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Co-Orienting Community Engagement In Hospital System Planning: Understanding Internal and External Perspectives

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ABSTRACT

This study explored the relationship between a large health care institution in Canada and its stakeholders as a means of understanding how "the community" wants to be engaged in ongoing hospital restructuring and system planning. A mixed-methods research design (focus groups, depth interviews and Q-methodology) was used to assess stakeholders' perceptions of effective community engagement strategies and frameworks for sustainable community and organizational outreach. Findings show that the community members expect health care organizations to engage in mutually beneficial, two-way symmetrical communication and dialogue. Results provide scholars, public relations practitioners and organizational leaders with insights on the community's expectations and willingness to engage.

Keywords: community engagement, public relations, citizen participation, decision-making, symmetrical communication.

INTRODUCTION

Universal health care – health care paid for by the government from tax revenues and provided free to all citizens – is a fundamental and treasured feature of Canadian society. Observers like former politician Lloyd Axworthy, and global health expert Jerry Spiegel state the importance of universality in a Canadian context:

> The principle of universal access based on medical need rather than on ability to pay speaks both to our sense of fairness and to our sense of community. Canadians have accepted a vision of social justice that sees health care as a fundamental human right. Within this tradition every citizen, regardless of ability to pay, is viewed as part of the same social community. It has been repeatedly noted that we Canadians regard our public health care system as a defining attribute of our national identity (2002, paras 2, 3).

Although the commitment to universality is still strong in Canada, the country's health care system is suffering the same financial strain that is being experienced by other

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nations around the globe. At a time when the population is aging and demands on health providers are rising, the tax base is declining and funding for hospitals is not keeping up with increasing costs. This is forcing hospitals to make difficult decisions about how to find efficiencies and, in some cases, services to reduce in order to balance budgets.

Community members feel they have a stake in these changes and some are demanding to be consulted on the choices hospital leaders are making. This involvement can take many forms, from representing the community on a health care organization's board of directors, to sitting on a patient advisory committee for a particular hospital program, to responding to a public survey about health care system decision making. There are many different ways to get involved and these activities are described as community engagement or citizen engagement.

In some Canadian provinces, community engagement is required by legislation (e.g., Ontario Local Health System Integration Act, 2006). In other provinces, it has been formalized by political and government leaders as part of system planning (e.g., Alberta Health Services Advisory Council Charter, 2009).

These regulations have grown out of a widely held conviction that public consultation will make the health care system better.

In the governance of health systems, public involvement plays four major functions: i) to improve the quality of information concerning the population's values, needs, and preferences; ii) to encourage public debate over the fundamental direction of the health system; iii) to ensure public accountability for the processes within and outcomes of the system; and iv) to protect the public interest (Gauvin & Abelson, 2006, p. 6).

The development of a new social environment is perhaps the most relevant factor driving this research study. Health Canada (2000) summarizes it as: "… a decline in public trust and a questioning of institutional legitimacy, an aging and increasingly diversified and more demanding Canadian population, and an increasingly influential civil society that sets a new context for governance … (p. 8)". A decline in trust is a significant problem for any service industry, but for health care, it's critical. For instance, the College of Physicians and Surgeons of Ontario (2008) describes trust as fundamental to a physician-patient relationship.

> Trustworthiness is the cornerstone of the practice of medicine. It is the demonstration of compassion, service and altruism that earns the medical profession the trust of the public … in the absence of a trusting relationship, the physician cannot help the patient and the patient cannot benefit from the relationship (para. 4).

Institutional integrity is also fundamental to the success of a hospital. The organization's reputation impacts public opinion that in turn drives donor and political support - key enablers in a publicly funded health care system. Perspectives on the community's role

in health care decision-making have also changed as Canada's population has become increasingly diverse. In order to be responsive to the unique needs of evolving cultural and demographic groups, hospitals must understand what those needs are, and the best source of that information is the community itself. Indeed, it seems that the community wants to be heard on a range of topics. In 2005, EKOS Research Associates polled Canadians to find out how they think citizens should be involved in government. Because hospitals provide a public service that is government funded, this data is strong justification for community engagement in health care.

