Leading by Design Case Study Account: Wayne Ruga

1. Introduction

This case study account presents my own learning in designing, developing, and participating in the Leading by Design research project. Because of my role as the founder of the Leading by Design project, and the introductory material that my case study contains, it serves as the foundation for all of the following participant case studies.

2. Summary of Purpose

I designed the Leading by Design project as a learning process to enable its participants to understand how to actively exercise 'health design leadership', as a means for them to develop increasing mastery in cultivating 'generative space'.

When participants cultivate 'generative space', they are demonstrating their mastery in creating environments where it begins to become possible to systemically and sustainably improve health and healthcare delivery.

3. Leading by Design Overview

Research and the Learning Process

The Leading by Design learning process is, itself, a model of how to cultivate 'generative space' in practice.

The Leading by Design research project enables this learning process and its related outcomes to be operationalized, refined, expanded, documented, and disseminated. The research project supports the promotion of new understandings of how to systemically and sustainably improve health and healthcare with the design of the environment to a wide range of diverse, health-related stakeholder groups.

As the researcher, I have had a continuous personal debate as to the legitimacy of my own life and work qualifying as a Leading by Design case study. I have decided in favor of my being a Leading by Design case study, with the primary focus of my own case study research being: to research and develop the Leading by Design learning process as a vehicle for actively exercising 'health design leadership' for the purpose of cultivating 'generative space'.

My case study, like the others in the Leading by Design project, follows the action research methodology – with its iterative and increasingly expansive pattern of utilizing a continuous personal reflexive assessment to: (1) reflect on my practice; (2) generate new learnings from these reflections; and (3) inform my practice with these new learnings.

This iterative learning process provides the analytical framework that is applied to each Leading by Design participants' life and work to provide the evidence of how improving the environment has systemically and sustainably improved health and/or healthcare. It should be noted that, because of the inherently creative nature of this learning process, participants have the freedom to apply it flexibly.

Further, it should be noted that the learning process that the Leading by Design project utilizes is not a conventional, 'academic-type' of classroom or book learning. Rather, the Leading by Design learning process relies on an approach to experiential learning requiring each participant to draw upon specific challenges that their own unique day-to-day experiences provide the situational context for.

Personal Context: My Own Learning Journey

My journey to become both the originator of the Leading by Design project, and a case study participant in it, actually can be traced back to 1973. At that time, as an undergraduate student of architecture, I became passionately interested in better understanding how the environment can be used to improve health and healthcare.

As the years progressed, my interest in developing this better understanding deepened. I committed myself to a career in healthcare architecture, and subsequently enrolled in a Master of Architecture program that offered a specialized 'health facility planning and design' graduate degree.

I developed a successful career as a practicing architect – yet, my interest and curiosity continued to deepen as I yearned to discover how to make healthcare facilities that tangibly improved health. As my quest for this discovery spanned the globe for practical answers – and I found very few – my focus began to evolve away from a desire to be a practitioner toward becoming more of an influencer. Although my interest and passion did not waiver, I began to see my self in the role of influencing the overall industry to better understand how to build more life-enhancing healthcare facilities – rather than my actually designing them myself, anymore.

During the period of 1978 – 1985, while still engaging in professional practice as an architect – because of my shifting focus on learning and influencing, rather than practicing – I began to spend increasingly more of my time teaching in universities and design schools, lecturing at conferences, and writing articles.

In 1985, I made the landmark decision to start a new symposium that would engage a diverse cross-section of healthcare and design-related stakeholders in an inquiry into both the desirability and the practicality of creating 'healing environments'. The first symposium was held in 1987. The twentieth annual symposium was held in Chicago in 2007. During this twenty year period, the entire healthcare industry has dramatically – and visibly – advanced.

In my dual role, both as a practicing architect and as the leader of this rapidly expanding symposium, it had become increasingly apparent to me that quality research was now required to lend support to claims that the environment could be more effective in its support of healthcare.

In 1993, I founded The Center for Health Design to serve as the umbrella organization for an expanding portfolio of initiatives – of which, by now, the symposium was just one of the many. One of the core purposes for my founding The Center for Health Design, was for it to function as a non-profit organization and – therefore – be well positioned to fund, produce, and disseminate quality research. Today, The Center for Health Design continues to function in this useful capacity.

1998 was an extremely eventful year for me, as I continued to follow my interest in developing a better understanding of how the environment can be used to improve health. I was awarded a Loeb Fellowship for Advanced Environmental Studies in the Graduate School of Design at Harvard University. This provided me with a one-year residency at Harvard, and access to its vast resources, for the purpose of improving my effectiveness as an industry leader. I spent the year immersed in leadership studies within the Kennedy School of Government, having realized that learning more about effective leadership was the single-most useful resource that Harvard could provide to me.

