

PUBLIC RELATIONS ROLES AND POWER IN UNITED STATES HOSPITALS

By

CHRISTINA BOSILKOVSKI

A THESIS PRESENTED TO THE GRADUATE SCHOOL  
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT  
OF THE REQUIREMENTS FOR THE DEGREE OF  
MASTER OF ARTS IN MASS COMMUNICATION

UNIVERSITY OF FLORIDA

2011

© 2011 Christina Bosilkovski

To my parents and my academic mentors

## ACKNOWLEDGMENTS

I would like to thank Dr. Moon Lee for keeping me tethered to the University of Florida—for her immovable confidence in my abilities, resolve, and desire to learn and for her resolute optimism. Mom and Dad, you are the reason I came to highly value an education, when so many others can only dream to have the opportunity. I would not have been able to make my goals a reality without your constant support, love, faith, and encouragement. Lastly, I would like to thank the public relations graduate class of 2010 for the time we were able to spend learning together, supporting each other's endeavors, and making friends in the process.

## TABLE OF CONTENTS

	<u>page</u>
ACKNOWLEDGMENTS.....	4
LIST OF TABLES.....	7
ABSTRACT .....	8
CHAPTER	
1 INTRODUCTION .....	9
2 LITERATURE REVIEW .....	14
Reasons for the Increasing Importance of Public Relations in Hospitals .....	15
Public Relations: A Brief History of Relationship-Centered Practice .....	20
History of Hospital Public Relations .....	22
Public Relations Role Typologies .....	25
Practitioner Perceptions of Power.....	29
The Role of Education .....	31
Hypotheses and Research Questions .....	33
3 METHODOLOGY .....	36
Sample.....	36
Instrument Building .....	39
Data Analysis.....	44
Role Function Items .....	44
Power Items .....	46
Activity Items: Managerial or Technical .....	47
4 RESULTS .....	51
Profiles of Practitioners .....	51
Hospitals.....	51
Practitioner Roles in Hospitals (RQ1) .....	52
Daily Activities and Practice .....	52
Roles .....	53
Perceived Power in Hospitals (RQ2).....	54
Potential Predictors of Power (RQ3).....	55
Demographic Correlations.....	55
Correlations with Roles.....	55
Educational Training (RQ4) .....	56

5	DISCUSSION .....	59
	Limitations.....	61
	Suggestions for Future Research .....	64
	LIST OF REFERENCES .....	66
	BIOGRAPHICAL SKETCH.....	74

## LIST OF TABLES

<u>Table</u>		<u>page</u>
3-1	Role item loadings .....	48
3-2	Power item loadings .....	49
3-3	Managerial versus technical activity loadings.....	50
4-1	Mean scores of managerial versus technical items .....	58

Abstract of Thesis Presented to the Graduate School  
of the University of Florida in Partial Fulfillment of the  
Requirements for the Degree of Master of Arts in Mass Communication

PUBLIC RELATIONS ROLES AND POWER IN UNITED STATES HOSPITALS

By

Christina Bosilkovski

May 2011

Chair: Moon Lee

Major: Mass Communication

The purpose of this study is to identify the roles and functions public relations practitioners serve in hospitals. Discovering what roles practitioners serve, what training practitioners have, as well as their perceptions of practice and their power in the hospital industry in the United States can help illuminate the current status of public relations in hospitals. The study was conducted through an online survey, administered to professionals working in hospital public relations departments. Determining what skills are most in demand today and what power practitioners believe they have can help better prepare public relations students for employment in hospitals, as well as show what functions of public relations practice need to be strengthened to prevent encroachment by other professions who could take those voids as opportunities.

## CHAPTER 1 INTRODUCTION

There is an increasing demand for public relations services in the health industry (“PR blotter,” 2009). The Public Relations Society of America (PRSA) directory of firms lists 26 industry specializations within public relations, including health/medical (Counselors Academy, 2009). Public relations has had its place within the health industry for more than 40 years (Thomas, 2006) and within hospital practice specifically since the 1960s (Gordon & Kelly, 1999). Practitioners are employed in diverse health organization settings, such as “health maintenance organizations, hospitals, other health-care agencies (such as nursing home corporations), pharmaceutical companies, medical clinics, health-science centers and nonprofit health agencies” (Newsom, Turk & Kruckeberg, 2000, p. 16).

In the past, the role of public relations in health industry work was that of information dissemination, but as a result of a shift toward a market-driven health industry (Thomas, 2006), its role has expanded to include wider functions, such as building health campaigns alongside those intended to be the target receivers of the message to ensure effective implementation (Parrot, 2004). Research on types of message appeals, communication channels used, and the effect of cultural beliefs on campaign reception has increased the presence of the consumer in crafting organizational or campaign messages (Parrot, 2004). The type of outreach expected of public relations practitioners has an element of advocacy to it, “combin[ing] social networking and mobilization, interpersonal communication and negotiation, as well as the use of media for generating public pressure” (Servaes & Malikhao, 2009, p. 1).

Each year, the United States (U.S.) invests billions of dollars in the health industry. In 2008, total U.S. health expenditures amounted to \$2.3 trillion (“Historical,” 2010), and by 2018, spending is projected to reach \$4.4 trillion (“National Health” 2010). With increasing investment being made into this economic sector, an increasing amount of support services will be needed to accommodate its growth. Health industry communication needs range “across all care aspects, including effective policy formation, public health campaigns, individuals seeking health information, e-health, patient-health practitioner communication, and communication between health practitioners, both within and across professional and subspecialty boundaries” (Jones & Watson, 2009, p. 115). The salience of the health field itself draws more attention to the communication and relationship management services needed to support it: “Health is central to our lives, a major topic of news, is politicised, underresourced, and a subject open to alternative perspectives, so it is unsurprising that this sector of the public relations industry is expanding” (L’Etang & Pieczka, 2006, p. 254). But while public relations has long had its place in hospitals, there has been confusion about exactly what functions hospital public relations practitioners should serve (Gordon & Kelly, 1999) and are serving.

What this study investigates is how public relations specialists within hospitals define their roles. Most role studies have used the four frames set out by Broom and Dozier: expert prescriber, communication facilitator, problem-solving process facilitator, and communication technician (1986). This study, however, uses newer role groupings identified by Leichty and Springston (1996), although based on Broom and Dozier’s four roles, in hopes of capturing a greater degree of the intricacies in each role behavior;

Leichty and Springston's alternative groupings are internals, generalists, externals, managers and outliers. Examining hospital public relations practice through this framework will show whether public relations practitioners are employed in roles that theory predicts to be most likely to produce excellent practice; the investigation also will advance research regarding alternative role proposals. It is important to investigate the applicability of these alternative roles to hospitals to determine if they are acceptable, more descriptive measures than those developed in 1986, and to continue pushing public relations research forward.

Specifically, identifying public relations roles within hospitals has not been attempted since 1999 (Gordon & Kelly); new research is needed to re-evaluate the roles public relations holds in hospitals in 2011. Students preparing for employment as public relations professionals in hospitals need to know what skills are considered most important to work in this setting, and what to prepare to meet the demands of potential employers; likewise, university instructors need to know which skills are important to teach in the classroom to prepare students for practice in the field.

In addition to roles questions, practitioners are also asked about how they perceive their power within the hospital (Cho, 2006; French & Raven, 1959) to determine how power and role interact and what types of power are more prevalent within the roles enacted by hospital public relations practitioners. French and Raven's (1959) typology of five powers—coercive, reward, legitimate, referent, and expert power—are used for measurement. Practitioners who enact different types of role behaviors may have different types of perceived power; some types of power may not appear at all in hospital public relations practice. Identifying which types of power

practitioners perceive they have will help to reveal the position of the department in the larger organizational structure of the hospital and indicate how important hospital managers believe public relations to be to the success of the hospital.

While power studies are not new to public relations academia (Cho, 2006; Porter & Sallot, 2003; Sallot, Porter & Acosta-Alzuru, 2004) and roles research has long sought to identify the higher and lower level functions (i.e. management versus technical behaviors) of public relations practice (Broom & Dozier, 1986), there has yet to be a study connecting roles research with practitioner power perceptions specifically in hospitals. Gordon and Kelly's study indirectly addresses the question of practitioners' positions within the organizational hierarchy of a hospital by examining the connection between model/role performance and departmental potential for excellence in hospitals, as determined by their likelihood to engage in strategic planning. Cho (2006) applied French and Raven's power measures to health public relations practitioners, but this sample encompassed a variety of medical-related contexts that can be very different from one another and only assessed practitioners' perceptions of power in *media* relations. University instructors can use information on power prevalence to understand the types of power they should be preparing students to practice as professionals in the hospital public relations field.

Thus, there is a need not only to perform a roles study in hospitals to update studies conducted more than ten years ago in 1999, but also significant value in determining how power coincides with these roles. Results are needed to identify what types of employment opportunities exist for public relations practitioners in hospitals, what is expected of practitioners in these positions, and to compare current findings to

those from 1999, which determined that practitioners were functioning in mostly technical positions that fell short of excellent practice standards according to theory. Lastly, consumers of hospital services need to know what principles and practices guide the professionals in charge of advocating for their interests within the organization; because health is central to every person's life, individuals should have knowledge of who can serve as a resource for improving the service they receive and making sure their needs are being taken into consideration within organizational decision-making.

This study was conducted through an online survey of public relations practitioners within hospitals. Professionals in the field are in the best position to illuminate the status of hospital public relations and to evaluate which skills employers deem important for practice. Findings can help practitioners prepare for employment in hospitals, as well as illuminate whether public relations practice in hospitals aligns with what public relations theory recommends.

## CHAPTER 2 LITERATURE REVIEW

Public relations (PR) is based in a tradition of continual relationship-building (Ferguson, 1984) to manage stakeholder values on multiple platforms. It contributes to the effectiveness of hospitals by “identif[ying] the most strategic publics as part of strategic management processes and conduct[ing] communication programs to develop and maintain effective long-term relationships between management and those publics” (Hon & Grunig, 1999, p. 9). In an effort to adapt to challenges posed by the evolution of communication practices in the 21<sup>st</sup> Century, “health communicators will be required to take a more interdisciplinary approach to information approach” (Thomas, 2006, p. 181); thus, calls are being made for “models of communication that take account of the complexity of health communication that involves multiple systems, such as multiple organizations being involved in a patient’s care, different professions and specialties within a health care system, and family systems” (Jones & Watson, 2009, p. 117).

While health-related public relations is discussed as a rapidly expanding field (L’Etang & Pieczka, 2006) with “robust opportunities” (Wilcox & Cameron, 2007, p. 256), there is a dearth of research concerning public relations interaction with the health industry (Wise, 2001). Moreover, few studies have been conducted on hospital public relations. Health public relations is an area of “growing sophistication” (Wilcox & Cameron, 2007, p. 257), and the health industry is among those that are currently hiring the most for public relations work (“PR blotter,” 2009). Findings support “that PR practitioners working for health organizations believe that they are recognized by their professional peers as proficient media communicators as well as experts in the field” (Cho & Cameron, 2007, p. 16), but this still leaves open questions about what greater

roles PR practitioners serve in health organizations as well as whether practitioners are recognized for their work by people other than their professional peers.

Thus, this study seeks to examine this question in the hospital public relations environment because assessing whether organizational practice mirrors what Excellence theory suggests as best practice in hospitals can contribute to enhance organizational performance (Gordon & Kelly, 1999). In the competitive market of health services, hospitals need to be as effective as possible. As the health sector—hospitals as a large part of it— has been rapidly expanding and is accordingly expected to be in increasing need of public relations services, it is important that practitioners are prepared to meet this potential demand and fulfill the expectations of employers . If the public relations field is not ready to offer the services hospitals may increasingly need, professionals in other fields may advance to the detriment of public relations. If encroachment phases public relations out of the communication process, the department that takes over may have principles based in solely organizational interests, rather than multiple stakeholder representation.

