THE HOSPITAL AND ITS PUBLIC RELATIONS

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INTRODUCTION

Since the enactment of the National Hospital Survey and Construction Act of 1946 (Hill-Burton) more than 80 Mississippi communities have built hospitals and health centers. Some of these were built to replace or complement existing but inadequate facilities. However, most of them were built in communities where no hospital had previously operated.

Many of these new hospitals have experienced a great degree of success in meeting community health needs. Others have experienced varying types and degrees of organizational and administrative problems, including among other things: low rates of occupancy, high rates of staff turnover, heavy charity loads, and in some cases maladministration. Equally as important also has been the failure of some communities to accept the hospital as a part of the institutional structure of the community and to support it in the same sense that the schools, churches and other institutions are supported.

The Problem

This paper reports the findings of a study which was conducted in an effort to determine the acceptance of new Hill-Burton hospitals by the communities in which they have been built. The purposes of the study were: (1) to determine the acceptance of hospitals by their various publics in the community, and (2) to arrive at criteria or standards that could be used by hospital administrators and other hospital personnel for establishing a program of favorable public relations between the hospital, its several publics, and the community at large.

The assumption upon which the study was based was that the hospital as a local institution has a number of different kinds of publics with which it must maintain favorable relationships if it is to render maximum service to the community. The following groups were assumed to be publics of the local hospital: (1) the board of trustees and other governing bodies, (2) personnel employed by the hospital, (3) the medical staff, (4) patients and other persons using the hospital's services, (5) social, public and voluntary agencies, (6) key or prominent people in the community, e.g., the important local leaders, (7) the general public interested in community welfare, (8) the larger general public and (9) the people and groups instrumental in establishing and developing the hospital.

The significance of this type of study was shown when leaders in the hospital field began to look closely at the problems confronting some of the new hospitals in Mississippi. It was first thought that many of the problems of Mississippi hospitals were financial and could be solved through such things as increased use, better billing and collecting procedures, and lower charity loads. However, a closer examination of the problem indicated that it was in part sociological, that in some cases, the new hospitals had failed to become integrated into the institutional structure of the community, that in some instances the hospital did not enjoy the support that the other institutions in the community did; and that gaining this support was dependent upon the establishment of favorable relationships with each of the hospital's publics in the community.

The Design

In keeping with the stated purposes of the study a five-year schedule was established and the study was divided into three phases which were accomplished in succession. The first phase was largely exploratory and was concerned with an analysis of the available statistical data on the general service hospital of 25 or more beds within the state. These data included

*This study was supported by a research grant, W-46, from the National Institutes of Health, Division of Research Grants, U. S. Public Health Service.
information on the hospitals which was on file with the Mississippi Hospital Association, data supplied by the hospitals to the American Hospital Association, and census materials on the county in which the hospitals were located. These data were examined in light of the social, economic and demographic data on the counties in which the hospitals were located. In addition to permitting the testing of several hypotheses with respect to hospital-community relations, the data indicated the number and types of hospitals, trends in the increase of hospitals and hospital beds since 1950, and the size of hospitals in relation to occupancy, length of hospitalization, and hospital costs.

The second phase of the study was concerned with the public relations of hospitals and their administrators. During this phase data were collected from a majority of hospital administrators in the state, either by personal interview or mailed questionnaires. These data were concerned with the history of the hospital, its present status, its equipment, its activities, its personnel, personal and professional characteristics of the administrator, and the administrator's relationships with the board of trustees.

The analysis of these data was made in terms of characteristics of hospitals and administrators which were related to the public relations of hospitals. Prior to the collection of the data the hospitals in the state had been rated as to the quality of their public relations by six persons in public and private agencies whose daily work brought them in close contact with hospitals throughout the state. They were asked to rate the public relations of each general short-term hospital in Mississippi with 25 or more beds, as being either "very good", "good", "average", "poor", or "very poor". This resulted in fifteen hospitals being classified as "good" to "very good", and sixteen as "poor" to "very poor". Sixty-two remaining hospitals received mixed ratings.

Hospitals rated as "good" to "very good" with respect to their public relations were compared with those whose public relations were rated as "poor" to "very poor." This analysis permitted the testing of several hypotheses with respect to the characteristics of hospitals and the role of the administrator in the public relations of the hospitals, and helped set the stage for the final phase of the study.

The final phase of the study consisted of intensive case studies of three hospitals. These were chosen so as to represent three distinct types insofar as the hospital's relationships with its publics were concerned. Personal interviews were conducted with the administrator, the staff, the board of trustees, a representative sample of former and potential patients, and where applicable, members of the hospital auxiliary. The interviews were designed to show the relationship of the hospital with each of these publics and to discern factors in the past and present which might help explain the relationship. It is desirable to examine the findings of the two early phases of the study before proceeding to the discussion of the case studies. The following section, therefore, considers pertinent data on the hospitals and on the hospital administrators in the state.

Characteristics and Trends of Mississippi Hospitals

In 1957 Mississippi had a total of 6,566 short term hospital beds in 114 short term general hospitals and 21 limited service clinics and hospitals. These facilities were located in 72 counties. Short term general hospitals had an average of 55 beds and the limited
service clinics and hospitals averaged 12 beds.

Almost 80 percent of the short term general hospitals were publicly owned and over 70 percent of the limited service clinics and hospitals were privately owned.

From 1950 to 1957 the number of county (Hill-Burton) hospitals increased from 15 to 48. During this time the number owned by nonprofit associations decreased slightly, and the number owned by church bodies, corporations and the state remained largely unchanged.

The number of hospital beds increased from 1950 to 1957 by 35 percent. Of more significance, however, is the fact that the number of "acceptable" beds increased by 51 percent during this time while non-acceptable beds increased by less than one percent.

Nearly two-thirds of Mississippi hospitals and clinics had fewer than 50 beds during 1957. However, less than one-third of the beds devoted to short term care in hospitals were in these smaller hospitals. Only 11 percent of Mississippi hospitals, on the other hand, had 100 or more beds, but these accounted for more than one-third of the short term hospital beds. The larger general hospitals also contained more equipment and staff to perform more complicated procedures. This is reflected in the fact that these hospitals handled nearly as many admissions as the smaller hospitals; that the length of stay in these hospitals was longer than in the smaller ones; and that the average cost per patient in hospitals of 100 or more beds was $110.00 compared to an average cost of $53.37 in hospitals with fewer than 25 beds and an average cost of $63.42, $68.33, and $91.33 for patients in hospitals with 25-49 beds, 50-74 beds and 75-99 beds, respectively.

As would be expected most of the hospitals were located in small towns. Communities with fewer than 2,500 persons contained two-fifths of the hospitals, but only one-fifth of the beds. Communities with fewer than 10,000 persons contained two-thirds of the hospitals and clinics and two-fifths of the beds. Cities of 50,000 or more population had only 4.4 percent of the state’s hospitals, however, these hospitals contained 13.2 percent of the beds.

Characteristics of Hospitals and Hospital-Community Relations

One of the first tasks in the study was to discover the relationship between characteristics of hospitals and the hospitals' relations with their publics. This analysis was made with data which had been supplied by the hospitals to the American Hospital Association and with other available data on hospitals in the state. Due to the nature of the available data this part of the study was primarily concerned with the relationship between the characteristics of hospitals and their relationship with the larger general public or community at large. The analysis was made only for hospitals with 25 or more beds, as it was thought that the smaller hospitals and clinics would be atypical of the general hospitals in the state.

The first consideration in the analysis was with the characteristics of hospitals and of hospital communities which were related to community relations of hospitals. The analysis was made by comparing the characteristics of hospitals which had been judged by the panel of judges to have good community relations with those of hospitals which had been judged to have poor community relations. An examination of the data showed:

(1) Whether the hospital's community relations were "good" or "poor" did not depend upon the percent of occupancy of the hospital, nor the average length of stay for patients.

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(2) Hospitals with good community relations did not necessarily have a low cost per patient and show a profit.

(3) Hospital-community relations were not related to the proportion of bills paid by hospital insurance.

(4) The number of facilities per bed was not related to the community relations of hospitals.

(5) The percentage of increase in bed size was not related to the community relations of hospital.

(6) The size of the hospital community and its location in the state was not related to the hospital’s community relations.

(7) The average income of families and unrelated individuals in the hospital community was not related to the hospital’s community relations.

(8) Hospital-community relations were not related to the racial and residential composition of the county’s population in which the hospital was located.

Characteristics of hospitals which were related to the hospital’s community relations were:

(1) **Age of hospital** — The hospitals which received a high rating in community relations were considerably newer than the low rated hospitals.

(2) **Type of ownership** — A much higher percentage of the high rated hospitals than of the low rated ones were publicly owned.

(3) **Percentage of bills paid by state and charitable organizations** — Low rated hospitals did very little charity work compared to the high percentage of charity care rendered by high rated hospitals.

(4) **Method of founding** — Hospitals founded by M.D.’s were generally rated low in community relations by the panel of judges. Most high-rated hospitals were founded by leaders from the community at large.

(5) **Size of hospital and of hospital community** — Although size of the hospital and of the hospital community were not significantly related to the hospital’s community relations, there was a tendency for high rated hospitals to be above average in size and located in the larger communities. This also meant that these hospitals were better equipped, had higher cost per patient, the average length of stay in these hospitals was longer, and in most cases these hospitals had a staff which could handle a wide variety of cases and procedures.

**The Hospital Administrator and Hospital-Community Relations**

In the early stages of the study it was hypothesized that the hospital administrator is the key person in the promotion of the hospital among its several publics. Three events led to the formulation of this hypothesis. The first was a preliminary survey of a sample of hospital administrators designed to ascertain their conceptions of hospital-public relations and the type of public relations programs which the administrators had. Forty-five administrators were asked to participate, but only 21 cooperated to the extent that they supplied the information requested.

