-level meetings and to act as facility problem solvers.

Although many respondents reported satisfaction with their impact on management decisions, some were unsatisfied with their power in this area. In addition, a sizeable number of these high-level public relations practitioners, needed prior approval from management for external communications, and nearly one in four were not given sole responsibility for media messages. The agree and disagree percentages for each statement is found in Table 2.

Table 2

Percent of Agree/Disagree Responses for Statements 1 to 13

	Agree	Disagree
1. Public relations is valued by your hospital's top management.	91	5
2. Public relations is valued by your hospital's top physicians.	70	10
3. Your facility provides adequate financial support for PR programs.	64	23
4. Your top management considers PR ramifications when changing policies.	71	14
5. Management does not interfere with the PR department's daily operation.	68	14
6. Management does not need to approve external communications in advance.	51	40
7. You are satisfied with the impact you have on management decisions.	58	25
8. PR staff is given adequate opportunity to argue against company policies.	56	28
9. Top management protects PR staff who oppose proposed policies.	42	15
10. The CEO publicly supports PR efforts.	85	5
11. Your input is requested when the facility faces problems.	71	17
12. Your presence and participation is expected at top-level meetings.	71	16
13. You have sole responsibility for the messages conveyed to the media.	70	23

Note. Each category includes responses for both strongly and somewhat. Neither agree/nor disagree responses are omitted.

CHAPTER V

SUMMARY AND DISCUSSION

Overall, this survey's results seem to indicate that hospital public relations practitioners in Northern California are content with their status and impact within their organizations, with 57% agreeing they felt valued by top management, and 58% satisfied with their decision-making impact. Indeed, the mean power score of 2.235, on a range from 1 to 5 with one being the most powerful score possible, indicates a fairly high overall level of power. Certain problem areas were found, however, with 23% of respondents not feeling adequate resources were devoted to public relations needs, and 40% of the practitioners needing prior top management approval for external communications. Significant minorities of respondents also felt powerless to argue against poor management decisions, and many felt they lacked credibility with the facility's physicians, traditionally a difficult sub-group within the hospital for public relations practitioners to reach. Although a small number, it is also of concern that 5% of the respondents did not believe they had the support of the CEO, although it might be inevitable that at least a minimum number of practitioners would find themselves in such a situation.

However, this study failed to find support for the hypotheses that size and technological complexity impact public relations practitioners' power and authority in hospitals, as they do in other types of organizations. This finding is not altogether unexpected. Although Schneider was able to make a correlation between these two variables and public relations power in her study, researchers have generally found it difficult to define or categorize organizations in a precise enough way to make universal conclusions about their communications efforts. An apparent research shift away from categorizing organizations by obvious and easily quantifiable variables, such as size, toward the use of more qualitative definitions that rely on interpretations of management style, corporate culture, or organizational effectiveness show that these previously used categories are problematic in mass communications studies.

Schneider's structural approach to organizational research, rather than a constraint approach, is particularly problematic when it is applied to hospitals. This is clearly demonstrated by the lack of support for this study's hypothesis that larger hospitals will have more powerful public relations staffs than smaller hospitals, and for the hypothesis that more complex hospitals will grant more power to public relations practitioners. This failure may be due, at least in part, to differences between the way typical

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organizations are managed and the way hospitals are run. Traditionally, hospitals have not functioned like other corporate environments. Hierarchical divisions within hospitals can make the organizational chart resemble a checkerboard more than a pyramid. Individual physicians and other clinicians in a hospital may have more decision-making power, and more ability to influence institutional decisions, than a high-level administrator, due primarily to the prestige and influence society affords the medical profession. Furthermore, funding and budgeting is an ongoing and often illogical process in hospitals. Patient demands fluctuate wildly and unpredictably and can be fueled by unexpected crises, such as the AIDS epidemic or the increase in crack cocaine use. Also, constant updating of clinical technology quickly renders one procedure obsolete, replacing it with another procedure that requires additional and costly equipment. Administrators who forgo the advances of medicine are likely to find themselves sued or avoided by patients who demand a community standard of medical care.