Eighty-five percent of Canadians would be more confident in government decisions if it was clear that the government sought citizens' input more regularly and 68 per cent of Canadians believe that there are not enough citizen engagement initiatives on issues of public policy (as cited by Sheedy, 2008, p. 9).

Indeed, the appropriateness of community engagement in the health care sector has long been recognized. Abelson observes: "that the public should be involved in these decisions is no longer under serious debate as decision-makers, faced with increasingly difficult resource allocation decisions, welcome the opportunity to share this task (and the associated blame) with the public" (2001, p. 777).

As this interest in community input on health care planning has risen, so has the development of a wide range of frameworks for community engagement, along with the tools and strategies that are necessary to carry them out. The challenge facing health care organizations is how to evaluate these various models, and how to select or develop one that meets legislated requirements as well as the needs of the organization and the community it serves.

That is the purpose of this research study. The leaders of a large health care organization in Ontario, Canada, expressed interest in building a formal community engagement program to enhance the work the organization is already doing to improve and develop community relationships and partnerships.

While supportive of the initiative, the organization’s leaders also recognize that there are significant challenges ahead. As summarized in the Canadian Policy Research Networks Handbook on Citizen Engagement (Sheedy, 2008):

> Apprehensions and skepticism regarding citizen engagement should not be ignored. Some question the value and benefit of engaging citizens, especially when it comes to addressing complex social or scientific questions. Others worry about citizens taking over or hijacking the delicate policy process or about raising expectations beyond reasonable limits. Pragmatists are reluctant to ramp up citizen engagement because of tight timelines and budgets (p. 10).

Despite these potential pitfalls, the organization was committed to being more strategic about seeking public input on its activities and decisions. The organization's leadership also agreed with Creighton (2005) that there is no "one-size-fits-all" approach to public participation (p. 2).

LITERATURE REVIEW

The task of researching and making recommendations for a community engagement program at this health care organization is being taken on by its Public Relations Department. Unlike other frameworks which have been created by experts in administration and finance, this one will be guided by fundamental principles of communication and a strong commitment by the Public Relations Department to the value of Grunig's (1992) classic model of two-way, symmetrical communication.

This approach could help to make the framework more relevant and applicable to other health care organizations that view the communications function as vital to the achievement of the organization's goals. In addition, at a time when all public health care organizations in Canada are looking for efficiencies, this model could be more appealing to administrators since it is led by a team that already exists in many hospitals – public relations – and does not require the establishment of a new team dedicated to community engagement.

It is also the opinion of the researchers that public relations' experience and expertise in relationship building and "boundary spanning" makes the profession an ideal facilitator of community engagement. Leading scholars and practitioners also recognize the potential of advancing the public relations role to serve as a catalyst for consensus building and direction setting. Flynn (2006), for example, has proposed a broader model for public relations that balances theory, practice and outcomes.

> I would argue, in fact, that we need to move well beyond the current two-way thinking about publics and begin to re-conceptualize public relations in a multidimensional perspective where dialogue, collaboration, and negotiation with multiple stakeholders and stakeseekers occur simultaneously and that the new role of the public relations practitioner is to maintain an equilibrium that satisfies the mutual interest of all parties (p. 193).

Support for this aspirational role for public relations is shared by Berger (2005) who posits that public relations practitioners should be activists. "If public relations is to better serve society, professionals and academics may need to embrace an activist role and combine advocacy of shared power with activism in the interest of shared power" (p. 5). Another view on the evolving role of public relations comes from the Arthur W. Page Society, a U.S.-based association of senior public relations professionals. In its report on the state of public relations, The Authentic Enterprise (2007), the Society describes an *interactive* role for the profession that "represents the most strategic and synthesized level of thinking about communication" (p. 48). The authors explain that

"the general public has increasingly become part of the corporate ecosystem and that [the corporations'] top communication executives must effectively engage and incorporate the public into the fold of values-based messaging" (p. 48).
It is in this context -- the evolution of public relations and the intersection between two-way symmetrical communication and community engagement -- that the researchers explored a potential community engagement framework for this organization.