### **Reasons for the Increasing Importance of Public Relations in Hospitals**

“Hospitals, health agencies, pharmaceutical companies, and governments often find themselves embroiled in issues that pit them against factions opposed to their policies or proposals” (Knight, 1999, par. 18), rendering relationship management a constant necessity. Certain factors have recently converged to require a more specialized approach to address these new industry-wide concerns that have a direct, trickle-down, or ripple impact on hospitals.

First is a shift in the health paradigm: “Healthcare has shifted in the 20th century from a focus on acute to chronic care and prevention, thus making health promotion in

the medical encounter, and therefore, communication, more crucial to health and wellbeing than ever” (Gray, 2008, p. 422). It is because of this shift that “the context, messages, audiences and other aspects of health communication can be expected to change” (Thomas, 2006, p. 181). A 2009 report released by the American Hospital Association (AHA) states, “Hospital care is the largest component of the health care sector” (p. 1). Thus, hospitals are no longer just a place to go for the fatally ill or already-diseased—they have become a mainstay in a healthy American society.

Because there is an emphasis on continual care in all health services (including hospitals), there is an increased need for public relations to build relationships to enable, facilitate, and enhance the health services people are receiving through better communication about them. Hospitals have been typified as cold, unwelcoming places, and practitioners work to dissociate these characteristics from how hospitals are perceived; more hospitals are engaging their patients in an effort to cultivate a dialogue that will enhance organizational performance and reputation (Thomas, 2007).

Practitioners must work proactively to establish trusting, mutually beneficial relationships between hospitals and stakeholders so that organizational messages will be well-received at all times rather than only trusted when there is a serious health threat for which hospital expertise is explicitly being sought; this type of forward-looking communication can guide the chronic care and prevention approaches to health promotion by ensuring health threats are communicated effectively when they are still in the potential stage, before they augment into an actual or full-scale health hazard to the public.

Secondly, concerned publics have become increasingly vigilant, following recent years of corporate scandal and manipulation in the health industry. Hospitals are affected by the volatility of consumer trust in organizational motives; as consumers of hospital services, publics are keeping a closer eye on the way hospitals integrate stakeholder interests with those of the organization. As a result, the communication process has turned toward a more transparent method of relating to stakeholders as a way to reduce stakeholder concern, criticism, and fear (Rawlins, 2009). Online media centers are one example of how hospitals are trying to address demands for transparency and accessibility.

Thirdly, there has been a shift in the way people seek and receive health information and services from hospitals. Patients are engaging their health decisions in a more proactive manner (Thomas, 2007), and communication must mirror this trend to allow for a more participatory dialogue between hospitals and their publics (Servaes & Malikhalo, 2009). There has been “an overall shift from a paternalistic model of medical practice towards a patient-centred healthcare firmly based on mutuality, patient autonomy, professional neutrality and shared decision making” (Sarangi, 2004, p. 1). This shift suggests that practitioners will have to more actively engage with hospital patients and their families on a level that respects their input into the hospital treatment process as much as that of a doctor.

Hospitals have shifted to a market-based focus, expanding the number of voices who have an interest in health communication issues, from advertisers to pharmaceutical companies to policy enforcement agencies; as a result, hospitals find themselves in the position of having to work to attract and retain patients in a

competitive market environment. To accommodate this need to maintain a steady client base, practitioners in hospitals must engage in role behaviors that advocate for the hospital (Wise, 2001) and manage its reputation to ensure its stability as a patient-based institution. While this may seem contrary to the integrity of the aforementioned goal of fostering participatory dialogue between hospital staff and patients, it is the challenge and responsibility of the practitioner in balancing these two goals. As such, public relations must span both technical and managerial roles within hospitals; at the very least, direct access to managers will help advance public relations by providing valuable feedback and “boundary spanning” (Wise, 2001, p. 477) to identify growing health trends.

The publics engaged in this communication have also changed, as the American public has become more differentiated (Thomas, 2006), demanding more responsive, personalized approaches to communicating about health issues. This need for “tailored messaging,” “the new frontier for health communication” (Wilcox & Cameron, 2007, p. 257) brings about challenges to practitioners in hospitals in how to reach their audiences in an appealing manner. The role of dialogue and practices like boundary spanning in the process of tailoring health messages are functions that make public relations an important part of reaching hospital audiences. Dialogue within public relations goes beyond unidirectional communication practices—like the public information and press agency models—to foster good-will between an organization and its publics (Kent & Taylor, 2002). Practitioners navigate the complex interests of various stakeholder groups, from health care clients to “doctors, medical reporters, investors, and patients” (Wilcox & Cameron, 2007, p. 257). Women, the primary health consumers

of the household, receive a significant amount of medical information “from public relations sources” (Wilcox & Cameron, 2007, p. 257). Because hospitals also focus on chronic and preventative care, the range of clients a hospital may serve necessitates extremely different communication measures; a patient who is at the hospital for diagnosis of a terminal illness needs specific messages and communication outreach measures that differ from those practitioners use for a patient recovering from minor surgery.

Lastly, the way people choose to communicate has been altered dramatically by the prevailing impact of the Internet and digital technologies. In 2009, 61% of adults in the United States sought health information online (Fox & Jones, 2009). An estimated 28% of adults use the Internet to find information on hospitals and other medical facilities, largely to seek rankings or reviews of hospitals (Fox & Jones, 2009). The Pew Internet and American Life Project (Fox & Jones, 2009) reports that women, specifically younger, higher-educated female internet users are more likely to look for information online about medical facilities. In addition to their doctor and traditional sources of health information, patients are finding information and discussing issues in online forums and social media communities (Kane, et. al., 2009). Emergent media have rapidly become an integral part of modern communication in countless industries; likewise, hospitals are trying to understand how to harness the power of social media to advance industry goals (Kane, et. al., 2009). A conference held at the Public Relations Society of America (PRSA) Health Academy in 2009 found that “the overriding message that emerged...is that even social media requires the particular skill that is at the core of our profession: building and nurturing mutually beneficial relationships” (Payton, 2009,

p. 18). Thus, the next section examines the impact the concept of “relationship” has had on public relations and the components that comprise the relationship unit.

### **Public Relations: A Brief History of Relationship-Centered Practice**

In the past 25 years, public relations scholars have come to value the relationship as the center of public relations efforts; this relationship-focused approach in regard to “relationships between organizations, between organizations and one or more groupings in society, or more generally with society itself” (Ferguson, 1984, p. 16) is a defining characteristic of what sets public relations apart from other communication practices. It is what allows public relations to command a presence in hospitals as a distinct, valuable, and necessary function.

The introduction of the relationship as the central unit of study in public relations in the 1980s caused a shift in thinking about public relations from a practice centered on communication output measures to one based on relationship measures (Bruning, Castle, & Schrepfer, 2004; Ferguson, 1984; Hon & Grunig, 1999; Wu, 2005). Ferguson posited the relationship as the key to cultivating and maintaining lasting, mutually beneficial partnerships that achieve both the short-range and long-term goals of public relations. Moreover, the measure of a relationship can be adapted to both macro and micro levels in guiding public relations campaigns and management plans. As “multidimensional abstractions” (Ferguson, 1984, p. 16), interorganizational relationships, for instance, require a communication approach that allows flexibility for the constantly changing environment of these interactions; thus, no matter who the involved parties are, public relations is able to coordinate a situation that is satisfying to the parties involved because it is based on an examination of what is important in their particular relationship dynamics. Without this type of adaptability, it would be difficult to

coordinate the varying levels of relationship-development a hospital engages in with its many stakeholders.

Following Ferguson's proposal of relationship-centric practice, focus turned toward developing a way to measure the components that comprise the makeup of relationships. Building on previous work, Bruning and Ledingham (1999) provided measures for the complex factors of organization-public relationships. Categorized as professional, personal, or community, organization-public relationships exist on many levels; hence, they require a measurement tool that is accordingly "multi-item" and "multi-dimensional" (Bruning & Ledingham, 1999, p. 165). This organization-public relationship scale includes measures of trust, openness, involvement, investment, and commitment as indicators of relationship quality.

Hon and Grunig (1999) also developed relationship measures, focusing on the six factors of control mutuality, trust, satisfaction, commitment, exchange relationship, and communal relationship. Control mutuality refers to the balance of power relations existing in the relationship. Trust is the mutual faith displayed by the involved parties in the abilities and intentions of the other; trust can be further broken down into integrity, dependability, and competence. Satisfaction is related to the reinforcement of positive feelings when relationship expectations are fulfilled. Commitment refers to the desire to continue relationship efforts. Exchange relationship involves one member conferring benefits upon the other in faith that the favor will be eventually returned or because a favor has already been granted. Lastly, a communal relationship occurs when the well-being of the other party is the main motivator for actions, regardless of benefit to the first party in the relationship.

It has been discussed that “there is perhaps no other field that could benefit more from the application of relationship management than public health” (Park & Reber, 2008, p. 3), and hospitals are at the center of many community battles to foster better health, serving as the main information hub and health program-provider that connects the local public on community health issues. While the “[r]elationship is a core concept for many disciplines, such as interpersonal communication, organizational communication, labor-management studies, international relations and public relations” (Wu, 2005, p. 25-26), it is particularly the specialty and central unit of measurement of public relations. Likewise, as relationship management, “public relations...necessitates integrating concepts from the disciplines of mass media, interpersonal communication, interorganizational behavior, social psychology, marketing, and management” (Bruning & Ledingham, 1999, p. 159). Thus, the relationship should still be the unit of analysis as the primary measure of mutually beneficial relationship-building (Park & Reber, 2008) that contributes to the “effective long-term success” (Hon & Grunig, 1999, p. 9) of hospitals’ interests. Public relations work encompasses the tasks of “choosing credible sources, developing a message strategy, defining the appropriate sources of data, and determining the settings and/or channels for optimal communication delivery” (Rimer & Kreuter, 2006, p. S195) as part of relationship-building strategies, of which “the goal is to create a substantial behavioral relationship, which may be enhanced by effective communication” (Wan & Schell, 2007, p. 28).

### **History of Hospital Public Relations**

In terms of public relations, “practitioners, with the necessary training and support, could play vital roles in helping public health bodies achieve their organizational goals with respect to providing essential health services” (Wise, 2001, p.

477). And while health public relations practitioners feel valued most for their expert power in media relations expertise (Cho, 2006), their work extends much deeper than that. As “their traditional roles as media and community liaisons offer opportunities for framing issues of interest,” so do “their less-recognized roles as lobbyists, negotiators, and environmental scanners” (Knight, 1999, par. 10). Hospitals use public relations in a variety of functions, including “employee relations, media relations, government relations, community relations, and...marketing relations” (Guth & Marsh, 2007, p. 37). Public relations in a hospital setting is outlined to have two main functions: “to strengthen and maintain the public’s perception of the institutions” and “to help market the hospital’s proliferating array of services” (Wilcox & Cameron, 2007, p. 566). While valid, the two main functions Wilcox and Cameron (2007) identify for public relations in hospitals simplify the complexity of the public relations practitioner’s responsibility to advocate for multiple stakeholders simultaneously. It also plays an integral role in managing internal governance (Van Kooy & Ettinger, 2002) at hospitals as well as in external policy negotiations with the United States (U.S.) government (Moon, 2007) and other external stakeholders.

In 1966, health-related public relations focused heavily on publicity (Weiner, 1966). A review of hospitals a little over a decade later demonstrated that public relations in hospitals was still heavily dominated by publicity-gearred activities (news releases, publications, media relations) as well as fundraising practice (Gelineau, 1979). A 1993 study of Canadian hospitals warned against the possibility of encroachment of public relations by other fields—that “there is potential for public relations to be restricted to the role of technical support in the areas of publicity and internal

communications as fund raising moves from amateur to professional status and as hospital administrators investigate the revenue generating potential of marketing” (King & Scrimger, p. 40). This is as true now in the United States as it was in Canada in 1993. Gordon and Kelly’s (1999) review of public relations departments in hospitals found that one-way models were more commonly practiced than the two-way models so promoted by Excellence theory, and practitioners were more likely to be employed in a technician role rather than a managerial role. The public information model was found to be more prevalent as well. While Gordon and Kelly examined public relations role performance in hospitals in 1999, they categorized roles according to the manager-technician dichotomy, simultaneously giving a clear picture of well-defined roles and limiting practitioners to diametrically opposed categories that do not allow for variability. Practitioner roles in hospitals have yet to be assessed using newer role identifications that allow for the greater depth of hybrid roles, as well as in connection with the types of power practitioners perceive they have. It is necessary to pursue research using newer methods that build on older, more accepted measures to ensure research is evolving in a progressive direction, as well as keep up with the evolution of practitioner responsibilities in modern [hospital] practice.