Also in 1998, in my ongoing role as the President and CEO of The Center for Health Design, I succeeded in selling the production rights for the annual symposium to a for-profit, event-producing partner. This transaction provided The Center for Health Design with a much-needed infusion of capital, and allowed the important transition to be made from an event producing organization to becoming a resource producing organization, with a partner providing the platform for The Center's content to continue to be presented upon.

During this period of twenty-five years, that I have just outlined – and, particularly, during the last 3 to 4 years in this period – it had become apparent to me that something, quite significant, was still missing in our ability to develop a better understanding of how the environment can be used to improve health. Indeed, our inquiry into 'healing environments' resulted in a noticeable overhaul of our healthcare building stock – both in the US and around the developed world, and the idea that the design of the healthcare environment could be – and should be – evidence-based had become well established. And yet, it seemed to me, that a large gap remained in our ability to develop this better understanding and to implement it in such a manner that health became materially improved.

This gap, it seemed to me, had something to do with the ability of the environment to support, encourage, and reinforce both systemic and sustainable improvements in health. In many of the projects that I designed during my years as a practicing architect, as well as in the Planetree projects, and in an occasional rare discovery – the environment did enable systemic and sustainable improvements in health - - - however, in most other projects, this did not appear to be the case.

In early 1999, having completed my residency at Harvard, I met with my Executive Committee at The Center for Health Design to discuss how my recent experience – as a Loeb Fellow – could inform the work of The Center for Health Design.

In my discussion with my Executive Committee, that afternoon in early 1999, we talked about this gap. I proposed that, since there were so many more questions than we had answers for, I wanted to contribute toward closing this gap by engaging in original research to explore these questions – and, in the course of doing so, work toward earning a PhD. The conclusion of our discussion was my departure from The Center for Health Design as its founder, president and CEO.

Professional Context: Founding The CARITAS Project

In March of 1999, I founded The CARITAS Project to serve as the organization that would pioneer the next generation of resources for improving health and healthcare with the environment. In August, 2000, I was awarded a three-year grant from the UK government to conduct original research to pioneer these new resources, that would lead to my receiving a PhD.

In July, 2005, The Manchester Metropolitan University awarded me a PhD for the completion of a dissertation entitled: 'An "Action-Oriented" Research Investigation To Develop A Better Understanding Of How Space Can Be Used To Improve Health And Healthcare Delivery'. In conducting this investigation, I spent 3 years doing fieldwork with 18 individuals to learn about improving health from their unique experiences with the local healthcare environment. I, then, spent an additional year analyzing my fieldwork, reflecting on its implications, and 'writing-up' my findings.

Research Context: Designing the Leading by Design Research Project

It was during this time that I began the Leading by Design project. There were three distinct reasons for my deciding to do this. First, since my fieldwork was complete, I already had a clear indication of what my research findings were. I was excited to test these findings out with participants representing larger stakeholder interests and across a wider geographical field.

Secondly, within the University framework for writing a dissertation, there is a section that must be written on 'further work'. This section is intended to describe how the original research will be further developed for its practical application, beyond the completion of the dissertation. I used the opportunity that this section provided to formulate and describe the initial research design for the 'Leading by Design' project – and, also, I wanted to take advantage of the scientific scrutiny that the rigorous academic review process would provide.

My third reason for beginning the Leading by Design project was to actively take the work of The CARITAS Project forward, and – as such, for it to serve as the practical means to enable The CARITAS Project to succeed in pioneering the next generation of resources to improve health and healthcare with the environment. The CARITAS Project had already conducted two projects, since its founding in 1999 – a Leadership Summit, in 2001, for 22 invited participants; and an international conference, in 2003, for 100 invited professionals and 2500 local participants.

I used this initial description as an 'invitation' to invite diverse, non-competing healthcare stakeholders to join the project. Now, four years later, there have been a total of 14 participants and there are currently 11 active case studies that are engaged in operationalizing the findings of my research in their respective contextual situations.

4. Key Learnings and Outcomes

Year One: Defining a New Practice of Leading

My PhD research provided me with the dramatic evidence and first-hand experience that it is possible to create the environment in a new and different way, so that health and healthcare can be systemically and sustainably improved.

Reflections on my practice –

I found that the overall concept of 'generative space' is relatively simple for most people to understand – however, as I reflected on my many attempts to explain how to cultivate 'generative space' I realized that the actual practicalities of explaining it are both elusive and difficult to visualize. Consequently, I decided to make a diagram to make it simpler for me to discuss the cultivation of 'generative space' with the participants in the Leading by Design project, and with prospective participants.

Generate new learnings from these reflections –

In my initial sketches, of this diagram, I used the findings from my dissertation to illustrate the relevant and overlapping knowledge domains, their relationship to one another, and the respective thematic findings in each of these domains. In the research for my dissertation, I had concluded that there were three relevant knowledge domains – health, culture, and environment. Each one of these domains included various thematic findings related to the exercising of leadership.