Community -- Over the years, many definitions of community have been posited by scholars and activists. They range from a philosophical notion that community is a way of living and what happens when people come together, to rigid definitions that suggest community can only be described by a specific, geographic place (Born, 2009).

For the purposes of this research study, the organization's community is its stakeholders – to be specific, individuals and organizations who feel invested in its services and vision. Besides the 800,000 patients who are cared for by the organization's hospitals each year, this includes the organization's 10,000 staff members and physicians, 1,500 volunteers and 42,000 individual donors.

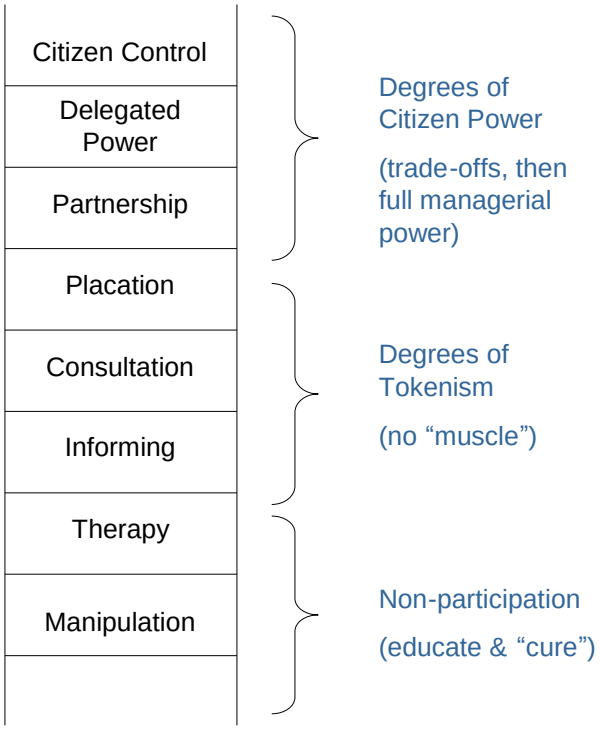
Within the community and the region, the organization is also closely associated with other health care providers and agencies such as other hospitals, community-based care providers, the ambulance system, and the Local Health Integration Network (the provincial government's regional health authority.)

Community Engagement -- The Tamarack Institute, a Canadian community development support organization, defines community engagement in a relatively focused way, i.e., "a method to improve communities by identifying and addressing local ideas, concerns and opportunities" (Tindana, 2007, para 6). The U.S. Centers for Disease Control broadens its definition to describe common characteristics: "a process of working collaboratively with and for groups of people affiliated by geographical proximity, special interests or similar situations to address issues affecting the well-being of those people" (Tindana, 2007, para 6). In the United Kingdom, the University of Central Lancashire's definition incorporates the idea of equity through support, i.e. "the simultaneous and multi-faceted engagement of adequately supported communities and relevant agencies around an issue or set of issues in order to raise awareness, assess and articulate need, and achieve sustained and equitable provision of appropriate services" (Tindana, 2007, para 6).

Democratic theory provides an additional perspective and is embedded in other definitions of community engagement. For example, Arnstein (1969) whose article on the "Ladder of Citizen Participation" first described the levels of community engagement, notes:

> Participation of the governed in their government is, in theory, the cornerstone of democracy -- a revered idea that is vigorously applauded by virtually everyone. The applause is reduced to polite handclaps, however, when this principle is advocated by the have-not[s] (p. 216).