Not only does the relational perspective illustrate “the need for public relations practitioners to be conversant with strategic planning and other managerial processes,” it “also provides a framework for scholarly inquiry, a platform for developing educational curricula, and a rationale for practitioners charged with accounting for program initiatives” (Ledingham, 2003, p. 182). Thus, the importance of education, to be discussed later in this review, is underscored. In their study of practitioner role and

power perceptions in connection with web usage, researchers Sallot, Porter, and Acosta-Alzuru assert, “Without the power to participate in strategic decision-making, practitioners are often relegated to technician-type staff positions, merely producing informational materials at the bidding of others” (2004, p. 270). Thus, in coordination with assessing the role behaviors practitioners in hospitals display, this study delves into their perceived power to help depict the status of public relations within the hospital’s greater organizational structure: exactly how much power practitioners believe they have professionally in the hospital, and how they practice it.

### **Public Relations Role Typologies**

Studies on public relations roles (Berkowitz & Hristodoulakis, 1999; Sallot, Porter, & Acosta-Alzuru, 2004; Wu & Baah-Boakye, 2007; Wu & Taylor, 2003) and power perceptions (Sallot, Porter, & Acosta-Alzuru, 2004; Wu & Taylor, 2003) within organizations have been widely discussed in public relations literature. Broom (1982) outlined four roles that practitioners tend to play in organizations: those of the expert prescriber, communication facilitator, problem-solving process facilitator, and communication technician. A practitioner in the role of expert prescriber “researches and defines the problem, develops the program and takes major responsibility for its implementation” (Broom, 1982, p. 18). A communication technician is valued more for his or her communication, journalism, and media skills, while a communication facilitator is “a liaison, interpreter and mediator between the organization and its publics” (Broom, 1982, p. 18). The process facilitator guides the planning, programming, and implementing of all program phases, as well as identifying and solving the accompanying problems.

While these roles are widely respected in public relations literature, criticism of these four roles has led researchers to seek alternative ways of characterizing public relations role behaviors. A criticism of Broom and Dozier's manager-technician dichotomy is that it assumes the mutual exclusivity of both (Leichty & Springston, 1996; Porter & Sallot, 2003). In fact, positive correlations between the manager and technician scales suggest the possible existence of hybrid roles that consist of activities from both (Leichty & Springston, 1996). Another criticism is that there is a lack of theoretical basis for the management scale; "the management factor consists of eighteen items that might be labeled the *"everything other than technical activities factor"* (Leichty & Springston, 1996, p. 468).

Leichty and Springston therefore developed and tested additional role activities to try to capture the intermediate levels of public relations activity. The eight role activity factors identified were: advocacy, public relations catalyst, gatekeeping, public relations training, public relations counsel, technical activity, research and information acquisition. Advocacy "dealt with representing the organization to external publics" (Leichty & Springston, 1996, p. 469). Public relations catalyst was measured by four items from Broom and Smith to assess "the extent to which the practitioner serves as a PR project manager by keeping people informed, enthusiastic, and involved" (Leichty & Springston, 1996, p. 469). Gatekeeping assesses "decisions as to what information to pass along and whom to pass it to" (Leichty & Springston, 1996, p. 470), while public relations training involves nonpublic relations employees. Public relations counsel regards the expert knowledge practitioners dispense as part of teamwork. The technical activity scale refers to writing and producing materials, while information acquisition information

collection regards external publics. The research items look mostly at quantitative research.

Based on these activities, five groupings emerged from Leichty and Springston's study: internals, generalists, traditional managers, externals, and outliers. Internals are most similar to the role of problem-solving facilitator because they spend much time coordinating efforts within the organization, showing both high levels of process leadership and technical activity. Generalists show crossover with some of the other role activities, as generalists perform various activities as part of their daily responsibilities. One possible reason for the lack of specialization of the generalist is that practitioners who fall into this category may tend to work in departments of smaller size (Leichty & Springston, 1996). Similar to the internalist, the generalist provides support for internal public relations processes and shows high technical activity, but is also highly active with external publics (advocacy, information acquisition, research, etc.).

Traditional managers, like Dozier's notion of the communication manager, show low technical activity, but higher scores on public relations counsel, gatekeeping, information acquisition, advocacy, and public relations catalyst. They are "expert prescribers with a collaborative orientation" (Leichty & Springston, 1996, p. 475), and typically have the most experience and work in the largest public relations departments. Traditional managers and generalists perceive their roles to be more managerial than the other groupings do. Like internals, externals are strong in technical activity, but give higher attention to advocacy and information acquisition; externals can be likened to Broom and Smith's communication technician role. They "interacted with publics

frequently, but played passive roles within their organizations” (Leichty & Springston, 1996, p. 473). Lastly, outliers, the weakest grouping, represent individuals who score significantly below average on seven of the eight activities measured; one possible explanation for their different markings is that these individuals may be part-time practitioners (Leichty & Springston, 1996).

Insistence that public relations participate in a management role within organizations has grown (Wehmeier, 2009). The assertion that “public relations in the health industry has emerged in recent years as a vital member of the management team” (Broom, 2009, p. 449) suggests that there is room for public relations, but that it has yet to be extensively discussed in academic literature. Choice of role behavior for practitioners, however, often depends on the decisions of upper level managers: “Which model the dominant coalition chooses depends on whether the dominant coalition feels threatened by that model and whether it fits with organizational culture, the schema for public relations in the organization, and whether the public relations department has the potential to carry out the preferred model” (Grunig, 1992, p. 303). In cases where public relations is not given a management role in the communication process, practitioners are still responsible for presenting issues to the dominant coalition and fairly mediating all stakeholder interests (Knight, 1999).

Surveying 191 heads of public relations departments in U.S. hospitals, Gordon and Kelly (1999) found, however, that hospitals that employ public relations as a management role can achieve greater organizational effectiveness. They defined organizational effectiveness by four performance measures: whether the hospital met its budget, achieved long-term strategized objectives, reached short-term objectives, and

advanced its mission (p. 151-152). Organizational effectiveness is crucial to hospitals in the wake of the shift to preventative care, advent of technologies, and new consumer expectations; inefficient hospitals that cannot meet consumer expectations or fail to adapt to the new technological norms will suffer and be surpassed in the industry. The study's main finding was that hospital public relations departments were most heavily engaged in technical work and practiced mostly unidirectional models, particularly the public information model. With emergent technological tools at practitioners' disposal (Seltzer & Mitrook, 2007), it would be beneficial to evaluate whether hospital public relations practice still falls short of two-way symmetrical practice 12 years later. Moreover, recent attention to social media as business tools may have also altered practitioners' perceptions of their power within the hospitals, as they become the hospitals' gatekeepers with the expertise in social media use.

### **Practitioner Perceptions of Power**

Using the power typology developed by French and Raven in 1959, practitioner perceptions of power within hospitals can help give a reference point from where to analyze their identified role behaviors. French and Raven's power typologies, while developed in the 1950's, are still widely used. The measures are well-established in marketing (Busch, 1980; Narayandas & Rangan, 2004; Dwyer & Walker, 1981; Kasabov, 2007; Mayo, Richardson, & Simpson, 1998; McDaniel, Futrell, & Parasuraman, 1985), health (Bolam, Mclean, Pennington, & Gillies, 2006; Popovich & Warren, 2010), and business management (George & Sleeth, 2000; Kudisch, Poteet, Dobbins, Rush & Russell, 1995; Kutschker, 1985; Porrini, 2006; Wilcox, Howell, & Breivik, 2008) literature. French and Raven's power constructs have only been minimally explored in public relations (Spicer, 1997), and there have only been a few

applications to health-related public relations (Cho & Cameron, 2007; Cho, 2006). This study seeks to use these cross-disciplinary measures in the hope of expanding the scope of traditional public relations literature.

French and Raven identified five types of power individuals wield within organizations: coercive, reward, legitimate, referent, and expert. Raven contends that a sixth power base is informational, but French maintains that the informational element is an influence, not a power, as power does not have the same conceptual foundation as “information-based exchange” (Raven, 2008, p. 12). Given that much of public relations work in hospitals involves that active exchanging of information, this sixth element was included, using measurement items developed in this study. Coercive power is that which is based in punishment to be inflicted from failure to comply with expected behavior, while reward power is that which one individual can wield over another by means of incentive (French & Raven, 1959). Legitimate power refers to that which occurs when one individual is obligated to submit to the influence of another due to an accepted norm that the individual has a legitimate right to wield that influence over the other party. Referent power relies on identification between two parties, where one feels a favorable sense of likeness or membership to the other, thus ascribing to that association, while expert power cannot occur without the superior contribution of knowledge by one party over another. Informational power “derives from the persuasiveness of communications and arguments provided by the influencing agent” (Koslowsky & Schwarzwald, 1993, p. 136).

Leichty and Springston’s hybrid roles would suggest power is constantly in flux and a subject for negotiation. Raven suggests that powerholders could benefit from

using multiple types of power concordantly, but with the caveat that “one basis of power may undermine another” (2008, p. 14). A traditional manager, for example—expected to show high levels of gatekeeping and advocacy, and PR catalyst— thus would be expected to show informational and expert power as well as some levels of reward, legitimate or referent power, being in a typically respected position of authority. It is possible that the manager wields coercive power as well. A traditional manager that lacks the higher types of power (e.g. legitimate) may not be an effective leader at all, or may indicate that public relations is not valued as a central function in that hospital’s department. Thus, it is important to identify which types of power practitioners perceive they hold. Public relations practitioners in hospitals may not demonstrate all five-six types of power, but different role behaviors may produce different patterns of perceived power. Identifying which types of power are not perceived to play a part in hospital public relations can be just as important as identifying which types are prevalent. In addition to role behavior and power, educational background may also influence how public relations practitioners function and perceive their power in hospitals; while formal and informal training are an ongoing part of public relations job preparation, education very basically forms the foundation for optimal, or ideal, public relations practice.

### **The Role of Education**

In order for public relations to have an impact on organizational effectiveness, Kelly (1994) indicated that practitioners must first and foremost have an educational background in public relations. Kelly advocated educational training as a way to curb the dangerous possibility of encroachment by other professions. Newsom (1977) lamented the lack of college and university course offerings for public relations, and while the educational curriculum has expanded over the last 30 years, it still suffers from

limited offerings and lack of consistency. Gelineau's study of practitioners working in hospitals found that two-thirds of practitioners surveyed had no formal educational training in public relations (1979). Quane noted in 1973 that "few colleges offer graduate degrees in public relations at all, let alone courses that relate to hospital PR" (p. 21).

A study of hospital public relations department heads in 1999 found that two-thirds of practitioners surveyed had at least some college training in public relations or communication (Gordon & Kelly). While this figure may seem to be an improvement, an argument can be made that an organization is only as strong as its weakest link; many factors can intervene between a manager's formal public relations knowledge and his employee's ability to carry out that knowledge in a way that fulfils the greater purposes of public relations. Research by Ledingham supports the inclusion of public relations in management functions with "practitioners trained in management processes and able to apply those skills to public relations problems and opportunities" (2003, p.184). Yet Gordon and Kelly's evaluation found only 9% of public relations department heads in hospitals had a master's or doctoral degree, and 28% a bachelor's degree (1999, p. 153). It is important, however, to test for the formal educational training and knowledge of hospital practitioners beyond those in the managerial role. A health or medical degree may make a difference in the status public relations practitioners wield in hospitals (Cho & Cameron, 2007).