The information supplied showed that the administrators had fairly clear conceptions and programs of effective relations with the board of trustees, the medical staff, personnel employed by the hospital, and with patients and other persons using the hospital. However, very few had clear concepts of public relations with other publics, namely the social, civic and public agencies, the community power group, the general public interested in social welfare, the larger general public and the persons instrumental in founding and developing the hospital.

The second event which gave rise to the belief that the administrator is the key figure in promoting the hospital occurred when the statistical data from the American Hospital Association were analyzed. Administrators of hospitals whose public relations were rated as
“good” to “very good” supplied most of the information asked for by this agency. Administrators of hospitals whose public relations were rated as “poor” to “very poor” supplied considerably less. The most unpopular items of information among the latter group had to do with costs and length of stay. There is reason to believe that many of the administrators of the low rated hospitals either did not have this information or were not interested enough to supply it. Either might be construed as an indication of poor administration.

A rating of hospital administrators by a panel of judges according to the quality of their public relations, and its comparison with the quality of the hospitals’ public relations was the third event which contributed to the belief that the administration is the key figure in promoting the hospital in the community. This comparison showed that all administrators of hospitals which had been rated low in public relations also received ratings on their public relations as only “fair” or “poor”. On the other hand, administrators of all hospitals which were considered to have good public relations received ratings of good.

It was therefore decided to examine more closely the role of the administrator in the hospital’s public relations. This involved the collection of data on administrators and comparing characteristics of administrators of hospitals rated high in public relations with the characteristics of those rated low. As in the previous analysis, these data were primarily concerned with the administrators’ relations with the large general public or community at large.

The analysis showed that several characteristics of administrators were not related to the rating on public relations which their hospitals had received. These were: marital status, number of children, occupation of father, whether or not the administrator was a native of the community in which he works, and whether he was educated in or out of the state.

Several of the characteristics of administrators did prove to be related to their rating on public relations. These were as follows:

1. **Type of job training**—almost all of the administrators of high rated hospitals had had training in hospital administration. Only one administrator of a low rated hospital had had such an experience.

2. **Professional identification**—administrators of high rated hospitals generally identified with only one profession, administration. About one-half of the administrators of low ranked hospitals were M.D.’s and identified professionally with medicine as well as administration.

3. **Salary**—administrators of high rated hospitals received higher salaries than administrators of low rated hospitals. The median annual salary of the first group of administrators was $8,500; for the second group it was less than $5,000.

4. **Job mobility**—administrators of high rated hospitals had changed jobs more frequently than administrators of low rated hospitals with reference to non-hospital jobs. When only hospital jobs were considered, however, the administrators of low rated hospitals had changed jobs more frequently.

5. **Participation in professional organizations**—the participation of administrators of high rated hospitals in professional organizations far outweighed the participation of administrators of low rated hospitals as measured by the number of organizational memberships and the number of offices held.

6. **Participation in community organizations**—administrators of high rated hospitals participated in an average of three community organizations and held two offices in these organizations. Administrators of low rated hospitals belonged to an average of two community organizations and held one office.

As previously stated the first two phases of the study were intended to set the stage for the final phase by sug-
gesting hypotheses which would be examined more closely when case studies were conducted of different hospital situations. However, before the third phase of the study is discussed it is desirable to state the tentative conclusions which were drawn from the earlier phases and to examine these conclusions in light of their practical significance to the hospital service industry.

The statistical data have suggested that the quality of public relations of hospitals is largely dependent upon factors which are not necessarily connected with the hospital itself, but reside within the realm of "human" factors. It is reasonable to assume that these factors may not be the same in every situation. Therefore, it is the responsibility of the administrator who is concerned about the future of his hospital to discover what these factors are and to manipulate them to his hospital's advantage.

For example, the data showed that the quality of public relations of hospitals taken as a group is not related to percent of occupancy, average length of stay per admission, percent of bills paid by hospital insurance, number of facilities per bed, percent of increase in bed size, size and location of hospital community, racial and ethnic composition of hospital community, nor the average income of families in the community. This does not mean, however, that each or any combination of these factors may not be important considerations in individual hospitals. The efficient administrator should, of course, make an effort to discover when any of these factors play a role in the successful operation of his hospital.

The data do show that the quality of the public relations of hospitals taken as a group is related to the age of the hospital, type of ownership, method of founding, percent of bills paid by state and charitable organizations and size of hospitals. The typical hospital in Mississippi with good public relations is thus seen as a rather new hospital, founded by a group of community leaders, which handles a sizeable charity load, and is above average in size.

One cannot conclude from these data, however, that this unique combination of features will predispose good public relations. The examination of data on hospital administrators lends credence to the belief that the fate of the hospital lies largely in the hands of its administrator, at least insofar as public relations are concerned. The data show, for example, that marital status, number of children, occupation of father, community of birth, and place of education for the administrator have no relationship to the quality of the hospital's public relations. But, the administrators of hospitals whose public relations are good are professionally trained hospital administrators, who identify with the profession of hospital administration only, who have stayed in hospital jobs for long periods before changing jobs and participate in a number of professional and community organizations. Each of these factors is in part "human related" and would lead one to believe that the more efficient hospital administrators are cognizant of the "human element" in their job.

There are, of course, other important factors which operate to influence the prestige of the hospital in the community. The above discussion has largely ignored such things as history of the hospital, doctor-hospital relations, the relationship between the hospital administrator and the governing board of the hospital, the expectation of the community with respect to the hospital, and the support which the community is willing to lend to all of its institutions. This complex of factors provides an environment which acts to strengthen or weaken the administrator in his attempts to make his hospital an integral part of the social structure. In the following section consideration will be given to the role of some of these factors in the public relations program of the local hospital when the three case studies are discussed.
ATTITUDES TOWARD THE LOCAL HOSPITAL

The Local Hospital

In this section attention is directed to some findings of the case studies conducted in three hospital communities. One aspect of the case studies involved the measurement of attitudes toward each hospital as expressed by the larger general public in the hospital service area and by former patients of the hospital and their families. It is with this measure of acceptance that the following section will be concerned.

The three hospitals studied exhibited certain distinctive characteristics as well as some characteristics which were common to all hospitals. Each was a relatively new Hill-Burton unit, and each was located in a town of 10,000 or less population. Hospital One was located in South Mississippi in a cotton-truck farming area. Hospital Two was located in Northwest Mississippi in a part hill-part Delta county, and Hospital Three was located in Northeast Mississippi in a cotton-dairy county. There was a relative lack of industry in each county.

The Method

The method employed in this aspect of the study was to observe the attitudes of a sample of white housewives in each county toward the hospital, and to search for factors which might explain the attitudes. Two types of attitudes were tapped. All persons interviewed were asked a series of questions designed to indicate general attitudes toward the hospital. When placed on a continuum these attitudes ranged from thinking about the hospital as a part of the community to its actual support through use contributions, etc. It was felt that these attitudes would indicate general acceptance of the hospital as a part of the community, and these attitudes were used to construct a hospital acceptance index.

If a respondent or some member of their family had used the hospital, a series of questions designed to measure satisfaction with selected aspects of the hospital was asked. These more specific attitudes were combined into an index of hospital satisfaction and introduced as an independent variable in an effort to discern a possible relationship between general acceptance of the hospital and satisfaction with the way the hospital had performed its services.

The Sample

The county is the unit on which the hospital must ultimately depend for support. Therefore, the county was considered the hospital community for the purposes of this study. Persons who were interviewed in each county were chosen when houses were picked randomly from existing road maps of the county so as to yield approximately 30 white households in each of the five beats of the county. Negroes were not included because of their relative lack of use of hospitals, and because of their lack of involvement in community decision making. The sampling ratio varied for each beat depending upon its population characteristics and location. In some beats practically all white housewives were interviewed. Thus, according to rigorous sampling models the sample was an accidental one. However, a comparison of the samples with the county population on selected characteristics showed that the samples were representative of the general county population.

The Hospital Acceptance Index

The hospital acceptance index was constructed from answers to the nine questions designed to elicit general attitudes toward the hospital. The nine questions together with the way they were interpreted were as follows:

(1) What institutions in this community are you proud of? (List in order of rank)
If the hospital was mentioned as one of the first three it was assumed that this was a favorable attitude toward the hospital.

(2) If you were asked to show a visitor or one of your friends the institutions which make this community
a good place in which to live what would you show them? (List in order of rank)
If the hospital was mentioned as one of the first three it was assumed that this was a favorable attitude toward it.

(3) From what you know about hospitals in other communities how do you think the local hospital compares with the others in general appearance? Why?
Better or as good indicated a favorable attitude toward the hospital.

(4) How do you think the local hospital compares with these same hospitals from the point of view of services offered, equipment, etc.? Why?
Better or as good indicated a favorable attitude toward the hospital.

(5) Let's suppose I'm a complete stranger in this area, and I ask you to recommend a hospital for a gall-stone condition, which hospital would you recommend I use? Why?
Mention of the local hospital indicated acceptance of the hospital.

(6) If you discovered that you or some member of your family had a serious heart condition which hospital would you use? Why?
Mention of the local hospital indicated acceptance of the hospital.

(7) If the county tried to float a bond issue for the hospital to use in improving its plant or services would you vote for it? Why?
Yes indicated acceptance of the hospital.

(8) If you had surplus produce from your garden and decided to give it away what would you do with it?
If respondent indicated she would consider giving it to the hospital it was assumed this indicated acceptance of the hospital.

(9) If you had some spare time that you wanted to use to help out in a worthy cause what would you likely volunteer to do? (List in order of preference)
If this hospital was mentioned it was assumed that this indicated a favorable attitude toward it.

Responses to each of these attitude items were recorded for each individual and an item analysis was conducted to determine if the attitudes could be combined into an index of acceptance of the hospital. Scoring of attitudes was dichotomous. Each attitude of acceptance received a score of one, and attitudes which did not indicate acceptance received a score of zero.