Figure 1 - Arnstein's "Ladder" of Citizen Participation



Arnstein's description of the continuum of citizen engagement as a ladder of increasing involvement and power (Figure 1) has formed the basis for many other models that have followed. What she captured in this elegant graphic is how the method or degree of engagement reflects the impact the citizen has at each stage along the continuum. From one-way education at the bottom of the ladder to full-fledged citizen control at the top of the ladder, citizen influence ranges widely.

Thirty-seven years after Arnstein proposed her model, some observers in the Canadian health care community noted that the time for community engagement had arrived. The Health Council of Canada (Gauvin & Abelson, 2006), portrayed citizen engagement as the "new" public participation.

… renewed interest in deliberative democracy theory has gone hand in hand with the developing practice of citizen engagement … Collective problem-solving discussion is viewed as the critical element of deliberation, to allow individuals with different backgrounds, interests and values to listen, understand, potentially persuade, and ultimately come to more reasoned, informed, and public spirited decisions (p. 11).

Whether the commitment to democratic principles is historically entrenched or a new preoccupation, it helps to capture the goal of community engagement at the organization that is the subject of this study, i.e. to collaborate with stakeholders to build consensus and make meaningful progress in enhancing the health care system.

Public participation, a concept that is used interchangeably by some scholars, is also relevant to this study. For Creighton (2005) public participation "is the process by which public concerns, needs, and values are incorporated into governmental and corporate decision making. It is a two-way communication and interaction, with the overall goal of better decisions that are supported by the public" (p. 7).

RESEARCH QUESTIONS

RQ1 - What are public and staff perceptions about how this health care organization engages its community when making decisions about the delivery of health care?
RQ2 - From the perspective of the public and the staff, what community engagement strategies should the organization pursue?
RQ3 - How should hospitals structure and implement effective, sustainable community engagement programs?

METHODOLOGY

Research Design

This project utilized mixed research methods (two qualitative and one quantitative) to identify public and staff perceptions about ideal community engagement practices related to the organization being studied. "There is more insight to be gained from the combination of both qualitative and quantitative research than either form by itself. Their combined use provides an expanded understanding of research problems" (Cresswell, p. 203).

The methods included:

1. Two focus groups involving a total of 22 community members
2. One-on-one interviews with 10 hospital staff members who are currently involved in various community engagement activities
3. A "Q-methodology" survey which gave all 32 participants an opportunity to rank and comment on the relevance and usefulness of a total of 45 community engagement strategies identified by the community members, the staff members, and drawn from community engagement literature

Sampling and Data Collection

1. COMMUNITY PARTICIPANTS -- FOCUS GROUPS -- Randomly selected community members participated in two focus groups - N=12 and N=10. The groups lasted approximately 60 minutes each and were facilitated by one of the researchers. The groups took place in meeting rooms at a hospital and a community library. The community participants were paid an honorarium of $50 each at the end of the sessions. They signed consent forms and the sessions were recorded for the researchers' reference.

Recruitment of the community participants was contracted to a market research company. The company's services were paid for by the health care organization. The market research company was successful in recruiting participants who represented different demographic groups based on variables including: age; gender; work status; income; marital status; education; ethnicity; place of residence; and experience with the health care system. Eleven were men and 11 were women. They ranged in age from 21 to 62.

2. HOSPITAL STAFF PARTICIPANTS -- INTERVIEWS -- Ten staff members who are involved in community relations participated in 30-minute, one-on-one interviews with one of the researchers. One interview was conducted in person (in the researcher's office) and the rest were conducted by telephone. The staff members signed consent forms and the sessions were recorded for the researcher's reference.

3. COMMUNITY MEMBERS & STAFF MEMBERS -- Q-METHODOLOGY SURVEY -- Approximately three weeks after the focus groups and interviews took place, the next stage of the data collection process began – the carrying out of a Q-Methodology survey. Based on input from the community members and staff members, as well as concepts drawn from community engagement literature, the researcher developed a list or "concourse" of 45 potential community engagement strategies. By creating the concourse primarily from ideas offered by study participants, researcher bias was minimized. This approach also helped to ensure that the strategies were stated in clear, succinct and unambiguous ways (Chinnis et al, 2001).