In a public relations textbook featuring 19 case studies, four of them are about medical/health issues (Parkinson, 2006). These case studies regularly appear in crisis communication chapters (Broom, 2009; Hansen-Horn, 2008; Wilcox & Cameron, 2007). The view that health-related public relations belongs under the umbrella of crisis

communication seems to indicate that communication in this realm is not as important unless something goes critically wrong to threaten the health of the public at large, However, public relations has greater applicability within health organizations than just resolving crisis situations; hospitals employ public relations personnel as part of their regular staff, although the roles practitioners in hospitals serve varies from one hospital to the next. Nonetheless, the repeated incidence of public relations in connection with health organizational case studies may be a starting point to gaining the greater recognition of health-focused public relations as a specialty.

### **Hypotheses and Research Questions**

Based on an examination of the functions public relations practitioners fulfill in hospitals, this study was designed to uncover the roles employers in hospitals assign as public relations' responsibilities, as well the perceived power of practitioners in their hospitals. In order to further understand the values important to current hospital public relations practice, this study sought to explore the ideas below.

**H1:** Practitioners in hospitals have roles that focus on higher technical activity rather than strategic management processes.

**H2:** Power types will interact differently with the different roles.

**H2a.** The more they perceive they are playing the traditional manager role, the more likely practitioners are to perceive that they are displaying coercive power.

**H2b.** The more they perceive they are playing the traditional manager role, the more likely practitioners are to perceive that they are displaying reward power.

**H2c.** The more they perceive they are playing the traditional manager role, the more likely practitioners are to perceive that they are displaying legitimate power.

**H2d.** The more they perceive they are playing the traditional manager role, the more likely practitioners are to perceive that they are displaying expert power.

**H2e.** The more they perceive they are playing the external [liaison] role, the more likely practitioners are to perceive that they are displaying expert power.

**H2f.** The more they perceive they are playing the external [liaison] role, the less likely practitioners are to perceive that they are displaying coercive power.

**H2g.** The more they perceive they are playing the external [liaison] role, the less likely practitioners are to perceive that they are displaying reward power.

**H2h.** The more they perceive they are playing the external [liaison] role, the less likely practitioners are to perceive that they are displaying legitimate power.

**H2i.** The more they perceive they are playing the internal role, the more likely practitioners are to perceive that they are displaying coercive power.

**H2j.** The more they perceive they are playing the internal role, the more likely practitioners are to perceive that they are displaying reward power.

**H2k.** The more they perceive they are playing the internal role, the more likely practitioners are to perceive that they are displaying legitimate power.

**H2l.** The more they perceive they are playing the internal role, the more likely practitioners are to perceive that they are displaying expert power.

**H2m.** The more they perceive they are playing the generalist role, the more likely practitioners are to perceive that they are displaying coercive power.

**H2n.** The more they perceive they are playing the generalist role, the more likely practitioners are to perceive that they are displaying reward power.

**H2o.** The more they perceive they are playing the generalist role, the more likely practitioners are to perceive that they are displaying legitimate power.

**H2p.** The more they perceive they are playing the generalist role, the more likely practitioners are to perceive that they are displaying referent power.

**H2q.** The more they perceive they are playing the generalist role, the more likely practitioners are to perceive that they are displaying expert power.

**RQ1:** What roles do public relations practitioners serve in hospitals?

**RQ2:** What types of power do practitioners perceive they have in hospitals?

**RQ3:** What are the potential predictors of the different types of power?

**RQ3a.** Do years of experience in public relations correlate with the types of power practitioners wield?

**RQ3b.** Is there a connection between the size of a hospital's public relations department and the types of power practiced by practitioners?

**RQ3c.** Are different roles correlated with different types of power?

**RQ4:** What training do hospital public relations practitioners have?

**RQ4a.** Does educational background have an effect on practitioner roles?

**RQ4b.** Does educational background have an effect on practitioners' perceived power?

## CHAPTER 3 METHODOLOGY

### **Sample**

As a way to gauge what functions public relations personnel in hospitals serve and the types of power they perceive they have, the researcher conducted an online survey of practitioners working at hospitals in the public relations (PR) department. The survey was launched October 19, 2010, and concluded January 6, 2011. In 1999, Gordon and Kelly enlisted the help of 30 state hospital associations to survey 191 heads of public relations departments in hospitals, from a sample size of 500; their response rate was 38.2%. Similarly, the first round of survey invitations in this study was administered through state hospital associations and regional member associations from the Society for Healthcare Strategy and Market Development (SHSMD). A probe email was sent to these members the week before to determine willingness to participate; chapters that agreed to participate received the survey October 19, 2010 or in the weeks following as some were pending board approval.

The second round of invitations, sent the week of December 20, 2010, consisted of a simple random sample taken from the American Hospital Directory (AHD), which lists just less than 4,000 hospitals in the United States. It is one of the most complete directories for U.S. hospitals. As the website lists hospitals in alphabetic order grouped by state, a list was compiled featuring all the hospitals listed, as such. The hospitals in the alphabetic listing were numbered, and a random number generator from Randomizer.org was used to choose 800 hospitals to comprise the sample. The following sample size formula was also used to calculate initial sample number selection:

$$n = \frac{[\text{Confidence level}^2 * (v) * (1-v)]}{\text{Confidence interval}^2}$$

$$n = \frac{[1.96^2 * (.5) * (1-.5)]}{.05^2}$$

According to this formula, a population size of 3,958 (Total number of hospitals on AHD list) requires a sample size of 384 to yield results at the 95% confidence level. The formula does not account for whether all of the hospitals had a public relations department or whether practitioners in those departments responded to the survey. A sample size of 800 was chosen so that response levels might sufficiently supplement those provided by the initial round of surveys administered through state/regional associations.

The websites of the 800 chosen hospitals were visited to attain email contact information for distribution of the survey to the main public relations practitioner contact(s) at the hospitals. The following key words were the most common indicators of public relations contacts: media affairs, public affairs, community relations, and marketing and public relations. In cases where direct contact information was unclear or not available on the website, the survey invitation was submitted through the website's general contact form with a request to submit to the public relations department. Practitioners who received the survey invitation served as the point of contact with additional practitioners within the hospital.

In addition, unresponsive state and regional associations were emailed a second time, resulting in nine state and eight regional groups total that agreed to distribute the survey; the survey invitation was posted to Public Relations Society of America (PRSA) Health Academy's LinkedIn and Facebook pages on December 22, 2010 as well.

Those hospitals that did not employ people specifically in public relations responded that they assigned public relations-like duties to individuals in human resources or marketing or simply did not have public relations departments. Twenty hospitals confirmed that they did not employ public relations personnel and were excluded from the study. Hospitals that employed persons as public relations practitioners but did not have a separate public relations department were included for analysis, as long as the persons indicated to be specifically devoted to public relations practice. A number of hospitals featured one department that combined two disciplines (i.e. Department of Marketing/Public Relations); these were included for analysis. Twelve hospitals were excluded because their hospital did not have a website, and 46 hospitals were excluded because their website did not feature any form of email contact or submission; practitioners from three hospitals responded that while their hospital did have a public relations department, they declined to complete the survey. A total of 207 surveys were analyzed.

Background information on hospitals was provided by the American Hospital Directory (AHD), which includes number of staffed beds, number of total discharges, and gross patient revenue. The AHD provided this information collected from the hospitals' most recent Medicare Cost Report. This information was linked to practitioner responses based on identification by the practitioner of the hospital at which they work.

The survey was designed with Qualtrics; survey invitations were distributed via University of Florida webmail so that practitioners received an immediate sense of the academic nature of the research in the hope of encouraging a respectable response rate. Those practitioners interested in the main findings of the study provided their email

address in the survey form and will be emailed a summary of the findings in April at the conclusion of research.

### **Instrument Building**

The survey was created using Qualtrics, and results were analyzed using PASW Statistics Software. The survey featured four sections. The first section assessed practitioner roles via daily task behavior. Adopted from Leichty and Springston (1996), the items used to measure role behavior represent eight postulated factors: advocacy, public relations catalyst, gatekeeping, public relations training, public relations counsel, technical activity, research and information acquisition. Four clear roles were expected to result from these items in accordance with Leichty and Springston's findings (1996): those of internals, generalists, traditional managers, and externals. A fifth role, outliers, was expected to be a weak grouping.

Respondents were asked to indicate the degree to which they felt the stated activity is a part of what they do. These role items were measured on a scale from 1 to 5, 1 being "Never True" and 5 signifying "Very Often True."

Five items were used to measure the advocacy factor. These items were expected to load together in a factor analysis to capture advocacy behaviors.

- Provide information informally to outsiders that will induce them to act favorably to your organization.
- Provide information informally to groups outside your organization to create a favorable image.
- Provide information on a formal basis to groups outside your organization intended to create a favorable image.
- Provide information informally to outsiders that will induce them to act favorably to your organization (this was an accidental duplicate—meant to read "formally," not "informally").

- Represent the organization at events and meetings.

The public relations catalyst factor was measured by four items.

- Take responsibility for success or failure.
- Keep management actively involved.
- Keep others in the organization informed.
- Operate as a catalyst.

Gatekeeping was measured by three items.

- Decide when to transmit information acquired from outside your organization to others within your organization.
- Decide what portions of information acquired from outside your organization to transmit to others within your organization.
- Decide to whom within your organization to send information obtained from outside sources.

The PR training factor was a three-item measure.

- Informally instruct others, not in PR, how to interact with people outside your organization.
- Formally instruct others, not in PR, how to interact with people outside of your organization.
- Work with managers to increase their skills.

The PR counsel factor was measured by four items.

- Collaborate with nonpublic relations people to define and solve problems.
- Plan and recommend courses of action.
- Make communication policy decisions.
- Keep management informed of public reactions.

The communication technician factor featured four items.

- Produce pamphlets and brochures.
- Edit/rewrite for grammar and spelling.
- Writing public relations materials.
- Do photography and graphics.

The formal research factor had two measures.

- Conduct communication audits.
- Report public opinion survey results.

Lastly, the information acquisition factor used two items.

- Formally acquire information from sources or groups external to your organization.
- Informally acquire information from sources or groups external to your organization.

Leichty and Springston's (1996) cluster analysis suggested that these eight factors should fall into the five patterns of role behavior described here. *Internals* typically scored high on technical activity, PR catalyst, and gatekeeping, but low on advocacy, training, information acquisition and research (p. 472). *Generalists* should show above average markings for all eight factors. *Traditional managers* demonstrated low technical activity and research, and above average scores for PR counsel, gatekeeping, information acquisition, advocacy, and PR catalyst (473). The fourth role, the *external*, typically showed high markings for technical activity, advocacy, and information acquisition, and low for gatekeeping, PR counsel, PR catalyst, research, and training. The last group, the *outliers*, was a weak grouping that scored very low on most of the factors and thus may have differed characteristically from practitioners in the other roles.

The second section contained two questions about practitioner daily activities. A question on the types of public relations practiced was developed based on the main types of public relations identified to be practiced by hospitals. One question on the specific activities practitioners engage in daily was developed using a combination of manager-technician items from Kelly's (1994) roles study and Gelineau's 1979 study on hospital public relations. Activity items in this survey corresponded with items used in

Kelly's (1994) and Gelineau's (1979) studies to maintain measurement in a form that was comparable to findings from these two researchers' previous studies.

The third section assessed what types of power practitioners perceived they wield in the hospitals where they work. Items used to measure power were adapted from Hinkin and Schriesheim (1989) to measure the five types of power identified by French and Raven (1959) reward, coercive, legitimate, expert, and referent—including items developed in this study to measure the contentious sixth informational influence/power.

The power items were measured on a scale from 1 to 5, 1 being "Strongly Agree" and 5 signifying "Strongly Disagree."

Five items assessed reward power.