The item analysis showed that seven of the attitudes were scalables. Only items eight and nine, those having to do with contributions of surplus produce and free time, did not meet the criteria for the index of acceptance. Thus, on the basis of the seven-item index, each person could receive a possible score of from zero to seven on the acceptance index.

**Findings**

The scores of respondents on the index of acceptance showed that the hospitals enjoyed rather wide acceptance as measured by the number of favorable attitudes expressed. See Table 1. The largest number of attitudes of acceptance was expressed

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3 A system of trace line analysis was used for the item analysis. This involves four basic steps: (1) assigning weights to each attitude item, (2) calculation of scores for each item and a total score, (3) correlating the total score with scores on each item, and (4) plotting the scores to observe direction of the relationship. For a description of this method see J. H. Copp, "Trace Line Analysis, An Improved Method of Item Analysis", unpublished manuscript, University Park, Pennsylvania, 1959.

4 A more comprehensive discussion of the method used to construct this index is contained in Gerald O. Windham and Marion T. Loftin, "Factors Associated with Public Acceptance of a New Hill-Burton Hospital", *Rural Sociology*, 26 (1961), pp. 418-222.

5 This index is believed to be logically valid. However, further use of it is necessary in order to establish its reliability and validity. A recent study in which the hospital acceptance index was used showed that actual use of the hospital and scores on the acceptance index were significantly associated. See: Vaughn Leroy Grisham, Jr., "Hospital-Community Relations in Rural County, Mississippi", unpublished Master's thesis, Mississippi State University, 1961.
toward Hospital two. Only thirty percent of the respondents in the county in which Hospital Two was located made scores of three or less on the hospital acceptance index. This compared to 47 percent of the respondents in the county in which Hospital Three was located, 39 percent of the respondents in the county in which Hospital One was located, and 39 percent of all respondents. These findings agreed with previous findings in the overall project which had indicated that Hospital Two’s public relations programs were superior to those of Hospital One and Three.

The relationship between scores on the hospital acceptance index and several objective factors were observed. Factors which were significantly associated with this index are discussed below under: (1) personal and class related factors, (2) contact with the hospital, and (3) personal influence.6

**Personal and Class Related Factors**

There was no significant association between scores on the hospital acceptance index and age of respondent, stage in the family life cycle, size of family, type of work in which engaged, tenancy status, and number of meetings attended monthly for persons in all of the hospital communities. However, age was significantly associated with hospital acceptance scores for persons in the county where Hospital Two was located. The relationship was negative. Two possible explanations for this relationship were observed. There was a tendency for a preponderance of older persons to express loyalty to a hospital and physicians in an adjoining county. Also a large proportion of older persons felt that they might need charity care if they were to use a hospital, and they thought it would not be easily obtained at Hospital Two.

The other personal and class related factors which were significantly associated with acceptance in some or all of the hospital communities are discussed below.

**Level of Living:** Level of living was significantly associated with scores on the hospital acceptance index for the total sample.7 There was no consistent relationship between scores on the hospital acceptance index and scores on the level of living index. However, there was a tendency for the relationship to be negative. See Table 2.

An examination of the level of living scores and hospital acceptance scores for respondents in each of the three hospital communities showed that there was a significant association between these variables for respondents in the counties in which hospitals One

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6 For more information on this phase of the study see: Gerald O. Windham, Elisabeth J. Stojanovic, and Marion T. Loftin, *Attitudes Toward a New Hill-Burton Hospital in a Northeast Mississippi County*: Mississippi Agricultural Experiment Station, Preliminary Report in Sociology and Rural Life No. 16, State College, 1961; Windham, Stojanovic, and Loftin, *Attitudes Toward a New Hill-Burton Hospital in a South Mississippi County*, Mississippi Agricultural Experiment Station, Progress Report in Sociology and Rural Life No. 18, State College, 1961; and Stojanovic, Windham, and Loftin, "Acceptance of a New Hill-Burton Hospital by Residents of a Northwest Mississippi County", Mississippi Agricultural Experiment Station Information Sheet 698, State College, 1961.

7 Level of living was measured by a nine item index consisting of: bathroom, automatic washer, telephone, separate freezer, vacuum cleaner, hardwood floors, separate dining room, subscription to a daily newspaper, and subscription to two or more popular magazines. These items were selected from a universe of level of living items by item analysis and are internally consistent. See previous note on trace line analysis for a description of the item analysis model used.
and Two were located. In County One the relationship was curvilinear, indicating that the hospital enjoyed the greatest relative degree of acceptance among those who were average on level of living. This appeared to be related also to the hospital's history and to its present policy with respect to charity care. This hospital is new and before it was opened persons went outside the county for hospital service. Many substantial middle class families have continued this practice because of their loyalty to physicians located in areas outside the county. Also this hospital is located near a regional state charity hospital. As a result Hospital One has refused charity patients. Thus, the element of the county population which depends upon charity care is by necessity oriented away from Hospital One.

The relationship between level of living scores and hospital acceptance scores for respondents in the county in which Hospital Three was located was positive. Scores on the hospital acceptance index increased consistently with scores on the level of living index at all levels. Although there was no significant association between levels of living scores and hospital acceptance scores in the county in which Hospital Two was located there was a tendency for these factors to be negatively correlated. This in turn appeared to be related to a number of class related items, such as income, education, tenure status, and place of residence in the county. This is a part hill, part Delta county, and the highest level of living was reported by planters in the latter part of the county. As a rule the planters have expected a large amount of charity care for their cropers and laborers. The hospital has not always honored these requests, and the planters as a result tend to show antagonism toward it.

**Total Family Income:** Total family income was significantly associated with scores on the hospital acceptance index. As with the level of living index there was no clearly discernable positive or negative relationship between the two variables. See Table 3. A classification of respondents in each county by scores on the hospital acceptance index and total family income showed that these variables were significantly associated in each of the three counties. For Hospital One there was a curvilinear relationship for these variables and persons with the lowest and highest income expressed the smallest number of favorable attitudes toward the hospital. Income and hospital acceptance scores were negatively related in the county where Hospital Two was located and, were positively related for respondents in Hospital Three’s county. Thus, as would be expected the relationship between income and hospital acceptance is the same as the relationship between level of living scores and hospital acceptance scores.

### Table 2. Classification of respondents by hospital acceptance scores and level of living scores. *

<table>
<thead>
<tr>
<th>Level of Living Scores</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>0 - 2</td>
</tr>
<tr>
<td></td>
<td>Percent N = 94</td>
</tr>
<tr>
<td>0 - 2</td>
<td>22</td>
</tr>
<tr>
<td>3 - 5</td>
<td>33</td>
</tr>
<tr>
<td>6 - 9</td>
<td>45</td>
</tr>
</tbody>
</table>

*P = .001 as indicated by Kruskal - Wallis analysis of variance model.

### Table 3. Classification of respondents by total family income and scores on the hospital acceptance index.

<table>
<thead>
<tr>
<th>Total Family Income</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2</td>
</tr>
<tr>
<td>0 - 999</td>
<td>16</td>
</tr>
<tr>
<td>1,000 - 2,999</td>
<td>26</td>
</tr>
<tr>
<td>3,000 - 4,999</td>
<td>23</td>
</tr>
<tr>
<td>5,000 - Over</td>
<td>35</td>
</tr>
</tbody>
</table>

*P = .05 as indicated by Kruskal - Wallis analysis of variance model.
in each of the counties. The possible explanation for each relationship is also the same.

**Last Grade of School Completed:** There was no significant association between scores on the hospital acceptance index and last grade of school completed for all respondents. However, there was a tendency for persons who were average in education to make higher scores on the hospital acceptance index. See Table 4. Education and scores on the hospital acceptance index were significantly associated among respondents in the counties where Hospitals One and Three were located. In Hospital One's county these variables were positively related and the number of favorable attitudes expressed toward the hospital increased consistently as education increased. The same relationship was observed in the county in which Hospital Three was located even though the relationship was not statistically significant. In the county where Hospital Two was located there was a negative relationship between education and scores on the hospital acceptance index. This was not surprising in view of the tendency for all class related factors to be negatively related to hospital acceptance scores in this county.

**Formal Social Participation:** Formal participation is a class related factor as well as a communication medium. Therefore, if other class related factors are related to hospital acceptance one would hypothesize that formal participation is also. Number of meetings attended monthly and number of power positions held in voluntary associations were not related to scores on the hospital acceptance index for the total sample. However, there was a significant association between number of organization memberships and hospital acceptance scores. Unlike other class related factors the relationship was positive. See Table 5. There was also a tendency for these variables to be positively related in each of the hospital communities. The role of social participation in promotion of the hospital needs to be examined more closely. Social participation will, therefore, be discussed again in a subsequent section.

**Health Consciousness:** Although health consciousness was not significantly associated with scores on the hospital acceptance index for the total sample, these variables were significantly associated for each of the samples when they were considered separately. Also there was a discernable positive relationship between these variables for the total sample. As the number of recommended health practices followed by respondents in the total sample increased so did the proportion of persons making higher scores on the hospital acceptance index. See Table 6. Thus, as would be expected, those persons who are most concerned with health as indicated by their behavior in following recommended health practices have the most favorable attitudes toward their own county hospital.

Table 4. Classification of respondents by formal education and scores on the hospital acceptance index.*

<table>
<thead>
<tr>
<th>Last grade of school completed</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2</td>
</tr>
<tr>
<td></td>
<td>Percent</td>
</tr>
<tr>
<td>Under 8</td>
<td>29</td>
</tr>
<tr>
<td>8 - 12</td>
<td>46</td>
</tr>
<tr>
<td>13 - 15</td>
<td>15</td>
</tr>
<tr>
<td>16 and over</td>
<td>11</td>
</tr>
</tbody>
</table>

*Not statistically significant.