The concourse list, along with small cards describing each strategy in brief, a Q-Methodology chart, and a covering letter with instructions, was mailed to each of the 32 participants. They were asked to complete the survey and send the results to one of the researchers in a self-addressed, stamped envelope that was also provided in the package. Along with the survey, they were asked to complete a brief questionnaire in which they commented on their top two and bottom two selections, and then provided some non-identifying demographic information about themselves. Nineteen surveys were returned over the course of the next four weeks. One could not be used because the participant did not complete the survey as instructed. The successful response rate was 56.25 per cent - 18 out of 32 participants.

The surveys allowed the participants to express their individual opinions about the 45 community engagement strategies. They did this by sorting the strategies from lowest to highest priority and positioning them on the chart accordingly, using a nine-point scale. The Q-methodology results facilitate the quantification and evaluation of clusters of subjective judgments using a relatively small sample, thus avoiding the many challenges of conducting large research studies. Q-methodology is also highly effective in identifying similar viewpoints, tastes or preferences -- in other words, personal profiles (van Exel & de Graaf, 2005).

RESULTS

1. FOCUS GROUPS -- A number of strong themes emerged from the focus groups.

Accountability -- “Community engagement means being asked for your input rather than being told this will happen.” This sentiment was repeated and expressed vigorously in both focus groups. While the participants agreed that health care is complicated and that resources to fund public health care services are limited, it was clear that they wanted to have input on the choices system leaders are making.

For example, one participant characterized the organization’s announcement of its plan to change one of the city's four emergency departments into a pediatrics-only service as a "slap in the face" to adults who use that emergency department. "People want to feel like they had some involvement – that someone heard their opinions, even when it makes no difference, they just want to be heard," said another participant.

Cynicism, Distrust – A few of the community members appeared to have no faith that public input would be taken seriously by health system leaders. "What’s the point of me explaining what my issues are because you’re going to do whatever you want to do because you have the big board and the big doctors who make the big pay cheques," said one participant. Another focus group participant observed, "Hospitals only reach out to you when they want donations."

Disengagement – Another theme that emerged from the focus groups was the level of disengagement felt by a number of the participants. "We don't care as long as we get the services we need when we need them," they said. Many also talked about the reality of their daily lives -- that they are too busy to learn about the often complicated world of health care delivery. "I don't want to be inundated with all kinds of information I don't need," was their comment.

2. STAFF INTERVIEWS -- There were some interesting parallels and differences between the staff and community comments.

Accountability -- Like the focus group participants, all the staff members recognized the importance of being accountable to the community they serve. They said that through community engagement, they are establishing some legitimacy for the organization's decisions by ensuring those decisions are consistent with the community's values.

The staff members also acknowledged the challenge of conducting effective community engagement. "It's all about relationship building and there is no quick win on that. It takes time," said one staff member. Others talked about how critical it is to be "up front" with community members about the organization's intentions. "If people are asked for their opinion too late when the plan is well down the road, they think it's tokenism."

Trust through Transparency -- While they agreed that building public trust in the health care system is fundamentally important, the staff members felt that the solution is to put a priority on being transparent in how decisions about the allotment of resources are made. "We need to be letting others know why we're making the tough decisions we're making," said one staff member. One took that concept further suggesting, "If the community knew some of the decisions we have to make, they would have more compassion and more understanding."

Bridging the Knowledge Gap -- An argument often used against the feasibility of community engagement in health care is that the typical citizen does not understand the complexities and nuances of health care administration. The staff interviewed for this study felt it is the responsibility of health care organizations to help community members become better informed and therefore better able to participate in decision making. "It's not on them, it's how we're presenting it. That's the key there. Sometimes we make it too complex," said a staff member.

The Value of Getting the Community Involved -- The staff members all felt that community engagement, even if it is as simple as a patient satisfaction survey, is valuable. "I don't know how else we can evaluate whether we're making a difference in the community. Without community engagement as a touchstone, I think we can be terribly misguided," said a staff member.