- I can increase pay levels at work.
- I can influence people at work getting a pay raise.
- I can influence people at work getting a promotion.
- I can provide others at work with special benefits.
- I can give people at work positive attention when they perform the way I want them to.

Coercive power was also measured by five items.

- I can make work difficult for people at work.
- I can make things unpleasant for people at work.
- I can make being at work distasteful for people at work.
- I can give others undesirable job assignments.
- I can give people at work negative attention when they perform in a way that is unsatisfactory to me.

Legitimate power featured five statements.

- I can make people at work feel like they should satisfy their job requirements.
- I give people at work the feeling that they have responsibilities to fulfill.
- I can make people at work recognize that they have tasks to accomplish.
- I can make people at work feel that they have commitments to meet.
- I can make people at work feel that they should contribute their equal part to team efforts.

Expert power related to the following five statements.

- I can give people at work good technical suggestions.
- I can share my considerable experience and/or training with people at work.
- I can provide people at work with needed technical knowledge.
- I can provide people at work with sound job-related advice.
- People at work seek my advice consistently on one or more specific (work-related) topics.

Referent power used these five items.

- I can make people at work feel valued.
- I can make people at work feel like I approve of them.
- I can make people at work feel personally accepted.
- I can make people at work feel important.
- I can influence others' personal standards at work by virtue of my own.

Lastly, informational power was measured by five items.

- I have knowledge of the inner technical workings of my hospital that make my job easier.
- I have knowledge of the inner personal workings of my hospital that make my job easier.
- I understand the reasoning behind why I perform the tasks that I do in a certain manner.
- I understand the reasoning behind the managerial decisions that are made.
- I have knowledge of which resources to seek outside of my hospital to make my job easier.

Hinkin and Schriesheim's measures showed high to acceptable levels of internal consistency, acceptable levels of reliability and discriminant validity, and some support for convergent validity (Drea, Bruner, & Hensel, 1993). External consistency was at an acceptable level as well (Borchgrevink & Susskind, 1996). Three single-item instruments have been previously used to measure the five power bases, the latter two of which are slight modifications of the scale proposed by Bachman et. al. in 1966, but all three of the instruments have been shown to have poor content validity, a potential high level of measurement error, and questionable reliability due to their single item nature; for practicality reasons concerning survey time estimate as well as the above-listed concerns, these scales were not included in the survey.

The last section asked demographic information of participants, including educational background, years of experience, years spent working at the hospital, department size, etc. These questions were designed to identify the characteristics that typified modern hospital public relations departments and practitioners. They were also used to examine correlations with roles and perceived powers found in these hospitals.

### **Data Analysis**

The data was subjected to factor analysis to determine which items aligned together regarding roles, powers, and activities. Factors with a Cronbach's alpha below .70 were discarded. Factors loading less than three items were dismissed as well.

### **Role Function Items**

Following the original researchers (Leichty & Springston, 1996), principal components factoring with a Varimax rotation was used to assess role functions to preserve the comparability of the resulting roles with those found in the 1996 study. The principal components method analyzes each measure under the assumption that the

original measures do not have measurement error. Coefficients with an absolute value below 0.4 were suppressed. Initially, seven factors loaded, but only five were kept for this assessment.

The first factor that emerged comprised five items intended to measure PR Catalyst (3 items) and PR Counsel (2 items); thus, this factor is termed PR Catalyst/Counsel, combining the original researchers' categories. The second factor loaded a total of four items for Research (1 item) and PR Training (3 items). The third factor produced included six items that spanned Communication Technician (2 items), PR Counsel (2 items), PR Catalyst (1 item), and Information Acquisition (1 item). As characteristic of a person responsible for diverse activities, the third factor is termed Factotum in this study because it encompasses items that span across several of the Leichty and Springston's (1996) original categories. The fourth factor loaded three Gatekeeping items. The fifth factor loaded four Advocacy items. The sixth (2 Communication Technician items, 1 Research item) factor was dropped because it had a Cronbach's alpha of .64. The seventh (1 Information Acquisition item, 1 Advocacy item) factor was dropped because it had a Cronbach's alpha of .67 and featured only two items—not enough to validate adequate measurement of a theoretical construct.

Thus, factor analysis produced five accepted categories; these factors were each transformed to scales by adding each respective factor's items together, and dividing by the total number of factors—five in this case. The first (Cronbach's alpha = .78), with its PR Catalyst and PR Counsel loadings, resembled the role that Leichty and Springston (1996) term "traditional managers." The second (Cronbach's alpha = .75), with its PR Training and Research alignments, did not follow any of Leichty and Springston's

prescribed roles, and was termed “[Internal] Organizational Auditors” in this study for their focus on assessment and instruction within the organization. The third factor (Cronbach’s alpha = .74) represented items from the widest range of activities, and therefore suited the role of Generalist. The fourth factor (Gatekeeping) had acceptable Cronbach’s alpha reliability of .73 and was most likened to the role Leichty and Springston called “Internals.” The fifth factor (Cronbach’s alpha = .71), composed entirely of Advocacy items, also did not fit any of the prescribed roles exactly, but coincided with Leichty and Springston’s idea of Externals; thus, they were termed “external liaisons” in this study for their focus on external representation and interface with outside publics.

### **Power Items**

Principal axis factoring with a Varimax rotation, suppressing coefficients with an absolute value below 0.4, showed that items loaded as expected for four of five types of power and Raven’s debated sixth power. Initially, items loaded into a seven-factor solution. Coercive power clearly loaded all five items intended to measure the power, with a Cronbach’s alpha of .87. Reward power loaded three items, all intended to measure reward power, at a Cronbach’s alpha of .83. Referent power loaded four items, one of which was an item intended to measure reward power (Cronbach’s alpha = .77). Legitimate power loaded four items (Cronbach’s alpha = .88). The expert and informational powers were divided in the nature of their loadings, spanning across three factor loadings. Factors 6 and 7 were dismissed because while they showed the most decisive loadings of expert versus informational power and Factor 7 had an acceptable Cronbach’s alpha of .79, they were both comprised of too few items to be considered a sufficient measurement of a theoretical construct: Factor 6 featured one item, and

Factor 7 contained two items. Thus, the final power found in this study combined both expert and informational items (2 expert, 2 informational), and as such, was considered the expert/informational power (Cronbach's alpha = .71). Given the lack of agreement between the original researchers French and Raven on the existence of a sixth power (informational), the loadings did not provide a clear answer either. The items were then transformed to scales to represent the five accepted factors into which they loaded.

### **Activity Items: Managerial or Technical**

To test the first hypothesis, the survey items adapted from Kelly (1994) and Gelineau (1979) were subjected to Principal Axis factoring, suppressing items below .40, to determine if the items loaded in a pattern resembling distinct manager and technical scales. Factor 1 clearly loaded four management items (Cronbach's alpha = .73), while Factor 2 consists of four technician items (Cronbach's alpha = .72). Factor 3 was dropped because it had a Cronbach's alpha of .66; Factor 4 was dropped because it loaded one item.

Table 3-1. Role item loadings

Items	Factors				
	F1	F2	F3	F4	F5
Keep management informed of public reactions	0.70				
Take responsibility for success or failure	0.65				
Keep management actively involved	0.55				
Plan and recommend courses of action	0.72				
Operate as a catalyst	0.57				
Formally instruct others, not in PR, how to interact with people outside of the organization		0.82			
Conduct communication audits		0.55			
Informally instruct others, not in PR, how to interact with people outside your organization		0.79			
Work with managers to increase their skills		0.68			
Make communication policy decisions			0.53		
Writing PR materials			0.72		
Collaborate with non-PR people to define and solve problems			0.51		
Keep others in the organization informed			0.51		
Edit/rewrite for grammar and spelling			0.62		
Formally acquire information from sources/groups external to your organization			0.42		
Provide information on a formal basis to groups outside your organization intended to create a favorable image					0.70
Decide what portions of information acquired from outside the organization to transmit to others within the organization				0.85	

Table 3-1. Continued

Items	Factors				
	F1	F2	F3	F4	F5
Decide when to transmit information acquired from outside your organization to others within your organization				0.53	
Decide to whom within your organization to send information obtained from outside sources				0.52	
Provide information informally to groups outside your organization to create a favorable image					0.81
Represent the organization at events and meetings					0.50
Provide information informally to outsiders that will induce them to act favorably to your organization					0.48

F1=Catalyst & Counsel (Traditional Manager); F2=Training ([Internal] Organizational Auditor); F3=Factotum (Generalist); F4=Gatekeeping (Internals); F5=Advocacy (External Liaisons)

Table 3-2. Power item loadings

Items	P1	P2	P3	P4	P5
I can make being at work difficult for people at work	0.88				
I can make things unpleasant for people at work	0.90				
I can give others undesirable job assignments	0.55				
I can give people at work negative attention when they perform in a way that is unsatisfactory to me	0.57				
I can make being at work distasteful for people at work	0.78				
People at work seek my advice consistently on 1 or more specific (work-related) topics		0.49			
I understand the reasoning behind why I perform the tasks that I do in a certain manner		0.60			
I can share my considerable experience and/or training with people at work		0.67			

Table 3-2. Continued.

Items	P1	P2	P3	P4	P5
I can influence people at work getting a promotion			0.57		
I can increase pay levels at work			0.83		
I can influence people at work getting a pay raise			0.90		
I can make people at work feel important				0.56	
I can give people at work positive attention when they perform the way I want them to				0.47	
I can make people at work feel like I approve of them				0.68	
I can make people at work feel personally accepted				0.66	
I can make people at work feel like they should satisfy their job requirements					0.59
I give people at work the feeling that they have responsibilities to fulfill					0.60
I can make people at work feel that they have commitments to meet					0.66
I can make people at work recognize that they have tasks to accomplish					0.58

P1=Coercive; P2=Expert/Informational; P3=Reward; P4=Referent; P5=Legitimate

Table 3-3. Managerial versus technical activity loadings

Producing an employee publication	0.57
Editing and/or Producing an annual report	0.54
Photography/design of non-employee publications	0.76
Advertising/Marketing hospital services	0.53
Managing people	0.64
Conducting evaluative research	0.57
Developing strategic planning/hospital policy decisions	0.53
Recruiting personnel	0.63

F1=Managerial, F2=Technical

## CHAPTER 4 RESULTS

### **Profiles of Practitioners**

A majority of respondents are female (77.4%, n=154). While age ranged from 23 years old to 67 and above, the average age of respondents was 43.3 years (SD=11.6). Nearly all respondents were employed in a full-time position (94.9%, n=186). Practitioners had worked on average eight years (SD=6.96) at their current hospital, having just over a decade (M=10.87, SD=10.21) of outside experience in public relations (PR) aside from their current position. Nearly a quarter (24%, n=46) of practitioners claimed zero years of experience outside their current position. Almost half (49.7%, n=93) of respondents reported an income of \$70,000 or more, while 26.8% (n=50) earn between \$50,000 and \$69,999.

### **Hospitals**

Hospitals in a minimum of 37 states are represented in this study. Professionals work in hospitals that average 474 (SD=1,941.22) staffed beds, 12,414 (SD=10,514.26) total annual discharges, and \$1,329,588.17 (SD=4,358,247.57) in gross patient revenue. A handful of hospitals that had staffed bed numbers of more than 1,000 account for the large deviations. Most respondents work in a hospital that has a public relations department (85.4%, n=170), with an average of four people (SD=4.65) working in the department in a public relations capacity. However, 32.4% (n=60) of respondents reported themselves as the sole person in the public relations position. Practitioners represented hospitals in every region of the United States. The Southeast (32.5%, n=54) and UpperMidwest (20.5%, n=34) were most heavily present, while professionals in New England (3.6%, n=6) and West (6%, n=10) hospitals were least present.