Perhaps the most important difference between hospitals and the more traditional businesses previously studied is that hospitals cannot produce, distribute, market, and sell a product in the same way as other organizations. They are providing a service that literally can be the difference between life and death. Furthermore,

their service, though frequently provided outside the governmental arena, is considered by many in this country to be a fundamental right. This creates additional constraints on hospitals, who must negotiate not only the usual market fluctuations or considerations of the business world, but the societal expectations as well. The idiosyncracies of hospital environments and the impact of public opinion and societal demand may make the application of general organizational theories, such as Schneider's, to medicine difficult both in this case and in future research.

The management differences and the inherent dissimilarities between hospitals and other organizations, however, are only one possible explanation for why Schneider's study failed to be generalizable. Another explanation may be a flaw within the study's hypotheses that hospitals could be grouped by size and technology to roughly correspond to Schneider's organic and mixed organizational categories. The overall level of technology and complexity in any hospital environment, no matter how small, is generally higher than in many other organizations. It is possible that hospitals are more appropriately grouped together as complex organizations with a high knowledge base, regardless of how unsophisticated they may appear to be when compared against each other. Size as a variable is also problematic in hospital settings. Even the largest

hospital, as measured by bed size, will generally have less than 5,000 employees, a workforce that would not be considered excessively large when compared to most other types of businesses.

If size and technology are to be considered viable variables, hospitals may need to be grouped in categories that are considered somewhat extreme. For example, they may be grouped by virtue of their larger-than-normal size or by their extreme levels of technological sophistication. The possible success of this type of more extreme categorization is lent some support by the observation that although not statistically significant, practitioners from very large hospitals, those with 400 or more beds, did have stronger power scores than practitioners in other hospitals, as would be expected based on Schneider's research. This nonsignificant trend was duplicated when very sophisticated hospitals were compared to very unsophisticated hospitals, with those practitioners from the former reporting feeling more powerful when compared to the latter; again, these findings are more in line with Schneider's results.

Lastly, Schneider's research fails to account for the very relevant issue of constraints and management style in both hospitals and other types of organizations. A small hospital may, as Schneider's research of organic organizations indicates, be less conducive to professional

public relations due, perhaps, to its limited resources. But its small, intimate size may also pose fewer communication constraints, and therefore the environment may prove more flexible and progressive in its approach to public relations. Conversely, a large hospital could be flush with available resources and a driving need for an excellent communication program, or it could be bureaucratic and highly constrained. In either scenario, the more important variable is the corporate culture, not the size. This emphasis on management style as an important variable is supported by this study's finding of a significant relationship between CEO attitude and public relations power. The findings showed that the more support a CEO gave public relations, the more powerful the public relations practitioners perceived themselves to be. This makes it possible to hypothesize that management philosophy rather than sheer size or technology is the more important variable in determining public relations authority in hospitals. This hypothesis would not be incongruent with research done by J. Grunig and Ryan, which uses a type of qualitative corporate personality as a variable for public relations use.

The most interesting significant relationship found in this study is between marketplace success and public relations authority. This relationship was not directly

pursued in Schneider's 1985 research, although she acknowledges there are indications that a successful organization in an uncertain environment uses "integrating individuals to coordinate the work of interdependent units or activities within the organization" (p. 569). Public relations personnel have typically been considered to have "boundary spanning" roles. Schneider also attributes the relatively higher authority of public relations personnel in larger organizations to the organizations' need for help to "cope with their environment" (p. 573).

Both of these statements in Schneider's research are applicable to this study's finding on marketplace success and its relationship to public relations power. Indeed, if any type of organization in the 1980s is struggling to "cope with their environment," it is hospitals, which are increasingly being forced to compete for customers, battle funding deficits and deal with an increasingly hostile environment. This study unequivocally shows that the hospitals that are most successful within their marketplace have abandoned the out-dated ladies auxiliary form of public relations and replaced it with powerful public relations practitioners who have the authority and ability to negotiate the marketplace, or as Schneider puts it, to span the boundaries, and to help their hospitals negotiate through uncertain business waters.

Although the relationship between a hospital's success and its strong public relations staff is clearly demonstrated by this study, the most obvious, and interesting, next question remains unanswerable: Which came first? Are hospitals that already had powerful public relations practitioners performing better in the marketplace because of the existence of the public relations staff, or are hospitals that are doing better in the marketplace more likely to hire public relations personnel in the first place and then to grant them considerable power? Another possible explanation for the results may be that the more successful hospitals are more interested in bringing attention to their success, and therefore are more interested in using public relations as a tool. Conversely, those hospitals doing poorly in a marketplace may actually be eliminating public relations practitioners in a short-sighted attempt at improving the bottom line. Yet, perhaps the positive relationship can be attributed to the more progressive management found in the more successful hospitals, an explanation lent some credence by the study's finding of a significant relationship between CEO attitude and public relations power.