One of the most poignant comments came from a staff member whose work in an intensive care unit exposes her to decision-making challenges on a routine basis. She said, "At the end of the day, it's all about relationships - how we treat each other. Do we want to live in a world where certain groups that have strong advocates, or certain groups that are angry as hell, get all the attention and all the resources? Is that the way we want to operate?" In this staff member's experience, it is important to ensure that all voices are heard.

3. Q-METHODOLOGY -- The qualitative results generated by the community focus groups and staff interviews were contrasted to the quantitative results from the Q-Methodology survey that followed. This triangulation enriched the value of all the data collected and provides a compelling view of the attitudes and opinions about community engagement in Canadian health care.

The concourse of 45 community engagement strategies that was developed for this study is itself an illuminating selection of data. All 32 participants contributed unique thoughts and ideas that enabled the researcher to build this comprehensive menu of options. Only four were drawn from the literature - the rest were suggested by the study participants. The strategies demonstrate the diversity and potential implementation of community engagement programs in public sector management.

The responses to the Q-sorts were computer tabulated using PQMethod 2.11 factor analysis software. The unrotated factor matrix, which looked for significant correlations or loadings, revealed that 15 of the 18 respondents sorted into three factors with

Eigenvalues of 2.3990 (Factor 1), 1.8087 (Factor 2) and 1.1760 (Factor 3). Factor loadings in this study were considered significant above 1.0 or below -1.0.

Factor 1: Staff Members with outward-looking preferences

The PQMethod tabulation showed that three staff members and one community member sorted into this factor.

Table 1: Staff Members with outward-looking preferences

#	Q Sample Strategy	Z-Score
LOADED POSITIVELY		
13	Partner with the media to spread information about the hospital, for example, a weekly segment on the local TV station	2.103
30	Conduct a community-wide information campaign using various media to start educating the community on health care issues.	1.743
28	"Go Big" - Use billboards, banners and short videos in movie theatres to promote the organization and its goals.	1.643
LOADED NEGATIVELY		
40	Create training opportunities for members of the community who are interested in various aspects of health care and hospital administration.	-1.546
35	Distribute mail-back, written surveys to randomly-selected members of the community.	-1.567
9	Put suggestion boxes or computer terminals in hospital lobbies to collect feedback from patients and visitors	-1.826

Factor 2: Community Members who want to have influence

The PQMethod tabulation showed that no staff members and six community members sorted into this factor.

Table 2: Community Members who want to have influence

#	Q Sample Strategy	Z-Score
LOADED POSITIVELY		
9	Put suggestion boxes or computer terminals in hospital lobbies to collect feedback from patients and visitors	1.947
1	Conduct frequent patient satisfaction surveys and act on the information received	1.846
32	Conduct one-to-one interviews with randomly selected patients after they have been discharged to find out what their experience was like and ask for their suggestions.	1.802
LOADED NEGATIVELY		
40	Create training opportunities for members of the community who are interested in various aspects of health care and hospital	-1.391

	administration.	
39	Make specific efforts to involve minorities and marginalized people (poor, non-English speakers, for example) in community engagement activities.	-1.497
15	Appoint people to the Board of Directors who are more representative of the community's population	-1.714

Factor 3: Staff and Community Members with Show-and-Tell preferences

The PQMethod tabulation showed that two staff members and three community members sorted into this factor.