## **Practitioner Roles in Hospitals (RQ1)**

### **Daily Activities and Practice**

The most commonly reported types of public relations activities practitioners engage in are media relations (M=4.75, SD=.58) and community relations (M=4.40, SD=.89). For example, most practitioners (81.3%, n=169) reported that they practice media relations on a daily basis. Employee relations (M=3.68, SD=1.14), crisis management (M=3.62, SD=1.12), and patient relations (M=3.16, SD=1.18) fell into the middle range. Least common among the type of public relations activities practiced on a daily basis were international relations (M=1.69, SD=1.26) and investor relations (M=1.54, SD=1.08). Seventy-four percent (n=154) reported that they never practiced investor relations, for instance.

In terms of specific activities, writing news releases/responding to media inquiries (M=4.84, SD=.55), advertising/marketing hospital services (M=4.24, SD=1.30), and producing an employee publication (M=4.16, SD=1.20) were the top three activities reported by hospital public relations professionals. From these top three, for example, 78.4% (n=163) of respondents said that they are nearly always involved with advertising/marketing hospital services. Most of the other activities listed were also rated largely on the positive end of the spectrum, as seen in the following examples. Seventy-two percent of respondents (n=150) said that they are nearly always engaged with photography/design of non-employee publications, as well as with coordinating fundraising/special events/press conferences. A majority of respondents also nearly always engage in giving speeches to community groups and representing the hospital at events (59.2%, n=123) and managing people (55.8%, n=116). However, less than half of respondents report the same high, positive level of involvement with developing

strategic planning/hospital policy decisions (47.3%, n=98) and counseling hospital management/governing board (43.8%, n=91). The three activities least often performed are recruiting personnel (M=1.91, SD=1.04), contacting public officials/legislators (M=2.70, SD=1.31), and conducting evaluative research (M=2.92, SD=1.25). Table 4-1 at the end of the chapter shows that practitioners rated technical items higher on average than they did managerial items, lending support for Hypothesis 1—that practitioners are practicing roles that demonstrate higher technical activity than managerial.

A paired samples T-test revealed support for Hypothesis 1, the idea that practitioners practice roles that focus more on high technical activity (M= 3.99, SD= 1.02) than managerial activity (M= 2.92, SD= .91),  $t(205) = -13.64$ ,  $p = .00$ ,  $\alpha = .05$ . In addition, Factor 1 (PR Catalyst/PR Counsel), which represented the Traditional Manager role, was compared with Factor 6, which consisted of two Communication Technician items that loaded together: Produce pamphlets/brochures and do photography/graphics. Factor 6 loaded a Research item as well, but this item was dropped to achieve an acceptable Cronbach's alpha of .71. A paired samples T-test also supported the idea that practitioners practice roles that focus on higher technical activity (M= 4.14, SD= 1.12) more than managerial activity (M= 4.35, SD= .59),  $t(207) = 2.51$ ,  $p = .01$ ,  $\alpha = .05$ . Therefore, this study provides evidence in support of H1.

## **Roles**

From the five factors identified, practitioners displayed highest involvement with the Advocacy (n=205, M=4.36, SD=.64), Catalyst/Counsel (n=207, M=4.35, SD=.59), and Factotum functions (n=203, M=4.34, SD=.52); thus, the top three roles practitioners represent are External Liaisons, Traditional Managers, and Generalists. They also

identified positively with the Gatekeeping role function (n=207, M=4.05, SD=.77); hence, the role of the Internal is present in hospital public relations as well. Furthermore, professionals indicated that they are moderately involved in PR Training processes (n=206, M=3.24, SD=.86), and thus, engage in some level of the [Internal] Organizational Auditing role.

### **Perceived Power in Hospitals (RQ2)**

Public relations practitioners believe they have high levels of expert/informational power (n=201, M=4.33, SD=.51) and referent power (n=202, M=4.16, SD=.58). They also perceive they have some measure of legitimate power (n=200, M=3.81, SD=.79). However, they do not perceive themselves to have much reward power (n=203, M=2.5, SD=.96) or coercive power (n=196, M=2.40, SD=.90).

Looking at the powers breakdown further, 84% (n=169) of practitioners reported that they have expert/informational power within their hospital, while .5% (n=1) reported they do not possess that power. Similarly, 71.9% (n=145) perceive that they wield referent power, while only 3% (n=6) do not believe that they do. Just more than half of hospital public relations practitioners (54.5%, n=109) reported they have legitimate power; however, since only 12% (n=24) believe they do not have legitimate power, there was a sizeable group of practitioners offering neutral responses on the subject. Lastly, reward power and coercive power are remarkably absent in hospital public relations practice: 10.8% (n=22) of practitioners said they have reward power, while only 4.6% (n=9) believed that they have coercive power.

## Potential Predictors of Power (RQ3)

### Demographic Correlations

Years of experience in public relations was not statistically correlated with the different types of power practitioners believe they possess. Both years of professional experience aside from current position in hospital and years of experience as public relations professional at current hospital were tested, but showed no correlations with power perceptions. Likewise, there was no significant correlation between the size of a hospital's public relations department, signified by total number of beds, and the types of power professionals believe themselves to practice.

### Correlations with Roles

The PR Catalyst/Counsel Factor, representing Traditional Managers did not correlate as expected. Statistical correlations were found with referent,  $r(199) = .33, p < .01$ ; legitimate,  $r(197) = .32, p < .01$ ; and expert/informational powers,  $r(198) = .40, p < .01$ . Hypotheses H2c and H2d are supported. There was a significant, if weak, correlation with reward power,  $r(200) = .18, p < .05$ , indicating support for H2b. The expected strong correlation with coercive power was absent  $r(195) = -.05, p = .52$ , indicating H2a is not supported. Furthermore, the correlation with referent power was unexpected.

The PR Training Factor, which represents the [Internal] Organizational Auditor role showed no strong correlations. Weak statistical correlations were found for reward power,  $r(199) = .17, p < .05$  and legitimate power,  $r(196) = .19, p < .05$ .

Factotum, which indicates Generalists, showed some statistical correlation with the referent,  $r(195) = .28, p < .01$ ; legitimate,  $r(193) = .27, p < .01$ ; and expert/informational powers  $r(194) = .34, p < .01$ ; therefore, there is support for H2o,

H2p, and H2q respectively. The expected correlation with coercive power,  $r(192) = -.01$ ,  $p = .87$  was absent, as was the expected correlation with reward power,  $r(198) = .06$ ,  $p = .42$ ; therefore, H2m and H2n are not supported.

The Gatekeeping Factor, capturing Internals, shows statistically significant, but weak correlations with referent,  $r(199) = .20$ ,  $p < .01$ ; legitimate  $r(197) = .33$ ,  $p < .01$ ; and expert/informational powers,  $r(198) = .25$ ,  $p < .01$ . Thus, H2k and H2l are supported, although the correlations are not strong. The originally anticipated presence of coercive power,  $r(195) = -.04$ ,  $p = .54$ , and reward power,  $r(202) = .13$ ,  $p = .07$ , is absent in the final results. Hypotheses 2i and 2j are not able to be supported.

Lastly, External Liaisons—the Advocacy Factor—were not correlated with any of the powers. Notably this role lacked the statistical correlation with expert/informational power,  $r(198) = .10$ ,  $p = .15$ ; thus, hypothesis 2e is not supported. Hypotheses 2f, 2g, and 2h are supported in the absence of correlations with coercive,  $r(194) = -.09$ ,  $p = .21$ ; reward  $r(200) = .07$ ,  $p = .32$ ; and legitimate powers,  $r(198) = .12$ ,  $p = .10$ .

#### **Educational Training (RQ4)**

Almost all respondents had some form of higher education: Nearly two-thirds of respondents (62.8%,  $n=125$ ) held a four-year (B.A./B.S.) degree, 29.1% ( $n=58$ ) a master's degree, and 2% ( $n=4$ ) a doctoral degree. Most practitioners held a degree in a communication-related field, though not necessarily specifically public relations; in fact, only 16.2% ( $n=32$ ) claimed to have a final degree in public relations. Journalism was the most prominent final degree category, but even that totaled only 18.7% ( $n=37$ ) of survey-takers.

No significant correlations were found to indicate that level of educational training (i.e. two-year, four-year, master's degree, etc.) was related to roles (RQ4a). Likewise,

no significant correlations were found between level of educational training and perceived power (RQ4b). A very weak statistical correlation was found with reward power,  $r(192) = .16, p < .05$ .

Table 4-1. Mean scores of managerial versus technical items

Items	Mean	Std Dev
Managing people	3.58	1.38
Conducting evaluative research	2.91	1.25
Developing strategic planning/hospital policy decisions	3.27	1.20
Recruiting personnel	1.92	1.04
Producing an employee publication	4.16	1.20
Editing and/or producing an annual report	3.57	1.57
Photography/design of non-employee publications	3.98	1.39
Advertising/marketing hospital services	4.24	1.30

## CHAPTER 5 DISCUSSION

Hospital public relations practitioners' work is mostly media and community-centric—a finding that is not surprising, given the heavy use of the media from any public service industry as an outlet for communication with the external community. As former American Hospital Association chairman Richard Umbdenstock noted, “Community support built the nation’s hospitals” (2006, p. 4). Umbdenstock stressed that in this communication age in which publics demand transparency from institutions, “it’s more important than ever that hospitals...strengthen their ties with their communities” (2006, p. 5). The community connection, he argued, extends its significance beyond the immediate context to larger advocacy trials, meant to trickle upwards to policy decision-makers in government, the media, and opinion leaders. The absence of international scope to practitioners' work and lack of contact with public officials/legislators indicates that hospital public relations professionals define their “community” in a directly local context.

Aside from the focus on media and community, hospitals hire one to a handful of public relations professionals to encompass a variety of communications activities, rather than for specialized modes. The absorption of Leichy and Springston's (1996) Formal Research items into other factors following this study's factor analysis suggests that research has become a function that practitioners in many roles must engage in. Marketing activities are among those expected of professionals, as many hospitals combined the marketing and public relations departments. Thus, professionals who are not adaptable to multi-disciplinary work may find it difficult to meet the demands of hospitals that require more range from their communication employees.

Practitioners reported high involvement with developing strategic planning/hospital policy decisions, but their lack of coercive power perhaps shows that while there has been movement toward involving public relations in management activities, they have not yet attained that leverage within the hospital's organizational structure according to the traditional definition of a manager in most disciplines. While Cho (2006) specifically studied media relations, his similar finding of the lack of coercive power health public relations practitioners perceive they have aligned with this study's findings. Cho's suggestion that this lack of coercive power could indicate that health public relations practitioners "seem to play a fair game" (2006, p. 575) could be applicable to hospitals as well. To clarify this idea, public relations professionals may disagree with, or be at odds with, the demands of some of the various publics of a hospital; however, if a practitioner is to fairly and ethically manage the relationships of an organization's stakeholders, accommodation and understanding may be the appropriate response in lieu of forcefulness.

The powers practitioners most strongly perceive themselves to possess are referent, legitimate, and expert/informational, while most estimated they have very little reward power within the hospital. These findings suggest that hospital public relations practitioners enjoy personal sway at their workplace, without having much tangible reward or compensation to offer others for that exchange of power. Public relations educators can evaluate the public relations coursework currently offered at universities to determine if they are adequately preparing students to possess referent, legitimate, and expert/informational powers in practice. Consumers of hospital services can take the lack of coercive power and the prevalence of referent, legitimate, and

expert/informational powers in public relations to indicate how well practitioners may be able to serve as advocates for patient interests in the organization; the powers public relations practitioners displayed are based in understanding rather than force.

Equal numbers (9.6%, n=19) reported final degrees in marketing and business, and a small number (5.1%, n=10) held a degree in health administration; while an educational background in journalism or a communication-related field is most prevalent, the results show that a specific degree in public relations is not necessary to enter this line of work. The number of higher education degrees hospital public relations practitioners hold, however, has only slightly increased from those recorded in Gelineau's (1979) review over 30 years ago. Surprisingly, the size of public relations departments, as indicated by the number of public relations professionals in the department, has increased only a little since the 1979 study. A possible reason for this lack of expansion may include hospital budget cuts and the current overall financial crisis seeping into all sectors of the United States economy, as Gordon and Kelly noted the immediate effect of budget cuts on hospital public relations departments even in 1999. Another possible explanation is that public relations responsibilities are being delegated to other departments or that hospital management does not view public relations as a necessary function that hospitals need.