---

*Health consciousness was inferred from a health practice index consisting of immunization shots within the past year, dental check-up within the past six months, complete medical examination within the past year, and chest X-ray within the past six months. These items were selected by item analysis and are internally consistent. The association between scores on the health practice index and scores on the hospital acceptance index was significant at \( P = .05 \) for Hospital One, \( P = .049 \) for Hospital Two, and \( P = .009 \) for Hospital Three. Kruskal-Wallis one way analysis of variance model was used to test for significance of association.*
Satisfaction with Community Institutions and Hospital Acceptance

The literature on hospital acceptance shows that acceptance has been defined on both the attitudial and behavioral levels. Empirical indexes of acceptance have been use of hospitals, attitudes toward hospitals in general, and likes and dislikes of specific hospitals. Each of these indexes has certain weaknesses. It is felt, for example, that attitudes toward hospitals in general do not measure adequately the acceptance of a particular hospital because Americans tend to express the same attitudes toward hospitals in general that they express toward mother and county. The expression of likes and dislikes toward a particular hospital more nearly measures satisfaction with the hospital than acceptance of it, and use of hospitals ignores that segment of the society which does not have contact with the hospital, but upon whom the hospital must sometimes depend for support in the community. Acceptance has been conceptualized in this study as a number of general attitudes toward a particular hospital. Inasmuch as these attitudes range from thinking about the hospital as a part of the community to its actual support through use and contribution, it is felt that these attitudes will permit inferences to be drawn with respect to the integration of the hospital into the institutional structure of the community.

Tests were made to discern what relationship if any existed between the acceptance of the hospital as measured by scores on the hospital acceptance index and acceptance of other community institutions. There was no significant association between scores on the hospital acceptance index and the way the total sample and respondents in each hospital community felt about their schools, churches, and county officials. There was a significant association between feelings toward the doctors in the community and scores on the acceptance index for the total sample. As scores on the acceptance index increased so did the proportion of respondents who expressed satisfaction toward the doctors in the community. See Table 7. This relationship held for each of the hospital communities. However, the relationship was not as apparent in the county in which Hospital One was located as it was in the other counties. A much higher percentage of respondents in this community than in the other communities expressed dissatisfaction with their doctors. Although there was a tendency for those who expressed dissatisfaction with the doctors to also score low on the hospital

Table 5. Classification of respondents by number of organization memberships and scores on the hospital acceptance index.*

<table>
<thead>
<tr>
<th>Number of Organization Memberships</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2 Percent</td>
</tr>
<tr>
<td></td>
<td>N = 94</td>
</tr>
<tr>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>5 or more</td>
<td>2</td>
</tr>
</tbody>
</table>

*P = .02 as indicated by chi square.

Table 6. Classification of respondents by number of recommended health practices followed and scores on the hospital acceptance index.*

<table>
<thead>
<tr>
<th>Number of Recommended Health Practices Followed</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2 Percent</td>
</tr>
<tr>
<td></td>
<td>N = 94</td>
</tr>
<tr>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>3</td>
<td>26</td>
</tr>
<tr>
<td>4</td>
<td>19</td>
</tr>
</tbody>
</table>

*Not statistically significant.
acceptance index, many qualified their statement to indicate that the hospital was acceptable, but they would not want to use it because of the doctors on its staff.

Feeling toward the county health department and scores on the hospital acceptance index were also significantly associated for the total sample as well as for respondents in each hospital community. The relationship as predicted was positive. See Table 8.

Feeling toward the commercial establishments in the community and the community as a whole were also significantly associated with scores on the hospital acceptance index. In each case the relationship was positive. See Tables 9 and 10.

It may therefore be inferred that feelings toward the county hospital are related to the feelings held toward the other community institutions for a large proportion of the population. Some people hold the hospital in more esteem than they do such institutions as the schools and the churches. Criticism toward these institutions was directed toward specific cases, however, such as forced consolidation of schools resulting in excessive transportation time, and arguments in the church over various matters. As would be expected attitudes toward health related institutions, such as the County Health Department and physicians more nearly influence attitudes toward the hospital than do attitudes toward non-health related institutions. It will also be remembered that health consciousness was positively associated with attitudes toward the hospital. Although a cause

### Table 7. Classification of respondents by feelings toward the doctors in the community and scores on the hospital acceptance index.

<table>
<thead>
<tr>
<th>Feelings Toward the Doctors in the Community</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2 Percent</td>
</tr>
<tr>
<td>Satisfied</td>
<td><strong>N = 84</strong></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td></td>
</tr>
</tbody>
</table>

*P = .01 as indicated by chi square.

**Size of N varies for some tables because of no answers.

### Table 8. Classification of respondents by feeling toward the County Health Department and scores on the hospital acceptance index.

<table>
<thead>
<tr>
<th>Feeling Toward County Health Department</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2 Percent</td>
</tr>
<tr>
<td>Satisfied</td>
<td><strong>N = 66</strong></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td></td>
</tr>
</tbody>
</table>

*P = .01 as indicated by chi square.

### Table 9. Classification of respondents by feeling toward the commercial establishments in the community and scores on the hospital acceptance index.

<table>
<thead>
<tr>
<th>Feeling Toward Commercial Establishments</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2 Percent</td>
</tr>
<tr>
<td>Satisfied</td>
<td><strong>N = 75</strong></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td></td>
</tr>
</tbody>
</table>

*P = .05 as indicated by chi square.

### Table 10. Classification of respondents by feeling toward the community as a whole and scores on the hospital acceptance index.

<table>
<thead>
<tr>
<th>Feeling Toward Community as a Whole</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2 Percent</td>
</tr>
<tr>
<td>Satisfied</td>
<td><strong>N = 89</strong></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td></td>
</tr>
</tbody>
</table>

*P = .001 as indicated by chi square.
and effect relationship cannot be posited between health related factors and attitudes toward the hospital, it seems that a generally favorable complex of attitudes toward health and medicine in general is conducive to the growth and development of a strong county hospital. A following section will examine more closely the role of the physician in the formation of attitudes toward the hospital.

**Contact with the Hospital**

One basis for the formation of attitudes toward any object is experience with the object. However, many persons in rural Mississippi probably do not possess enough knowledge about hospital administration to make objective evaluation of the hospital when they come into contact with it. This is especially true when it is considered that until recently the conception of the hospital in the Southern rural subculture was a place where people go to die. Moreover the present study has shown that the expectations of the hospital as held by many persons in rural Mississippi vary considerably from those held by professional persons in health and medicine and the theories and practices of modern hospital administration. Nevertheless it was hypothesized that experience with the hospital would be associated with the attitudes held toward the hospital. A number of tests of the hypothesis were made for the general public.

**Indirect Contact with Hospital:** Persons were asked if they had made any visits to the hospital in connection with the hospitalization of a friend or a member of their family. It was thought that this would permit the visitor to make some evaluations of his own and to hear the complaints or compliments of the person whom they were visiting. Four hundred and fifty-one persons had made such visits, and those who had visited made significantly higher acceptance scores than those who had not visited. See Table 11.

A similar relationship existed between scores on the hospital acceptance index and indirect contact with the hospital in each of the hospital communities. However, the association between these variables was not significant for the county samples.

**Direct Contact with Hospital:** It cannot be determined, of course, if persons who have visited in the hospital made higher acceptance scores because they were favorable toward the hospital before their visit, because of observation made during their visit, or because they were influenced by what the persons whom they visited said. A classification of the sample according to those who had used the hospital themselves, or had members of their immediate family use it showed, however, that a significantly higher proportion of the total sample who had used the hospital themselves makes higher acceptance scores. See Table 12.

The association between direct contact with the hospital and scores on the acceptance index was also significant for persons in the counties in which Hospital Two and Hospital Three were located. The relationship between these variables was positive in all communities. However, the association was not significant for persons in the county in which Hospital One was located.

**Satisfaction with the Hospital:** Neither type of illness for which hospitalized nor type of room in which hospital stay was spent were significantly associated with scores on the hospital acceptance index. This was true for the total sample as well as for each

---

**Table 11. Classification of respondents by indirect contact with hospital and scores on the hospital acceptance index.**

<table>
<thead>
<tr>
<th>Indirect Contact with the Hospital Through Visits</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had visited</td>
<td>0 - 2 Percent</td>
</tr>
<tr>
<td></td>
<td>N = 94</td>
</tr>
<tr>
<td>Had not visited</td>
<td>3 - 4 Percent</td>
</tr>
<tr>
<td></td>
<td>N = 176</td>
</tr>
<tr>
<td></td>
<td>5 - 7 Percent</td>
</tr>
<tr>
<td></td>
<td>N = 181</td>
</tr>
<tr>
<td><strong>Score</strong></td>
<td>86</td>
</tr>
<tr>
<td><strong>Percent</strong></td>
<td>94</td>
</tr>
<tr>
<td><strong>Percent</strong></td>
<td>97</td>
</tr>
<tr>
<td><strong>Percent</strong></td>
<td>14</td>
</tr>
<tr>
<td><strong>Percent</strong></td>
<td>6</td>
</tr>
<tr>
<td><strong>Percent</strong></td>
<td>3</td>
</tr>
</tbody>
</table>

*P = .01 as indicated by chi square.
individual sample. It was thought, however, that satisfaction with the services received while hospitalized would show a relationship to the general attitudes toward the hospital. Satisfaction was measured by a satisfaction index which consisted of the general reaction of former patients to eight aspects of the hospital's services. These reactions were coded as favorable or unfavorable and scores of one and zero were assigned to each aspect on this basis. The items were subjected to item analysis. However, there was such a high degree of satisfaction expressed with each service that the items were not scalable. Hence, they were combined without regard for scalability.

There was a significant association between scores on the hospital acceptance index and scores on the index of hospital satisfaction for the total sample, and the relationship was positive. A larger proportion of persons with scores of from two to four on the index satisfaction made scores of 0-2 on the acceptance index. As scores on the acceptance index increased so did the proportion of persons making high scores on the index of satisfaction. See Table 13.