Table 3: Staff and Community Members with Show-&-Tell preferences

#	Q Sample Strategy	Z-Score
LOADED POSITIVELY		
13	Partner with the media to spread information about the organization, for example, a weekly segment on the local TV station	1.977
7	Place ads in the local daily and weekly newspapers to inform the community about the organization's news and issues	1.799
11	Appoint an ombudsperson whose job it would be to take feedback from patients and the public, and convey that feedback to the organization's leaders	1.561
LOADED NEGATIVELY		
38	Conduct scenario workshops where community members and staff members participate together in discussions and brain-storming exercises based on scenarios related to specific hospital issues. The findings of the workshops inform the organization's decision-making process.	-1.989
5	Use social media vehicles like Facebook and Twitter to reach younger audiences	-2.133
41	Use mail drops – flyers or letters – to inform the community about important initiatives and to invite them to provide feedback.	-2.243

DISCUSSION

The Q-methodology data, when layered over the results of the community focus groups and staff interviews, has helped the researchers identify trends that will inform the organization's development of future community engagement strategies. Table 4 summarizes the perspectives of the factor groups as well as the overall trends those perspectives suggest.

Table 4: Summary of trends identified in the Q-methodology data

Group characterization	**FACTOR 1 Staff with outward-looking preferences**	**FACTOR 2 Community members who want to have influence**	**FACTOR 3 Mixed - Staff and community members with "show-and-tell" preferences**
Communication model represented	One-way asymmetrical	Two-way symmetrical	Two-way asymmetrical
Group membership	3 staff members 1 community member = **4**	0 staff members 6 community members = **6**	2 staff members 3 community members = **5**
Strategies loaded **positively** *i.e., the group prefers …*	- 6 out of the 9 top choices relate to media relations or advertising - Limited interest in face-to-face strategies	- 5 out of the 7 top choices relate to the hospital seeking community input - This includes direct feedback plus feedback through advocates	- 3 out of the 7 top choices related to media relations - 3 others focused on face-to-face communication with patients and community members
Strategies loaded **negatively** *i.e., the group is not interested in …*	- Suggestion boxes or other feedback mechanisms - Outreach such as a Community/Hospital "PTA", or communicating through family physicians	- Special accommodations such as making Board appointments that are more reflective of the community, involving minorities in community engagement initiatives or communicating with cultural groups	- Although the positive loadings for this factor were mixed, the negative loadings showed consensus - Not interested in getting involved - No to mail-drops, social media, scenario workshops, mail-back surveys, suggestion boxes, community E-newsletter
Communication/ Engagement strategies most likely to resonate	- Strong media relations program - Advertising - Consumer forums	- Suggestion boxes - Patient satisfaction	- Media relations program - Appoint ombudsperson

with group	- Consultation with specific community leaders	surveys - Interviews with discharged patients - Survey hospital staff and volunteers - Appoint ombudsperson	- Community forums - "Road Show" at public locations

Alignment with Models of Communication -- Since this research project is endeavouring to look at community engagement through a public relations lens, the initial analysis of this data will be how it relates to models of communication.

The three staff members and one community member who sorted to Factor 1 -- outward-looking preferences -- represent a traditional model of communication that is described in public relations literature as one-way asymmetrical (Dozier, Grunig & Grunig, 1995; Grunig, 1992). It is one-way because media sources and advertisements disseminate information to the public, but do not necessarily encourage a response or two-way dialogue.

The six community members who sorted to Factor 2 -- community members who want to have influence -- have made choices that are indicative of a more sophisticated model of communication called two-way symmetrical (Dozier, Grunig & Grunig, 1995; Grunig, 1992). In this model, communication facilitates the exchange of information between the organization and its stakeholders (balanced, two-way communication.) Ideally this enables both parties to negotiate mutually beneficial outcomes. Factor 2's clear preference is for strategies that call upon the hospital to ask patients and community members for their input on management decisions.

The two staff members and three community members who sorted to Factor 3 -- mixed, show-and-tell preferences -- have made choices that appear to reflect a blend of communication models. The priority they place on media relations indicates one-way asymmetrical communication. On the other hand, their preference for face-to-face communication (community forums, a "Road Show" and the appointment of an ombudsperson) is more representative of two-way symmetrical communication. This contrast may suggest that the Factor 3 group favours two-way asymmetrical communication where information is collected from the public, but isn't used to modify the organization's behaviour (Dozier, Grunig & Grunig, 1995; Grunig, 1992). However, unlike the characterization of Factor 1 as one-way symmetrical and Factor 2 as two-way asymmetrical -- both firm assumptions -- this portrayal of Factor 3 as two-way asymmetrical is more speculative.