Not surprisingly, this study found no relationship between public relations power and the inherent competition a hospital faced in its environment. This result shows that

the simple presence of external pressure on a hospital is not the important variable; rather, it is the success in which the hospital negotiates within its marketplace that affects public relations power. Again, a hospital in a very competitive environment may be firing the public relations staff in an attempt on the part of management to save money, rather than devoting resources to communicators who can address the community's preference for their rival facility. Indeed, a competitive environment could actually be fueled, or even created, by a hospital's poor public visibility and communication to the public, which allowed a competing facility to enter the marketplace. Clearly, the area of marketplace environment and public relations deserves further study. There would be powerful ramifications for the public relations profession if future studies find that a professional, authoritative public relations staff actually helps a hospital succeed in its marketplace.

One other important area in the study deserves further explanation: the inability to characterize the practitioners by public relations duties. This inability appears to be caused by the extreme breadth of duties assigned to the relatively small public relations staff in hospitals. With the mean number of staff at less than two per hospital, there is little room for significant role definition. Even the most powerful hospital public relations practitioner may

be responsible for such technician duties as the facility newsletter, and such liaison functions as media spokesperson.

This lack of definition is not necessarily a signal of the practitioners' low status, however. The data clearly showed that the practitioners had many of the higher level duties generally held only by the highest level public relations manager. Indeed, one in five of the respondents considered representing management as one of their top three duties; more than one-third listed advising management as one of their top three duties. Perhaps the communication researchers need to re-evaluate the strict definitions of communication technician, liaison, and manager as distinct responsibilities and instead view them as overlapping job duties. The more important role definer may be not what they do each day, but how much direct authority and access the practitioner has to influence the operations of their facility.

A model for defining hospitals based more on constraints and management philosophy and style should be developed to more accurately study the use of communications in hospitals. Further exploration of the relationship between the CEO attitude and the public relations staff is needed. Of particular interest is the question of how much the CEO's attitude actually is based on the professionalism

and excellence of the individual public relations practitioners, and how much is based on the CEO's personal beliefs or interest in overall modern management. Additional studies to examine the relationship between a strong public relations staff and the success of the hospital are also indicated. Measures of a hospital's success, other than the practitioners' opinions, as used in this study, would be desirable. Perhaps the input of patients, such as their perception of the hospital, could be compared to the practitioners' belief in their own power. These studies would be particularly interesting if they were done historically, with hospitals followed for several years to determine if negative changes in the hospitals' success resulted from changes in the public relations staffs' power or authority. Conversely, it would be of interest to see if positive changes in public relations use is reflected in more successful hospital organizations.

Also, additional studies need to address the overlap of public relations and marketing in hospitals, and the indications that marketing may be moving to replace public relations. Although this study did not directly address this issue, a sizeable number of the public relations practitioners had marketing duties or titles reflecting marketing responsibilities. Future studies may probe why this is occurring and how practitioners feel about this

change. Future studies may also probe practitioner job satisfaction and what specific constraints they believe may impede the success of public relations practitioners in hospitals, including such variables as experience, education, and gender.

Also of interest would be studies looking at the possible impact of the large number of women in hospital public relations. Nearly three out of four respondents in this study were women, and although not statistically significant, the male practitioners had a better mean power score than their female counterparts. Lastly, the power score testing could be applied to organizations similar in size and technology to hospitals to determine if it is applicable in other organizations. Perhaps the power scores of hospital public relations practitioners and business organization's practitioners could be tested for relative power and authority between the two types, allowing a study comparing practitioners working in different types of business, such as hospitals, banking, government, and telecommunications.

Though largely descriptive in nature, this study nevertheless shows that public relations continues to be an area of interest for research. Future studies into public relations roles and communication use in general would

benefit the public relations profession, the healthcare industry, its consumers, and the business world as a whole.

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APPENDICES

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One Washington Square • San Jose, California 95192-0055 • 408/924-3240

Dear Public Relations Practitioner:

As a mass communications graduate student and a practicing public relations practitioner at the Palo Alto Veterans Administration Medical Center, I am interested in learning more about PR and healthcare. But I need your help.