There was no significant association between scores on the acceptance index and scores on the index of satisfaction for each of the county samples. However, acceptance and satisfaction increased together in each of the counties.

**Personal Influence**

A number of studies have shown that personal influence and the mass media of communication play an important role in the acceptance of new ideas and techniques by various publics in the community. Thus, it was felt that these channels would also be important in the promotion of the hospital in the community. A number of personal influence and communication factors were therefore cross classified with scores on the hospital acceptance index in an effort to observe the relationship between these factors. Although only three of the personal influence items were significantly associated with scores on the acceptance index for the general public, it was apparent that these factors play a tremendous role in the hospital's total public relations program. The nature

---

**Table 12. Classification of respondents by direct contact with the hospital and scores on the hospital acceptance index.**

<table>
<thead>
<tr>
<th>Direct Contact With Hospital</th>
<th>Hospital Acceptance Scores</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2 Percent</td>
<td>3 - 4 Percent</td>
<td>5 - 7 Percent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N = 35</td>
<td>N = 106</td>
<td>N = 124</td>
<td></td>
</tr>
<tr>
<td>Respondent has been patient</td>
<td>46</td>
<td>62</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>Member of respondent's immediate family has been patient</td>
<td>54</td>
<td>38</td>
<td>34</td>
<td></td>
</tr>
</tbody>
</table>

*P = .01 as indicated by chi square.

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**Table 13. Classification of respondents by scores on the index of hospital satisfaction and scores on the hospital acceptance index.**

<table>
<thead>
<tr>
<th>Scores on the Index of Hospital Satisfaction</th>
<th>Hospital Acceptance Scores</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2 Percent</td>
<td>3 - 4 Percent</td>
<td>5 - 7 Percent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N = 35</td>
<td>N = 106</td>
<td>N = 124</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>12</td>
<td>7</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>20</td>
<td>13</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>30</td>
<td>34</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>27</td>
<td>42</td>
<td>48</td>
<td></td>
</tr>
</tbody>
</table>

*P = .01 as indicated by chi square.

Although scores on the index of hospital satisfaction could range from zero to eight, no one made a score of less than two.

---

*These were: (1) beds, bathrooms, general appearance, etc., (2) nurses, technicians and staff, (3) nursing services, (4) cleanliness, (5) food, (6) visiting hours, (7) rest and recuperative aspects, and (8) treatment from the business office.
of the role of personal influence varied considerably by hospital and was related to the total hospital-community environment of each. These differences will be considered for the most part in a subsequent section. However, relationships which have substantive importance will be considered before proceeding to the more subtle role of personal influence as a part of the hospital-community environment of each hospital.

**Mass Media:** There was no significant association between scores on the hospital acceptance index and reading about the hospital in the county paper, or attending a club meeting where the hospital was discussed as a part of the program for the total sample, or the individual samples when considered separately. A sizeable proportion of persons in the county where Hospital One was located and in the county where Hospital Three was located remembered reading about the hospital in the county paper. In both of these counties, however, the publicity was either unfavorable or involved both favorable and unfavorable aspects. Hence, in both counties the publicity might have done as much harm as good. Fewer persons in Hospital Two's county remembered reading about the hospital in the county paper, but in general the relationship between these variables in this county was positive. This indicates, of course, that favorable publicity does have a generally favorable effect on the hospital if handled correctly.

Attendance at a club meeting where the hospital was discussed as a part of the program was closely related to scores on the acceptance index. However, the association was not significant, due primarily to the small number of respondents who had attended such meetings. The administrator had discussed the hospital with certain community and church groups, in the county where Hospital Two was located and in Hospital Three's county the home demonstration clubs had discussed the county hospital as a part of their general program in health. In both of these counties persons who had attended these meetings made higher acceptance scores than persons who had not attended the meetings. Thus, it appears that social participation may be used effectively by administrators to promote their hospital among the general public. Also in view of the tendency for formal participation to be class related, this medium would be instrumental in reaching the middle

**Table 14. Classification of respondents by whether or not they had read about the hospital in the newspaper and scores on the hospital acceptance index.**

<table>
<thead>
<tr>
<th>Read about Hospital in the Newspaper</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2 Percent</td>
</tr>
<tr>
<td></td>
<td>N = 94</td>
</tr>
<tr>
<td>Had read about hospital</td>
<td>31</td>
</tr>
<tr>
<td>Had not read about hospital</td>
<td>69</td>
</tr>
</tbody>
</table>

*Not statistically significant.

**Table 15. Classification of respondents by whether or not they had attended a club meeting where the hospital was discussed as a part of the program and scores on the hospital acceptance index.**

<table>
<thead>
<tr>
<th>Attendance at a Club Meeting</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2 Percent</td>
</tr>
<tr>
<td></td>
<td>N = 94</td>
</tr>
<tr>
<td>Had attended a meeting where hospital discussed</td>
<td>10</td>
</tr>
<tr>
<td>Had not attended a meeting where hospital discussed</td>
<td>90</td>
</tr>
</tbody>
</table>

*Not statistically significant.

**In Hospital One's county this involved early administrative blunders which were politically inspired. The purpose of the publicity was aimed primarily toward the forced resignation of the first administrator. In Hospital Three's county the publicity involved a bond issue which was defeated twice before passage.**
class upon whom support of the hospital must ultimately depend for much of its support.

**Place of Residence:** Place of residence in the county as determined by the beat in which the respondents were residing was significantly associated with scores on the hospital acceptance index for the total sample. However, these data mean nothing unless examined separately for each county. In all of the counties certain patterns were apparent. In Hospital One's community two beats on one side of the county contained a large proportion of the total county sample making low acceptance scores. This was explained in terms of the proximity of these beats to a regional medical center where a large proportion of families had always gone for medical and hospital service. The middle class families were thus oriented by tradition to this medical center outside of the county, and the lower class families held their identification because of the charity hospital located there.

Two beats in the county in which Hospital Two was located contained a large proportion of large land owners who showed little respect for their county hospital. In fact this was the only county in which there was a statistically significant difference between farmers who owned fewer than 100 acres of land and those who owned more than 100 acres on hospital acceptance scores. The large land owners were concentrated in two beats and were in general vocal with respect to their dislike for their county hospital.

Two beats in the county in which Hospital Three was located also contained a large proportion of persons with low acceptance scores. In this county neighborhood influentials appeared to be responsible for unfavorable gossip and discussion of the hospital, and the source of this unfavorable publicity appeared to be politically inspired.

**Formal and Informal Discussion about the Hospital:** The literature on hospital-community relations has shown that persons who are connected with the hospital, such as the professional and sub-professional staff, and the family physician may have an influence on the attitudes which persons with whom they associate have toward the hospital. A number of items designed to measure this type of influence were considered. However, only two were significantly associated with scores on the acceptance index. These were having discussed the hospital with the family doctor and having a friend connected with the hospital. Almost 70 percent of the respondents with scores of 0-2 on the acceptance index did not know anyone connected with the hospital. This compared to 30 percent of respondents with scores of 5-7. Also those who had a good friend employed by the hospital made higher scores than those who did not have this connection. See Table 16.

A similar relationship was observed in each of the hospital communities. When asked how the person connected with the hospital whom they knew felt about the hospital, respondents generally said they praised it, or they have done much to make me appreciate it. However some respondents would not commit themselves. It, therefore, appears that employees of the hospital may be instrumental in promoting the hospital among the general public; of course, if employees are

---

**Table 16. Classification of respondents who had a friend connected with the hospital by scores on the hospital acceptance index.**

<table>
<thead>
<tr>
<th>Knows someone connected with the Hospital</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2</td>
</tr>
<tr>
<td>Does not know anyone</td>
<td></td>
</tr>
<tr>
<td>N = 93</td>
<td>61%</td>
</tr>
<tr>
<td>Has a good friend employed there</td>
<td></td>
</tr>
<tr>
<td>N = 177</td>
<td>13%</td>
</tr>
<tr>
<td>Has a friend employed there</td>
<td></td>
</tr>
<tr>
<td>N = 181</td>
<td>11%</td>
</tr>
<tr>
<td>Only speaks to someone employed there</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15%</td>
</tr>
</tbody>
</table>

*P = .001 as indicated by chi square.
Table 17. Classification of respondents who had discussed the hospital with their family doctor by scores on the hospital acceptance index.

<table>
<thead>
<tr>
<th>Discussed hospital with family doctor</th>
<th>Hospital Acceptance Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 2</td>
</tr>
<tr>
<td></td>
<td>N = 93 Percent</td>
</tr>
<tr>
<td>Discussed with doctor</td>
<td>14</td>
</tr>
<tr>
<td>Did not discuss with doctor</td>
<td>86</td>
</tr>
</tbody>
</table>

critical of the hospital they may also retard its acceptance.

A small proportion of respondents said that they had discussed the hospital with their family doctor. As the scores on the hospital acceptance index increased, however, the proportion of persons who had discussed the hospital with their family doctor also increased. See Table 17. Similar patterns were observed for each of the counties. When asked how their own family doctor felt about the hospital most respondents said their doctor liked it. Only in the county in which Hospital One was located and in the county in which Hospital Two was located did respondents say that their doctor was unfavorable toward the hospital. These were patients of one doctor in each community and interviews with the doctors and the hospital administrator indicated some hospitality on the part of these doctors toward the hospitals. Hospital Three at one time also had a doctor who was hostile toward the county hospital. Although this doctor no longer practices medicine in the community some of his former patients held rather negative attitudes toward the hospital at the time of the interview. However, many respondents said that they had changed their opinion of the hospital since Dr. X left the community.

One could draw tentative conclusions on the basis of the data above on the relationship between objective factors and hospital acceptance. However, certain non-objective factors were important in explaining the relationship between the general public as well as each of the specific publics. A following section will consider these non-objective factors.