The intersection between communication and community engagement -- The triangulation of data from focus groups, interviews and Q-methodology in this research project provides an opportunity to evaluate the implications of communication strategies

in advancing effective community engagement. Two-way symmetrical communication is regarded by most public relations practitioners as the "gold standard" of their profession. Dozier, Grunig and Grunig (1995) state:

> Arguably, symmetrical communication provides one foundation for ethical practices, because communicators play an active role as advocates of the public's interests in strategic decision making. When symmetrical communication practices prevail, communication and public relations make valuable contributions to society as a whole" (p. 13).

That same commitment to a respectful exchange of ideas and the pursuit of win-win solutions permeates community engagement literature. As noted earlier in this paper, effective community engagement provides institutions like hospitals with better information about the population's values and needs. It also encourages public debate and accountability, thus protecting the public interest (Gauvin & Abelson, 2006).

It would seem then, that anyone developing community engagement initiatives would do well to consider the synergy of these two frameworks. Community engagement strategies that utilize the principles of two-way symmetrical communication will benefit from 50 years of theory and practice by the public relations profession.

Where these findings lead this health care organization -- There are many insights to be gleaned from this research.learning. One of the most significant was just how candid and critical the community members and staff members were when it came to offering their opinions on how the organization currently connects with the community. In focus groups and interviews, the participants in this study expressed feelings of disappointment, cynicism and disengagement. They also talked about organization's failure to bridge the knowledge gap and, perhaps most significantly, the possible erosion of public trust. This qualitative data highlights the importance of developing a comprehensive community engagement strategy for the organization and its stakeholders. While it may not be implemented immediately or all at once, its need is obvious.

The participants in this research project have generated an extensive list of community engagement strategies. This remarkable menu of options has the credibility of being locally specific, and can be considered with confidence by the organization’s planners as they weigh different approaches to community engagement.

A component of the research findings that may show most promise is the direction provided by the community members in Factor 2 of the Q-methodology results. They were very clear that they wanted to see the organization consulting with the public and they identified suggestion boxes, patient satisfaction surveys, one-on-one interviews with discharged patients, surveys of hospital staff and volunteers, and appointment of an ombudsperson as their top six priorities. These recommendations are important for two reasons. One, is that they came from community members, not staff members. And two, they reflect two-way symmetrical communication, the most effective model for

communication according to public relations theorists and professionals. A community engagement program that begins by putting these strategies in place will be able to leverage a model of communication practice that has proven its worth in many sectors and innumerable situations.

Where these findings lead other health care organizations -- Although the data generated by this research project are specific to one health care organization, other large, acute care teaching hospitals may find the concepts and research strategies applicable to the development of their community engagement programs. Focus groups, interviews and Q-methodology surveys take time, but they are not expensive. The methodology described in this paper could be reproduced by other public sector institutions at a low cost. Public relations practitioners, in particular, may find this approach practical and familiar.

CONCLUSIONS

Limitations of this research -- One of the researchers is an employee of the organization that was studied and all the participants in the project were aware of that. This may have made them hesitate to voice criticisms of the organization. The findings (the research methodology and the strategies themselves) have yet to be validated. That is because the organization is moving forward with community engagement in a gradual way and it will be some time before any significant number of the strategies described in this study are implemented and evaluated.

Contributions of this research -- This research has raised awareness within the subject organization about the importance and the challenge of community engagement. It has also provided the organization with a framework upon which it can enhance and expand its community engagement efforts. In addition, this study has demonstrated the value of taking a public relations/communications approach to community participation. Two-way symmetrical communication is the touchstone of the public relations profession and its principles of accountability, transparency and fairness mirror the best practices of community engagement.

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