### **Limitations**

While a number of state hospital associations and regional hospital public relations organizations affiliated with the Society for Healthcare Strategy and Market Development agreed to distribute the survey to their members working in hospital communications, not all states were responsive to the request for distribution; thus, some states are better represented than others. Furthermore, the second method of

distribution, which included survey distribution to a sample of 800 chosen from the American Hospital Directory, may have yielded some responses outside the public relations field. Due to unavailability of contact emails for all public relations contacts online, in cases where no public relations contact was to be found, the survey invitation was addressed to the Department of Public Relations, but submitted through the hospital's general "Contact Us" form with a request to forward.

The initial method of contact email collection proposed (telephoning hospitals) was found to be ineffective when implemented on the mass scale needed to provide the desired sample size; of the 443 hospitals telephoned in July-August, contact emails were garnered for 149 hospitals, while 79 responded they did not have a public relations employee and the remaining number were unresponsive despite messages left on their machines. Thus, the telephone approach was abandoned for the email/contact us method. However, influence of entirely non-public relations personnel was limited by screening those responses out of the final response set.

The data collection period of this study was extended first to accommodate those regional associations that required board approval for survey distribution. When these efforts yielded insufficient response, a three-fold effort to boost the number of initial responses was made by sending out second requests to unresponsive associations, emailing the sample of 800, and posting on the Public Relations Society of America Health Academy's social networking sites. Survey timing proved difficult in regard to vacation time: a number of auto-response emails received indicated practitioners were out-of-office at various points of the holiday season. Thus, the survey concluded in the week following the New Year.

A major limitation this study faced is the combination of titles many of the respondents hold: specifically those with titles such as “marketing and public relations coordinator” or “director of communications.” While marketing and public relations, for example, are based in distinct academic principles of their specific communication disciplines, the combination of these two disciplines into one job title or position made it difficult to entirely isolate the public relations influence; it can also be used as an indication that employers want employees who can bridge multi-disciplinary practice.

In Leichty and Springston’s (1996) study, the eight role factors identified were subjected to cluster analysis to produce the five roles used as the basis of their study. However, a viable cluster analysis could not be replicated. Thus, as a substitute, the role factor loadings were examined to determine which of Leichty and Springston’s roles they most resembled. The first factor fit the notion of Traditional Managers because it loaded both PR Counsel and PR Catalyst items, but lacked the above-average levels of Gatekeeping, Information Acquisition, and Advocacy originally found. The second factor did not match any of Leichty and Springston’s roles and became the new role of [Internal] Organizational Auditor. The third factor resembled the Generalist description in its loadings of Communication Technician, PR Catalyst, PR Counsel, and Information Acquisition items. The fourth factor, while likened to Leichty and Springston’s Internal role, featured only Gatekeeping items and lacked the high technical activity and high PR Catalyst activities expected. The fifth factor, dubbed “External Liaisons” to resemble the Externals role, was composed entirely of Advocacy items and lacked the high levels of technical activity and Information Acquisition expected.

Another limitation concerned the ability to adequately test the first hypothesis. Only two of the Communication Technician items loaded together in the Principal Components analysis, and the clustering could not be completed to determine a Traditional Managers grouping according to Leichty and Springston's original method. Thus, for the purpose of answering H1, the discarded sixth factor—that of Communication Technician—was compared to Factor 1 in a paired samples T-test; however, the items used from Kelly (1994) and Gelineau's (1979) studies were also subjected to paired samples T-testing as a supplemental measure.

Lastly, the survey items are all self-assessed measures. Especially in regard to one's perception of his or her level of power within an organization, this type of measurement leaves room for error for the professional who perceives himself to be more or less powerful than he is in actuality, or for the one who desires to be seen as more powerful and so reports his levels as higher to fit a more desirable profile. However, the argument is made that the practitioner is the best person to estimate his own power levels because he experiences them firsthand and most intimately. If a practitioner *feels* powerful, it is likely because he *is* experiencing some measure of power.

### **Suggestions for Future Research**

Further testing needs to be done to clarify and refine new role measures, such as those proposed by Leichty and Springston (1996). Not only do the items need to be tested by confirmatory factor analysis to determine if they accurately measure what they are intended to measure, but the role categories need conceptual clarification. The loadings of this study did not reflect strong evidence for the need for eight factors to measure role behavior, for example. Furthermore, the outlier category that Leichty and

Springston propose, in particular, lacks a strong conceptual basis and is the weakest role category. However, the impetus for new role studies that diverge from traditional accepted theory is both needed and well-timed, as there has not been extensive research into alternative role proposals in decades; with the rapid evolution of new communication methods over the past decade alone, public relations roles must be reexamined to determine what new expectations exist for professionals in this field. Encroachment from other professions may be prevented if practitioners are prepared to meet the demands of the new communication climates into which their hospitals have been thrust.

From social psychology, more research on the possible existence of a sixth power should be conducted, as the loadings from this study showed split evidence for its existence. Examining power perceptions in different types of public relations (i.e. public affairs, investor relations, international relations) would be able to show the position of public relations within other types of organizations as well as test Cho's (2006) idea that coercive power is almost antagonistic to the goal of public relations.

## LIST OF REFERENCES

- American Hospital Association. (2009). Beyond health care: The economic contribution of hospitals. Retrieved 12 December 2010, from the World Wide Web: <http://www.aha.org/aha/research-and-trends/health-and-hospital-trends/2009.html>.
- Berkowitz, D., & Hristodoulakis, I. (1999). Practitioner roles, public relations education, and professional socialization: An exploratory study. *Journal of Public Relations Research, 11* (1), 91-103.
- Bolam, B., Mclean, C., Pennington, A., & Gillies, P. (2006). Using new media to build social capital for health. *Journal of Health Psychology, 11* (2), 297-308.
- Borchgrevink, C. P., & Susskind, A. M. (1996). The validity of the Hinkin and Schriesheim power scales and superior-subordinate power relationships within hospitality. *Journal of Hospitality & Tourism Research, 20* (1), 39-55.
- Bronn, P. & Bronn, C. (2000). A reflective stakeholder approach: Co-orientation as a basis for communication and learning. Paper presented at the 7<sup>th</sup> International Public Relations Research Symposium.
- Broom, G. M., (1982). A comparison of sex roles in public relations. *Public Relations Review, 8* (3), 17-22.
- Broom, G. M., (2009). Cutlip & Center's effective public relations. (10<sup>th</sup> ed.). New Jersey: Pearson.
- Broom, G. M., Casey, S., & Ritchey, J. (1997). Toward a concept and theory of organization-public relationships. *Journal of Public Relations Research, 9* (2) 83-98.
- Bruning, S. D., Castle, J. D., & Schrepfer, E. (2004). Building relationships between organizations and publics: Examining the linkage between organization-public relationships, evaluations of satisfaction, and behavioral intent. *Communication Studies, 55* (3), 435-446.
- Bruning, S. D., & Ledingham, J. A. (1999). Relationships between organizations and publics: Development of a multi-dimensional organization-public scale. *Public Relations Review, 25* (2) 157-170.
- Busch, P. (1980). The sales manager's bases of social power and influence upon the sales force. *The Journal of Marketing, 44* (3), 91-101.
- Centers for Disease Control and Prevention. 2009 H1N1 flu (swine flu). Retrieved 30 September 2009, from the World Wide Web: <http://www.cdc.gov/H1N1FLU/>.

- Cho, S. (2006). The power of public relations in media relations: A national survey of health PR practitioners. *Journalism & Mass Communication Quarterly*, 83 (3), 563-580.
- Cho, S., Cameron, G. (2007). Redefining the power of public relations in organizations: A national survey of health PR practitioners. Conference paper presented at the International Communication Association.
- Dolan, P. (2009). Should doctors use Twitter? American Medical Association. Retrieved 18 October 2010, from the World Wide Web: <http://www.ama-assn.org/amednews/2009/06/29/bisa0629.htm>.
- Drea, J. T., Bruner, G. C., & Hensel, P. J. (1993). Comparing alternative measure of the French and Raven power bases. *Journal of Personal Selling & Sales Management*, 13 (4), 73-80.
- Drevdahl, D., Dorcy, K., & Grevstad, L. (2001). Integrating principles of community-centered practice in a community health nursing practicum. *Nurse Educator*, 26 (5), 234-239.
- Dutta, M. & Basu, A. (2008). Meanings of health: Interrogating structure and culture. *Health Communication*, 23 (6), 560-572.
- Dwyer, R., & Walker Jr., O. (1981). Bargaining in an asymmetrical power structure. *The Journal of Marketing*, 45 (1), 104-115.
- Ferguson, M. (1984). Building theory in public relations: Interorganizational relationships as a public relations paradigm. Paper presented at the Association for Education in Journalism and Mass Communication Annual Convention.
- Fox, S. & Jones, S. (2009). The social life of health information. Pew Internet and American Life Project. Retrieved 5 November 2010, from the World Wide Web: <http://www.pewinternet.org/Reports/2009/8-The-Social-Life-of-Health-Information/01-Summary-of-Findings.aspx?r=1>.
- French, J. & Raven, B. (1959). Ott, J., Parkes, S., & Simpson, R. (Eds.). (2003). The bases of social power. *Classic Readings in Organizational Behavior*. 400-409. Belmont, CA: Wadsworth.
- Gelineau, S. D. (1979). Hospital public relations: A contemporary profile. *Public Relations Quarterly*, 24 (1), 10-15.
- George, G., & Sleeth, R. (2000). Leadership in computer-mediated communication: Implications and research directions. *Journal of Business and Psychology*, 15 (2), 287-310.

- Gordon, C. G., & Kelly, K. S. (1999). Public relations expertise and organizational effectiveness: A study of U.S. hospitals. *Journal of Public Relations Research*, 11 (2), 143-165.
- Gray, J. (2008). Message framing: A communication strategy for the medical encounter. *Journal of Communication in Healthcare*, 1 (4), 422-430.
- Grunig, J. E. (1978). Defining publics in public relations: The case of a suburban hospital. *Journalism Quarterly*, 55 (1), 109-124.
- Grunig, J. E. (Ed.). (1992). Excellence in public relations and communication management. Lawrence Erlbaum Associates: New Jersey.
- Guth, D., & Marsh, C. (Eds.). (2007). Public relations: A values-driven approach. (3<sup>rd</sup> ed.). Boston: Pearson.
- Hansen-Horn, T., & Dostal Neff, B. (Eds.). (2008). Public relations: From theory to practice. Boston: Pearson.
- Harris, G. (2009, September 2). Pfizer pays \$2.3 billion to settle marketing case. The New York Times. <http://www.nytimes.com/2009/09/03/business/03health.html>
- "Healthy People 2020: The road ahead." (2009). U.S. Department of Health and Human Services. Retrieved 16 November 2010, from the World Wide Web: <http://www.healthypeople.gov/hp2020/>.
- Hendrix, J., & Hayes, D. (Eds.). (2007). Public relations cases (7<sup>th</sup> ed.). Belmont: Thomson Wadsworth.
- Hinkin, T. R., & Schriesheim, C. A. (1989). Development and application of new scales to measure the French and Raven (1959) bases of social power. *Journal of Applied Psychology*, 74 (4), 561-567.
- Hon, L., & Grunig, J. E. (1999). Guidelines for measuring relationships in public relations. Institute for Public Relations. Retrieved 13 October 2010, from the World Wide Web: [http://www.instituteforpr.org/files/uploads/Guidelines\\_Measuring\\_Relationships.pdf](http://www.instituteforpr.org/files/uploads/Guidelines_Measuring_Relationships.pdf)
- Jones, L. & Watson, B. (2009). Complex health communication: A language and social psychological perspective. *Journal of Language and Social Psychology*, 28 (2), 115-118.
- Kane, G. C., Fichman, R. G., Gallaughier, J., & Glaser, J. (2009, November). Community relations 2.0. *Harvard Business Review*, 45-50.