THE UNIQUE HOSPITAL SITUATION

In each of the communities studied there were a number of "non-objective" factors which influenced the status of the hospital in the community. Some of these were alluded to in the previous section where attitudes toward each hospital were examined. In this section the unique situation of each hospital, together with factors which bear, either directly or indirectly, on the status of the hospital in the community will be considered.

Hospital One

This hospital opened in 1951 with a 26-bed capacity. However, an expansion program was later effected, and its capacity was increased to 47 beds. In spite of its recent construction the interior of the hospital does not give the appearance of a well kept institution. This results in part from poor construction and perhaps in part from poor housekeeping. Also many persons in the county are concerned over the lack of separate facilities for Negroes and whites in the hospital. The big concern in this respect is over the integrated nursery which has been criticized on several occasions in the press. However, the factors retarding acceptance of the hospital fall largely within three categories, namely: (1) tradition, (2) lack of confidence in the hospital and its medical staff, and (3) the political climate in which the hospital must operate. These factors contribute to the general climate of opinion toward the hospital and each needs to be examined rather closely.
Traditionally persons in this county have gone outside of the county for hospitalization and for medical services which require more than routine treatment. This is true because there was not a hospital in the county prior to 1951, and as mentioned earlier because of the proximity of the county to two regional medical centers. Thus, many persons in Hospital One’s service area have strong attachments to hospitals in the regional medical center outside of the county, and a high percentage of these persons named a physician in these centers as their family doctor. This was more true for the side of the county which is nearest to the regional center than for the county as a whole. However, it appears that a substantial number of the higher status persons will continue to use out-of-county facilities for other than routine services. Nevertheless, many of these favor having a hospital in the county, and they said they would support the hospital through means other than use.

Closely associated with the use of out-of-county hospitals is Hospital One’s policy with respect to charity. The administrator and medical staff of the hospital stated that there is no real need for the hospital to render charity care because all persons in the county are financially able to pay for services. The board of trustees and other political groups concurred. However, this is a poor county and many persons have gone to the nearby medical center for charity services. It was reported that at least one death occurred between Hospital One and an institution where charity care was available when the hospital refused to admit an alleged dying patient because the person could not pay for services. Other stories with the same implications were told to the research team. Actually some of the stories were at least in part true; some were exaggerated. However, many persons in the county felt that the hospital’s policy with respect to charity should be re-examined. It appeared to the research team that the policy with respect to charity was based more on sound fiscal policy than on the basis that no need for charity care was apparent. Since a state charity hospital was near it was more expedient financially for both the hospital and its medical staff to insist that charity patients use the charity hospital. On the other hand, it appeared that neither the administrator nor the medical staff were willing to admit to the public that this was the reason they did not serve the element of the county’s population which needed charity care.

The second factor which has been detrimental to Hospital One’s position in the community is the distrust which many persons said they had of the hospital and of its medical and nursing staff. Many persons criticized the hospital for its lack of registered nurses and an incompetent nursing staff in general. Many of these persons, of course, were not able to objectively judge the competency of the nursing staff. Nevertheless, a general lack of trust of the nursing staff was expressed among persons throughout the county.

A lack of confidence in the medical staff was also expressed by a large number of persons in the community. The physicians in this county are young and are just beginning their practice. The one exception is an older doctor who has not joined the staff of the hospital but continues the practice of referring patients who need hospitalization to physicians in one of the nearby regional medical centers. Because of their recent connection with medical schools and larger hospitals, the younger physicians probably possess knowledge with respect to the newer developments in medicine which an overworked older doctor might not possess. However, a large percentage of the general public fails to understand this, and these persons indicated that they will continue to use doctors outside of the county for serious illnesses.

The third factor which retards the integration of the hospital into the institutional structure of the community is the unfavorable political climate surrounding the hospital. The second and present administrator is
well liked by county residents. However, many persons feel that the hospital has been a political football in the past, and there is much resentment of this. The members of the board of trustees do not appear to possess much knowledge with respect to hospital administration. Interviews with the trustees showed, however, that they consider themselves to be charged with administering the hospital. They reserve for themselves a major role in all policies of the hospital and appear to want to reserve administrative prerogatives which rightly belong to a professional administrator. The present administrator appears to have minimized the potential conflict in his position. However, the emphasis which he must place on maintaining good relationship with the board of trustees makes it almost impossible for him to devote the time needed to promotion of the hospital among other groups. Hospital business keeps him out of virtually all community organizations and activities. His only membership in a community organization is the church. He is aware that some women want to organize an auxiliary but he has not capitalized on their enthusiasm. Neither would he reveal their names to the research team.

The relationships of this hospital and its administrator with the present political groups, the board of trustees, and the medical and nursing staff appear to be fairly good. However, the hospital needs to be vigorously promoted among the larger general public in the county. This would entail the utilization of present channels of communication to explain operation of the hospital to the general public. Also the administrator should cultivate additional communicative channels through an auxiliary or existing groups concerned with welfare in the community. Finally, the administrator should devise some means whereby the board of trustees might acquire more knowledge with respect to hospital administration, without reserving for themselves control of the hospital. This problem is wide spread and to correct it will either require legislation or a large scale program of education and indoctrination. It should, therefore, be studied further with the view of devising appropriate steps to correct it.

**Hospital Two**

This hospital was like Hospital One in that it was the only hospital in the county. However, a large number of persons did indicate that they would seek hospital service outside of the county should the need arise for such services. This was largely due to the hospital's alleged policy with respect to charity, and the persons who would use out of county hospitals because of this were of two types. Older persons in the hill section of the county said they would go to a nearby private hospital if hospitalized because they could get charity care there. Also the more prosperous farmers in the Delta side of the county said they could not get charity care for their tenants at Hospital Two and they did not like the hospital nor its administrator for that reason. However, very few persons said they would go outside of the county for hospitalization because of poor services rendered by Hospital Two or because of attachments to hospitals and physicians outside of the county.

It was the feeling of the research team that county residents misunderstood the policy of Hospital Two with respect to charity. The administrator admits that he has resisted excessive demands for charity care by the prosperous residents who are able to pay for services. However, he claims that persons who actually need charity care are not denied. A check on the number of persons who had received charity care lead the research team to believe that a cautious but community service oriented policy with respect to charity was followed. This in part explains why the hospital's rate of occupancy is higher than the average of all hospitals in the state, yet this one operates on a self supporting basis.

The degree of success of Hospital Two may largely be attributed to its administrator. His background in administration and his manipulation of political factors have placed him
firmly in control of the hospital's destiny. The board of trustees of the hospital and the board of county supervisors have acquired a cursory knowledge of hospital administration as a result of a concerted effort to inform them. These groups therefore appreciate the administrator's position, and policies which they must approve are generally accepted on his recommendation.

Hospital Two does not have an auxiliary. The administrator feels that this group would serve a useful purpose, but that they might start rumors and gossip about the hospital which in the long run would cancel out the good which this group might do. The administrator has therefore asked church groups, civic clubs and other organizations interested in social welfare to provide certain facilities and services. As a result many groups throughout the county have become involved in the hospital's program. However, there is one community in the edge of the county from which the hospital derives little support. Several ladies in this community are active in the auxiliary of a hospital in a nearby town. These ladies in turn have done much to support the outside hospital at the expense of Hospital Two.

The relationships between the administrator of Hospital Two and its medical and nursing staff were generally good. However, this community has one physician who has practiced in the community for a long time and is held in high esteem by a sizeable proportion of the population. This physician has criticized the hospital and its administrator to some patients. Many of this physician's patients made low scores on the hospital acceptance index and they volunteered remarks which Dr. X had made to account for their negative attitudes toward the hospital.

As a whole, the relationships of Hospital Two with each of its publics were superior to the relationships of the other hospitals and their publics. The criticism of Dr. X, a misunderstanding of policies with respect to charity, and the influence of ladies who serve in the auxiliary of another hospital largely explain any weak spots in Hospital Two's public relations program.

Hospital Three

Factors which were related to Hospital Three's status in the community may generally be subsumed under two broad categories: (1) a competitive hospital situation and (2) administrative blunders made by the first administrator during the early operation of the hospital.

This hospital was located in a county which also contained a small proprietary hospital and a limited service clinic. The limited service clinic was located in one side of the county and was staffed by an energetic young physician who was held in high esteem by many persons in the service area of the clinic. This clinic accepted only minor cases involving hospital confinement and was designed as a feeder unit to Hospital Three. However, most of the referrals from this clinic to larger general hospitals were made to a hospital outside of the county rather than to Hospital Three. This was due in part to the fact that persons in this community had traditionally gone to the out-of-county hospital for services involving more than routine treatment, and in part to a reluctance of Hospital Three's administrator and medical staff to cultivate a warm professional relationship with the physician on the staff of the limited service clinic.

The proprietary hospital in the county where Hospital Three was located actually received more support from the residents of the county than did Hospital Three. This hospital had operated as the only hospital in the county for several years prior to the construction of the county hospital; it was staffed by two of the six general practitioners and one of the two surgeons in the community. The general practitioners were well established in the community and they were revered by a large clientele. Therefore, the refusal of these physicians to use Hospital Three resulted in a large percentage
of the county population refusing to use it also.

A comparison of Hospital Three with the proprietary hospital in its community revealed some rather striking differences between the two institutions. Hospital Three was accredited by the American Hospital Association. Its plant was modern in every respect, and the hospital maintained a “hospital atmosphere”. The proprietary hospital, on the other hand, was not accredited and had an atmosphere of a large doctor’s office where patients came to be near their physician until they got well. There were no visiting hours and it is alleged that the nursing staff treated patients as if they were helpless to satisfy any need during their sickness. Many former patients of the proprietary hospital said that being able to go to this hospital was one incentive to get sick. Persons who used the proprietary hospital may be placed in two groups, with respect to their attitudes toward Hospital Three: (1) those who thought it was a terrible place and could give no reason why they felt this way, and (2) those who were more or less indifferent toward it, i.e., thought it was a nice hospital and were willing to give it support in every way except use. It is believed that the first group felt the way they did because of their loyalty to their physician at the proprietary hospital and because they liked the proprietary hospital itself. These people would not want to go to any other hospital and would be unhappy if their doctor said they should use Hospital Three. The second group felt loyalties to their doctor only and would probably be happy if he used Hospital Three or a more modern hospital.