I am conducting a study on the roles of public relations practitioners in hospitals. The results of this study should increase our knowledge about the public relations field in general, and healthcare public relations specifically. Would you please spend 15 minutes to complete the questionnaire and return it by mail to me as soon as possible?

You should understand that your participation in this study is completely voluntary. Also, although I ask for your name to facilitate possible follow-up, your responses will be anonymous within the survey and seen only by me. In addition, your names will be made illegible on the individual surveys at the study's completion.

The results of the survey will be available in the future through the Society of Healthcare Public Relations and Marketing of Northern California, of which I am a board member.

If you have any questions, please don't hesitate to call me at work at (415) 852-3298 or at home at (415) 826-1937.

Sincerely yours,

HOLLY FLETCHER
Graduate student
San Jose State University

SURVEY OF PUBLIC RELATIONS ROLES IN NORTHERN CALIFORNIA HOSPITALS

This is a survey of top-level PR practitioners in California hospitals. Your name was selected from healthcare organization membership lists. Please fill out the survey and return it in the enclosed stamped envelope within two weeks, if possible. Your input is desired even if public relations is only part of your job. My work number is (415) 852-3298. Thank you very much.

Please circle the number that best corresponds to your feeling about the following statements:

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
1. Public relations is valued by your hospital's top management.	1	2	3	4	5
2. Public relations is valued by your hospital's top physicians.	1	2	3	4	5
3. Your facility provides adequate financial support for PR programs.	1	2	3	4	5
4. Your top management considers PR ramifications when changing policies.	1	2	3	4	5
5. Management does not interfere with the PR department's daily operation.	1	2	3	4	5
6. Management does not need to approve external communications in advance.	1	2	3	4	5
7. You are satisfied with the impact you have on management decisions.	1	2	3	4	5
8. PR staff is given adequate opportunity to argue against company policies.	1	2	3	4	5
9. Top management protects PR staff who oppose proposed policies.	1	2	3	4	5
10. The CEO publicly supports PR efforts.	1	2	3	4	5
11. Your input is requested when the facility faces problems.	1	2	3	4	5
12. Your presence and participation is expected at top-level meetings.	1	2	3	4	5
13. You have sole responsibility for the messages conveyed to the media.	1	2	3	4	5

(over)

14. Circle the statement best describing your hospital's market environment.

A. Extremely competitive	C. Competitive	E. Uncompetitive
B. Very competitive	D. Not very competitive	F. Not applicable

15. Circle the statement best describing how your hospital is competing in the marketplace.

A. Extremely well	C. Adequately	E. Poorly
B. Very well	D. Not very well	F. Not applicable

16. Rank the duties listed below, with #1 being the duty you spend the most time doing, #2 being the duty you spend the next most time doing, etc. If you don't do it, leave it blank.

_____ Writing/editing	_____ Doing graphic design or layout
_____ Holding press conferences	_____ Doing employee relations activities
_____ Acting as hospital spokesperson	_____ Doing community relations activities
_____ Advising management	_____ Doing crisis response counseling
_____ Setting PR goals/objectives	_____ Representing management to the public
_____ Other (Please specify) _____	

17. Please rank how you learn about top-level decisions, with #1 being the way you learn most often, #2 the way you learn next most often, etc. Leave blank those that do not apply.

_____ Memo/letter	_____ Company publications
_____ Personal meeting with management	_____ General management meeting
_____ General employee meeting	_____ Informal meetings with other staff
_____ Grapevine/rumors	_____ Other (Please specify) _____

18. Your hospital's name: _____

19. Hospital type, ie federal, nonprofit: _____ 20. Number of operating beds _____

21. Check the services your facility provides on-site. Leave blank if they do not apply.

Transplant surgery (any kind) _____ Medical research _____ Trauma center _____
Open heart surgery _____ Neonatal intensive care unit, Level 3 or 4 _____

22. Your title: _____

23. Title of your direct supervisor: _____

24. Number of professional PR staff (including yourself): Full-time _____ Part-time _____

25. On the hospital organizational chart, is your position considered a: _____ Line position
_____ Staff position _____ Don't know

26. Your annual salary: _____ 27. Your age: _____ 28. Your gender: _____

29. Years in public relations: _____ 30. Educational level: _____