- Kasabov, E. (2007). Power and opposition to power: Mirror realities of complex consumption interactions. *Journal of Marketing Theory and Practice*, 15 (4), 365-375.
- Kelly, K. S. (1994). Fund-raising encroachment and the potential of public relations departments in the nonprofit sector. *Journal of Public Relations Research*, 6 (1), 1-22.
- Kent, M. L., & Taylor, M. (1998). Building dialogic relationships through the World Wide Web. *Public Relations Review*, (24) 3, 321-344.
- Kent, M. L., & Taylor, M. (2002). Toward a dialogic theory of public relations. *Public Relations Review*, (28) 21-37.
- Khanfar, N., Polen, H., & Clauson, K. (2009). Influence on consumer behavior: The impact of direct-to-consumer advertising on medication requests for gastroesophageal reflux disease and social anxiety disorder. *Journal of Health Communication*, 14: 451-460.
- Ki, E. J. & Shin, J. H. (2006). Status of organizational-public relationship research from an analysis of published articles, 1985-2004. *Public Relations Review*, 32, 194-195.
- King, B., & Scrimger, J. (1993). Public relations fund raising and marketing in Canadian hospitals: The potential for encroachment. *Public Relations Quarterly*. 40-45.
- Knight, M. (1999). Getting past the impasse: Framing as a tool for public relations. *Public Relations Review*, 25 (3), 381-198.
- Koslowsky, M., & Schwarzwald, J. (1993). The use of power tactics to gain compliance: Testing aspects of Raven's (1988) theory in conflictual situations. *Social Behavior and Personality*, 21 (2), 135-144.
- Kudisch, J., Poteet, M., Dobbins, G., Rush, M., & Russell, J. (1995). Expert power, referent power, and charisma: Toward the resolution of a theoretical debate. *Journal of Business and Psychology*, 10 (2), 177-195.
- Kutschker, M. (1985). The multi-organizational interaction approach to industrial marketing. *Journal of Business Research*, 13 (5), 383-403.
- Ledingham, J. A. (2003). Explicating relationship management as a general theory of public relations. *Journal of Public Relations Research*, 15 (2), 181-198.
- Leichty, G., & Springston, J. (1996). Elaborating public relations roles. *Journalism & Mass Communication Quarterly*, 73 (2), 467-477.
- L'Etang, J., & Pieczka, M. (Eds.). (2006). *Public relations: Critical debates and contemporary practice*. New Jersey: Lawrence Erlbaum.

- Mayo, D., Richardson, L., & Simpson, J. (1998). The differential effects of the uses of power sources and influence strategies on channel satisfaction. *Journal of Marketing Theory and Practice*, 6 (2), 16-24.
- McAllister-Spooner, S. (2009). Fulfilling the dialogic promise: A ten-year reflective survey on dialogic Internet principles. *Public Relations Review*, (35) 320-322.
- McDaniel, S., Futrell, C., & Parasuraman, A. (1985). Social power bases of marketing executives: The relationship with organizational climate. *Journal of Business Research*, 13 (1), 77-85.
- Moon, S. (2007, March). Hospitals gear up for battle over new round of budget cuts. *Hospital & Health Networks*, 14.
- Narayandas, D., & Rangam, V. (2004). Building and sustaining buyer-seller relationships in mature industrial markets. *The Journal of Marketing*, 68 (3), 63-77.
- National Prevention Information Network. "Health Communications Strategies." Retrieved 12 October 2010, from the World Wide Web: <http://www.cdcnpin.org/scripts/campaign/strategy.asp>.
- Neuhauser, L., Sparks, L., Villagran, M., & Kreps, G. (2008). The power of community-based health communication interventions to promote cancer prevention and control for at-risk populations. *Patient Education and Counseling*, 71 (3), 315-318.
- Newsom, D. (1977). PR education: It's more important than most employers think. *Journalism Educator*, 32 (2), 35-37.
- Newsom, D., Turk, J., & Kruckeberg, D. (Eds.). (2000). This is PR: The realities of public relations (7<sup>th</sup> ed.). Belmont: Wadsworth.
- Park, H., & Reber, B. (2008). Using public relations to promote health: A framing analysis of public relations strategies among health associations. Paper presented at the annual meeting of the International Communication Association.
- Parkinson, M., & Ekachai, D. (Eds.). (2006). International and intercultural public relations: A campaign case approach. Boston: Pearson.
- Parrott, R. (2004). Emphasizing "communication" in health communication. *The Journal of Communication*, 54 (4), 751-787.
- Payton, B. (2009, July). Health Academy spring conference recap: Taking the pulse of health care communications. *Public Relations Tactics*.
- (2009, May) "PR blotter." *Public Relations Tactics*. 4-4.

- Popovich, P., Warren, M. (2010). The role of power in sexual harassment as a counterproductive behavior in organizations. *Human Resource Management Review*, 20 (1), 45-53.
- Porrini, P. (2006). Are investment bankers good for acquisition premiums? *Journal of Business Research*, 59 (1), 90-99.
- Public Relations Society of America. Counselors Academy. (2009). "Health/Medical." Retrieved 13 October 2010, from the World Wide Web: <http://auth.iweb.prsa.org/xmembernet/main/caconnect/caresults.cfm>.
- Quane, M. (1973). No news is good news. *Public Relations Quarterly*, 18 (2) 20-26.
- Ratzan, S. (2007). Leadership in health: A renewed opportunity. *Journal of Health Communication*, 12 (1), 1-2.
- Ratzan, S. (2009). Quality health care and health communication: An ethical and societal challenge. *Journal of Health Communication*, 14 (4), 311-314.
- Raven, B. (2008). The bases of power and the power/interaction model of interpersonal influence. *Analyses of Social Issues and Public Policy*, 8 (1), 1-22.
- Rawlins, B. (2009). Give the emperor a mirror: Toward developing a stakeholder measurement of organizational transparency. *Journal of Public Relations Research*, 21 (10), 71-99.
- Research randomizer. Retrieved 28 May 2010, from The World Wide Web: <http://randomizer.org/form.htm> .
- Rimer, B., & Kreuter, M. (2006). Advancing tailored health communication: A persuasion and message effects perspective. *Journal of Communication*, 56 (Supplement), S181-S204.
- Rogers, E., & Scott, K. (1997, December 10). The Diffusion of Innovations model and outreach from the national network of libraries of medicine to Native American communities. National Network of Libraries of Medicine. Retrieved 20 November, 2010: <http://nnlm.gov/archive/pnr/eval/rogers.html>.
- Sallot, L., & Porter, L. (2003). The internet and public relations: Investigating practitioners' roles and world wide web use. *Journalism & Mass Communication Quarterly*, 80 (3), 603-622.
- Sallot, L., Porter, L., & Acosta-Alzuru, C. (2004). Practitioners' web use and perceptions of their own roles and power: A qualitative study. *Public Relations Review*, 30, 269-278.
- Sarangi, S. (2004). Toward a communicative mentality in medical and healthcare practice. *Communication & Medicine* 1 (1), 1-11.

- Schriesheim, C., Hinkin, T., & Podsakoff, P. (1991). Can ipsative and single-item measures produce erroneous results in field studies of French and Raven's (1959) five bases of power?: An empirical investigation. *Journal of Applied Psychology*, 76 (1), 106-114.
- Seitel, F. (2004). *The practice of public relations* (9<sup>th</sup> ed.). New Jersey: Pearson Prentice Hall.
- Seltzer, T., & Mitrook, M. (2007). The dialogic potential of weblogs in relationship building. *Public Relations Review*, 33: 227-229.
- Servaes, J., & Malikhao, P. (2009). Advocacy strategies for health communication. *Public Relations Review*.
- Singer, N. (2009). A birth control pill that promised too much. *The New York Times*. Retrieved 12 October, 2010:  
[http://www.nytimes.com/2009/02/11/business/11pill.html?\\_r=1&adxnnl=1&adxnnlx=1255590886-AO5+7UmQBNwMb8XxnTRtlw](http://www.nytimes.com/2009/02/11/business/11pill.html?_r=1&adxnnl=1&adxnnlx=1255590886-AO5+7UmQBNwMb8XxnTRtlw)
- Social media and health care today. (2009, June). Metropolitan Chicago Healthcare Council. Retrieved 22 November 2010, from the World Wide Web:  
[http://www.mchc.com/EWEB/docs/files/pa/MCHC\\_SocialMedia\\_WP.pdf](http://www.mchc.com/EWEB/docs/files/pa/MCHC_SocialMedia_WP.pdf).
- Spicer, C. (1997). *Organizational public relations: a political perspective*. Lawrence Erlbaum Associates, New Jersey.
- The campaign to control cancer. Retrieved October 1, 2009 from the World Wide Web:  
<http://www.controlcancer.ca/>
- Thomas, H. (2007). Engaging patients to understand and improve their experience of attending a hospital. *Journal of Communication in Healthcare*, 1 (1), 78-87.
- Thomas, R. (2006). *Health communication*. New York: Springer.
- Umbdenstock, R. (2006, March 20). Reaffirm your hospital's rightful place as a valued, vital community resource. *AHA News*, 4-5.
- U.S. Department of Health & Human Services. Centers for Medicare and Medicaid Services. "Historical." Retrieved 26 January 2010, from the World Wide Web:  
[http://www.cms.hhs.gov/NationalHealthExpendData/02\\_NationalHealthAccountsHistorical.asp#TopOfPage](http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage)
- U.S. Department of Health & Human Services. Centers for Medicare and Medicaid Services. "National Health Expenditure Projections 2008-2018." Retrieved 26 January 2010, from the World Wide Web:  
<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf>

- Van Kooy, M., & Ettinger, W. (2002). Involving medical staff in strategic decisions is key to success. *The Physician Executive*, 38-42.
- Wan, H., & Schell, R. (2007). Reassessing corporate image: An examination of how image bridges symbolic relationships with behavioral relationships. *Journal of Public Relations Research*, 19 (1), 25-45.
- Waters, R. (2007). Advancing relationship management theory: Coorientation and the nonprofit-donor relationship. Dissertation presented to the Graduate School at the University of Florida.
- Wehmeier, S. (2009). Out of the fog and into the future: Directions of public relations, theory building, research, and practice. *Canadian Journal of Communication*, 34 (2), 265-282.
- Weiner, H. (1966). Public relations in health and welfare. *Public Relations Quarterly*, 10 (3-4), 78-80.
- Werbell, M. (Ed.). (2009). *O'Dwyer's directory of public relations firms*. New York: J. R. O'Dwyer Co.
- Wilcox, D., & Cameron, G. (Eds.). (2007). *Public relations: Strategies and tactics* (8<sup>th</sup> ed.). New Jersey: Pearson.
- Wilcox, J., Howell, R., & Breivik, E. (2008). Questions about formative measurement. *Journal of Business Research*, 61 (12) 1219-1228.
- Wise, K. (2001). Opportunities for public relations research in public health. *Public Relations Review*, (27), 475-487.
- Wise, K. (2009). Public relations and health diplomacy. *Public Relations Review*, 35 (2), 127-129.
- Wu, M. (2005). Can American public relations theories apply to Asian cultures? *Public Relations Quarterly* 50 (3), 23-27.
- Wu, M., & Baah-Boakye, K. (2007). A profile of public relations practice in Ghana: Practitioners' roles, most important skills for practitioners, relationship to marketing, and gender equality. *Public Relations Quarterly*, 52 (1), 30-36.
- Wu, M., & Taylor, M. (2003). Public relations in Taiwan: Roles, professionalism, and relationship to marketing. *Public Relations Review*, 29 (4), 473-483.

## BIOGRAPHICAL SKETCH

Christina Bosilkovski is a public relations graduate student with a Bachelor of Arts in writing from Ithaca College. She currently lives in her hometown of Buffalo, New York, where she plans to seek employment in hospital public relations. Prior to coming to the University of Florida, she served as Circulation Assistant at Cornell Alumni Magazine.