An examination of the objective characteristics of each group showed that they did not differ significantly with respect to age, income, education, and other factors of this general order. However, there were members of both groups who cited examples of administrative blunders, malpractice, politics and the mercenary character of Hospital Three to rationalize or reinforce their attitudes toward it. Some of the examples cited had no basis in fact, but they were, of course, real to the persons who cited them.

The present administrator of Hospital Three felt that one of the biggest obstacles to the acceptance of this hospital by the public was the large number of rumors circulated about the hospital. Many people thought, for example, that Hospital Three’s prices were out of line with the proprietary hospital. A check on prices showed the prices to be similar. There was also a belief that Hospital Three refused charity patients and that the proprietary hospital did all the charity work. Actually there was little difference between the two hospitals with respect to their policy on charity. This belief arose when the administrator of Hospital Three, in an attempt to correct the belief on the part of many county residents that Hospital Three was a charity hospital, required a deposit when patients were admitted. The administrator soon abandoned this practice but the damage which was more or less permanent, had been done. Also many people in the county said that the present administration of Hospital Three was cold and unfriendly and that he and the hospital were run by a controversial member of the board of trustees. It was not determined whether or not this was true, but the tenure of this controversial person on the board of trustees did much to hurt the hospital among some groups in the county.

At the time of the survey all doctors in the county seat were complimentary toward the hospital, and this proved to be related to the attitudes which persons in the community held toward the hospitals. However, in the past several physicians had done much to create unfavorable impressions of the hospital among their patients. This also has had a lasting effect. There were two physicians in the outlying villages in the county who did not use either Hospital Three or the proprietary hospital, but used hospitals in adjoining counties. Although these areas were outside the service area of Hospital Three, this nevertheless had its
effect on the hospital, as the county is considered the hospital service area politically and these villages could not be counted on to support the hospital in such matters as expansion, and increased tax support.

There was some disagreement also between the auxiliary and the administrator of Hospital Three. Several auxiliary members criticized the administrator as being lazy and of destroying the good will which the auxiliary created. In the earlier phases of this study it was hypothesized that the auxiliary is an important means of promoting the hospital in the community. This belief is still held. However, in comparing Hospital Three with Hospital Two some reservation must be made in this respect. If the administrator cannot work harmoniously with an auxiliary certain advantages may accrue from working with other groups interested in welfare but less involved in the operation of the hospital.

**SUMMARY AND IMPLICATIONS**

**Summary**

This study was conducted in an effort to determine acceptance of hospitals by persons for whom they have been built, and to arrive at criteria which hospital administrators can use for establishing a program of favorable relations between the hospital, its several publics and the community at large. The study was conducted over a period of five years and included a study of all hospitals and hospital administrators in Mississippi. A final phase of the study consisted of case studies of three hospitals to determine their acceptance by the community and to observe factors which would help explain the relative success of each hospital.

The earlier phase of the study showed that hospitals in Mississippi which have good relations with their publics are new, publicly owned units, which were founded by community leaders, and which do a lot of charity work. This phase also showed that the administrator largely controls the fate of his hospital. Hospitals which have good relations with their publics are administered by persons who also score high in public relations. Hospital administrators with good public relations are trained in administration, and identify professionally with hospital administration only. They make better salaries than administrators with poor public relations; they do not change jobs often; and they participate widely in professional and community organizations.

The case studies were conducted in hospital communities which contained relatively new Hill-Burton hospitals with 50 or fewer beds. These studies identified publics of the hospitals and observed the acceptance of the hospitals by each of the publics. Acceptance by the general public was conceptualized as consisting of a number of general attitudes toward a specific hospital. This definition of acceptance was felt to be superior to existing definitions. The previously used definitions of acceptance are use of the hospital, attitudes toward hospitals in general and likes and dislikes of specific hospitals. The universe of attitudes toward the hospitals studied included variations of the above definitions of acceptance. However, it is believed that some weaknesses of the above definitions were overcome with a combined index of seven internally consistent attitudes toward the specific hospitals. The attitudes ranged from thinking about the hospital as a part of the community to its support through use and contributions. It was felt that this index would permit inferences to be drawn with respect to the integration of the hospital into the community.

These attitudes were observed for 150 white housewives in each of the hospital communities. Each person received a hospital acceptance score of from zero to seven, depending upon
the number of attitudes of acceptance expressed. A classification of respondents by hospital acceptance scores showed that the hospitals enjoyed rather wide, though not complete, acceptance. Hospital Two which was located in a part hill, part Delta county in northwest Mississippi enjoyed the greatest relative degree of acceptance as indicated by scores which members of the general public made on the hospital acceptance index and by the relations of the hospital and its administrator with the other publics.

Objective factors which are related to the acceptance scores of the general publics were personal and class related factors, contact with the hospital, and personal influence factors. Non-objective factors which made up the general environment of the hospital were also related to the acceptance of the hospitals by each of the publics and helped to explain variations in the acceptance scores of the general public for each of the hospitals studied. Thus, it is necessary to consider the non-objective factors in order to interpret the role of the objective factors in acceptance.

There was a curvilinear relationship between hospital acceptance and class related factors for Hospital One, an inverse relationship between these variables for Hospital Two, and a positive relationship for Hospital Three. Hospital One was not accepted by the upper and lower class elements of its community according to the definition of acceptance and class used in this study. Apparent reasons for this were: (1) this hospital accepts no charity cases and the lower class persons must use a nearby state charity hospital; (2) upper class persons go to nearby medical centers for hospitalization and medical services because of tradition; and (3) there is a general lack of confidence in Hospital One's medical and nursing staff as well as dissatisfaction with its physical plant.

Hospital Two was not accepted by the more prosperous farmers in its county. This group resented the fact that the hospital would not accept their croppers and laborers as charity pa-

tients without questioning the obligation of their employers to pay for services. Acceptance of Hospital Three increased consistently as one's social class position increased.

Attitudes toward other community institutions were related to the way persons felt about their hospitals. However, attitudes toward other health related institutions were more important in this respect than attitudes toward non-health related community institutions. Persons who were generally satisfied with the community's County Health Department, and the physicians in the community, and those who had adopted the largest number of recommended health practices were most favorable toward their county hospital.

Contact with the hospital was related to its acceptance in all counties. Persons who had visited or used the hospitals were much more favorable toward them than persons who had not used them. Also persons who had used the hospitals were highly satisfied with the services offered.

Personal influence was related to the acceptance of all hospitals. Persons who knew someone connected with the hospitals were more favorable toward them than persons who did not have this vicarious connection. Also the comments of hospital employees and physicians in the community did much to influence acceptance of the hospital. A physician in the county in which Hospital Two was located and in the community in which Hospital Three was located had openly criticized the hospital or its administrator and many patients of these physicians were unfavorable toward the hospitals. Also in one community several neighborhoods were identified where most persons were unfavorable toward the hospital, and the reason for this could be traced to neighborhood influentials who were vocal against the hospital. Resentment of these influentials could generally be explained by personal or political reasons, such as dislike of a member of the board of trustees or of the hospital administrator. Closely associated with each of the above were the rumors
and gossip about the hospitals. These ranged from the deaths which had occurred in Hospital One’s community because of the hospital’s refusal to admit dying patients who could not pay for services to the prevelance of staphylococcus disease in Hospital Three. Many of these rumors were unfounded, and their source could not be detected.

The mass media of communication were also influential in molding opinions toward the hospital. In the counties where Hospital One and Hospital Three are located, however, the press may have done more harm than good. Moreover, discussion of the hospital at club meetings and other public gatherings proved to be a favorable means of promoting the hospital in counties where this medium had been used to carry the hospital’s story to the public.

Implications

The findings of this study have certain implications for the hospital service industry. Also since the acceptance of a hospital by a community is in the main a “human related” problem the findings have implications for sociology in general. One purpose of the study was to arrive at criteria of effective relationships between the hospital and its various publics. Inasmuch as the larger general public is the ultimate group with whom acceptance of the hospital lies the first concern will be with criteria of effectiveness with this group.

The General Public

One index of acceptance among the general public is use of hospital. Many administrators who have no apparent competition tend to assume that their hospital has a monopoly on the hospital business in their community. This study has shown this not to be the case. If persons do not like a hospital they will drive a long distance to use one they do like. There may be several reasons why persons do not like a hospital. Some of these reasons may be inherent in the hospital itself, such as size of the hospital, distrust of the hospital and its medical staff, lack of equipment and personnel to handle certain types of cases adequately, and poor treatment of patients and their family by the nursing staff and the business office. Other reasons may be external to the hospital, such as traditional use of physicians and hospitals in other communities, dislike for the hospital and/or its administrator for various reasons, failure of the hospital to render charity care, or strained relationships between the hospital and large segments of the population. The effective administrator should be able to recognize groups who do not use his hospital, to determine why, and to formulate means whereby these conditions may be corrected.

If use of a hospital were the only index of acceptance those persons who do not use the institution by definition would not accept it. However, this study has shown that persons who do not use a hospital may be favorable toward it and willing to support it in every way except use. Thus, another index of acceptance is opinion which persons in the hospital’s service area have of the hospital. For the general public this includes both general and specific attitudes toward the particular hospital. For persons who use the hospital it includes likes and dislikes of the hospital, or satisfaction with the way the hospital is performing its task. This type of information is not always easy for the administrator of a hospital to acquire. However, the administrator might work through schools, churches, or other existing groups to get questionnaires completed wherein attitudes of the general public toward the hospital would be tapped. Also patients and members of their families might be asked to complete questionnaires which would furnish information with respect to likes and dislikes of the hospital. The findings from this study also lead one to believe that this would serve as an excellent public relations device for the hospital. It would get people to thinking about the hospital and perhaps make them feel that the hospital is concerned with their feelings toward the way it is performing its role.

Another index of acceptance among the general public is the amount and
type of gossip and rumors which one hears in the community about the hospital. Some administrators have said that this was the biggest obstacle which their hospitals had to overcome in winning acceptance among the general public. These rumors may arise out of dissatisfaction with the way the hospital is performing its services or they may result from dissatisfaction with other aspects of the hospital.

The source of rumors is frequently hard to determine, and the administrator may never know of the rumors himself. However, each administrator should employ methods to project a favorable image of his hospital to the public. This may be done through the local press, speeches to civic clubs or other community organizations, and the personal influence of employees and other persons connected with the hospital.

In the field studies it was found that persons who remembered reading articles about the hospital in the county paper expressed more favorable attitudes toward the hospital than persons who could not remember reading about the hospital. Also persons who had attended a club meeting where the hospital was discussed as a part of the program expressed significantly more favorable attitudes toward the hospital than persons who had not attended such a meeting.

Former patients are also important means of projecting a favorable image of the hospital to the community. One satisfied customer is perhaps worth a million words. Therefore, the hospital should strive to satisfy the patient’s needs insofar as possible. In many cases this will include the satisfaction of basic emotional and psychological needs in addition to routine nursing care, food, cleanliness and diagnosis. In one community persons were asked why they continued to use an obsolete proprietary hospital when by their own admission the county hospital had better equipment, a nicer plant, and offered more sophisticated services. The answers revealed that the persons not only had their physical needs satisfied when they went to this hospital, but the atmosphere was such that emotional and psychological need of patients would usually be satisfied also.

This study has revealed that rural residents in Mississippi expect some degree of informality and “folkness” from the hospital, and when the rural hospital becomes too sophisticated patients and their families begin to complain. This desire for folkness is part of the expectation complex which potential patients have of the hospital. It is not too surprising in view of the fact that until recently all but major illnesses were handled in the home in the southern rural sub-culture, and that the hospital was perceived by many as a place to go to die. The degree to which the hospital fulfills the expectations of its patients is associated with the degree of acceptance and satisfaction of the hospital. Talks with patients and their families may give the administrator some indication of the expectations of his hospital. The efficient administrator must then decide how to adjust performance to expectation, or vice versa.

A final index of acceptance among the general public is the amount of support which residents of the hospital’s service area give the hospital in comparison to support given other institutions. In the case of Hill-Burton hospitals this includes tax support as well as use and contributions. Willingness to support the hospital through one means may not mean willingness to give whole hearted support. In one county for example residents of one neighborhood remarked that they liked the hospital and would use it, but that they would not support any move to add to the plant or equipment of the hospital as long as Mr. X remained on the board of trustees. It was a common tendency for persons to indicate willingness to support the hospital in every way except through increased taxes. The reason for this is in most cases a misunderstanding of the obligation of tax support to maintain the hospital or to improve its plant and services. In many cases this condition could be overcome with a good public information program. The administra-
tor needs to know what conditions stand in the way of a willingness to assume financial support before he can try to overcome them. Working through neighborhood influentials is one good way to get this information.

It is not common for Hill-Burton hospitals to ask for support in the form of contributions. However, several hospitals have asked for contributions from persons and groups in their service area. One involved the churches and other community groups in a fund raising campaign to build and equip a small chapel in the hospital, and to provide other services which lay outside of the area of hospital care. Also in one case the auxiliary asked persons for surplus produce from home gardens to be used in the hospital kitchen. In both cases the involvement of persons and groups in this type of support of the hospital served as a public relations device. Anytime persons and groups are made aware of the needs of the hospital and respond favorably, the administrator can be assured that he has elicited a stronger commitment of support in the long run.

The Board of Trustees

Outside of the general public probably no group is more important to the success of the Hill-Burton hospital than the board of trustees and the board of county supervisors. Administrators frequently judge their effectiveness with these groups by their support in financial matters, and in making and implementing policy. However, it should be remembered that these groups are closest to the general public, and they can have a tremendous influence on the success of the administrator and the hospital among the general public.

Perhaps one of the biggest problems of the new county hospitals is a clear definition of the role of the trustee in the operation of the institution. In many communities the county hospital is perceived by the board of trustees, the board of county supervisors, and a large proportion of the general public as being a sort of Jeffersonian bureaucracy. Thus, in these counties the board of trustees may want to assume more power in the daily operation of the hospital than is rightly theirs. In one county, for example, all members of the board of trustees were particularly happy with the administrator because, as they expressed it, "he more or less let them run the hospital."

In most cases members of the board of trustees are uninformed on all aspects of hospital administration. Therefore, if they are to have more than a nominal role, some means must be taken to inform this group of the many facets of hospital administration. This would include information with respect to the role of the hospital as a business organization as well as a community service organization. It is the belief of the research team that one of the most urgent needs of the new county hospitals is some standard procedure to recruit board members, to indoctrinate them once they are chosen, and to provide for some sort of continuing education once the program is begun.

The Medical Staff

The physician is one of the key persons in the promotion of the hospital. This study has shown that a large percentage of persons will choose a particular hospital because their doctor uses it. Thus, when there is a choice of hospitals in a community the decision is made on the basis of the hospital which the family physician uses. Also families who must use a hospital outside the community generally follow the recommendation of their family physicians on where to go, what specialists to consult, and what hospital to use.

There is evidence that persons place more confidence in their physician than they do in the hospital. Thus, even mild criticism of the hospital by a physician in the presence of patients may create an unfavorable impression of the hospital in the eyes of the patient. The data showed that this was true for both Hospitals Two and Three. Also the physicians can be beneficial to the hospital in explaining policies with respect to charity. In the county in which Hospital One was located neither the hospital nor the physicians
were willing to assume their share of the responsibility for the hospital’s policy on charity. However, the policy was financially expedient for both parties. There is also evidence that patients do not know whom to blame for minor dissatisfaction with respect to service and diagnosis, and such things as visiting hours and other regulations. It is easy for the hospital as well as the doctor to shift the blame to the other unless a satisfactory arrangement for handling complaints is worked out.

It is therefore incumbent upon the administrator to maintain favorable relationships with his medical staff. The personality of the physician and of the administrator may bear upon this problem. However, administrators must be able to identify potential areas of conflict between the medical staff and the hospital. Policies must be established jointly by the medical staff and the administrator if they are to be satisfactory to both parties. Also communication between the two levels must flow freely so that conflict is made apparent and can be resolved, and each party must be willing to assume its obligations as well as rights. All persons involved in medical and hospital care have a stake in the hospital. Therefore, a regular review of its status together with a consideration of internal and external problems is of importance to all concerned.

**Local Community Leaders**

Any program designed to create a major change in the status of the hospital in the community will require a long period of time. It will also need the support of community leaders who exert their influence through informal channels as well as those who are easily identified as community leaders by virtue of their positions in formal community organizations. Obviously to secure the support of the community power structure one must be able to identify persons who have influence. This may be no easy task in view of the fact that the persons with the most power may not hold any formal positions of influence in the community. However, the effective administrator will be concerned with the identity of power holders and will discern the most effective way to work through the existing structure.

Failure to win support of community influential has spelled defeat for expansion programs of some hospitals as well as programs of a more general nature involved in the day to day operations. Also it will be remembered that neighborhood influential in part accounted for the negative attitudes which persons in several neighborhoods held toward Hospital Three. There is no magic formula for working with the community power group. However, administrators should be cognizant of its importance and use it when possible for the hospital's advantage.

**Persons and Groups Interested in Community Welfare**

There are many persons and groups in every community who are interested in welfare. These groups may have governmental connection such as the county health and welfare departments, or they may be local groups, such as churches and civic clubs, which have welfare programs as a part of their overall program. Each of these is either directly or indirectly a partner of the hospital in providing services which are essential to the welfare of the community. Also many of these groups serve as the connecting link between the hospital and a large segment of the general public.

As a community service institution Hill-Burton hospitals have an obligation to render some charity care. Close cooperation between the hospital and such groups as the county health and welfare departments can be beneficial to all groups concerned in the handling of charity cases. The health and welfare departments frequently wish to recommend persons to the hospital or to a medical doctor for charity care. On the other hand, the cautious administrator may sometimes desire the help of the welfare department or other groups in establishing eligibility of some charity patients.

Certainly all groups concerned with welfare can be of benefit to the hos-
pital in formulating and publicizing policy with respect to charity. This is another of the major needs of Mississippi hospitals. Many persons have the notion that all Hill-Burton hospitals are charity hospitals. Thus, some people who are able to pay expect free services. Some administrators have attempted to solve this problem by refusing charity patients. However, this policy appears to be more detrimental than beneficial to the hospital. Administrators, therefore should cultivate channels of communication through existing groups interested in welfare to inform the general public of the hospital’s need to be self supporting as well as its desire to serve all elements of the population.

Other persons and groups interested in welfare may be beneficial to the hospital if handled properly. One such group is the ladies in the community who are interested in the hospital auxiliary. These ladies are generally higher status persons who desire some channel through which they can render a welfare service to the community. Thus, they have resources in the form of time, talent, and sometimes money which the hospital can use to an advantage. Also these women are usually members of or close to the existing power structure of the community and they can exert influence at this level to the benefit of the hospital. However, only the administrator who has a clearly defined and useful program for the auxiliary should attempt to have one. If the auxiliary members spend a small portion of their time criticizing the hospital or its administrator they may do more harm than good.