This activity of developing a diagram provided me with the opportunity to reflect on the practical application of my dissertation findings to the more broad field of practice. In these reflections, I realized that, in fact, I had not given adequate recognition to the overall importance that the subject of leadership plays in cultivating life-enhancing environments for health and healthcare.

This reflection, of the overall importance of leadership, significantly informed my practice by enabling me to reconfigure the findings from my dissertation into four knowledge domains – with the newly defined domain of leadership becoming the all-encompassing domain, within which the other three became situated (see Appendix, Figure 1).

And more precisely, this series of reflections generated a new learning for me by clearly establishing the primacy of the practice of 'leading' as the critical understanding that is required in all attempts to cultivate 'generative spaces' that make both systemic and sustainble improvements.

Inform my practice with these new learnings –

This new learning allowed me to appropriately define the overall practice of working toward cultivating 'generative space' as the practice of 'health design leadership'.

Specifically, this practice of 'health design leadership' will not, in-and-of-itself, create spaces that are generative- rather, developing mastery at the practice of 'health design leadership' is just one of the competencies necessary in a process of learning that supports the ability to cultivate 'generative space' predictably, reliably, and consistently.

And finally, at the end of my first year in Leading by Design, my most significant new learning – as I engaged with my own practice to define a new practice of leading – was the understanding that Leading by Design is a learning process about personal leadership. Now, having arrived at this essential clarity, I focused my efforts in the second year at developing a coherent learning process that would provide increasingly advancing mastery in the practice of cultivating 'generative space'.

Year Two: Defining the Leading by Design Project

Reflections on my practice –

In the beginning of my second year of Leading by Design I realized that this second phase of my research really had the potential to have a significant influence upon mainstream practice – yet, as I reflected on my practice of engaging with Leading by Design participants in the research, it was not perfectly clear to me exactly what the critical essence of this learning process of Leading by Design was – or, how to most effectively share it with others.

This reflection enabled me to focus my attention on demonstrating the tangible benefits of cultivating 'generative space' to make systemic and sustainable improvements to health and healthcare. As I reflected on my new practice, I realized that the benefits of these improvements are precisely what prospective participants are seeking, and that my ability to design and deliver a learning process that enables participants to produce these benefits was the unique contribution of the Leading by Design project.

Generate new learnings from these reflections –

My reflections helped me to become highly focused on engaging in conversations – both with the Leading by Design participants, as well as prospective participants – that identified their own practical leadership challenges as the subject of our conversations. This new and sustained focus, which was a learning generated by my reflections, enabled me to identify those contextual challenges – that were unique to each of the participants – as the material to apply the Leading by Design learning process to.

Inform my practice with these new learnings –

Up until this time, it was my practice to discuss 'generative space' conceptually – without ever having written a working definition that could be shared with all of the participants. My new focus on the contextual leadership challenges of the participants – as a new learning – informed my practice by enabling me to understand the need to draft a working definition of 'generative space' (see Appendix, Figure 2). This working definition augmented the Leading by Design diagram (Figure 1) and helped to further define the overall Leading by Design project.

Year Three: Validating the Leading by Design Project

Reflections on my practice –

The first two years of the Leading by Design project were challenging, to say the least: I was defining the research and the project as I was doing it; I was continuously learning how to cultivate 'generative space', myself, and to actively demonstrate it; and three of the participants did not renew their participation after their first year.

At the very end of the second year, I convened the first Learning Collaborative. Five of us met for 3 days in May 2005. At the conclusion of the meeting, the group was delighted with its outcome and were enthusiastic about planning our next Learning Collaborative. This enthusiasm indicated to me that these other four participants would continue their annual participation because they were receiving definite value for their investment – I took this as an important, and needed, signal of personal encouragement.

Additionally, two new participants had just joined – but it was too soon for them to make the arrangements to attend the Learning Collaborative. As I reflected on my practice during the past two years of developing the Leading by Design project, I found that I had a life-affirming sense of personal and professional validation for this work.

Generate new learnings from these reflections –

As I reflected, further, on my new sense of validation – a new learning emerged: both the Leading by Design project and I were now ready to engage in a larger scale validation project.

This new learning formed the agenda for the next eighteen months – an international speaking tour to present the Leading by Design project to professional and academic audiences. My new learning about the importance of peer review validation of this research initiated the third phase of the Leading by Design research project – that of a peer review process through presentations made to an international group of diverse healthcare stakeholders.

Inform my practice with these new learnings –

By the middle of the fourth year, I had made 12 peer review presentations about the Leading by Design project. My own personal practice of actively exercising 'health design leadership' to increase my own mastery in cultivating 'generative space' reached a new level of confidence as a direct result of both this peer review process, as well as the through the validation that this process afforded the Leading by Design project. I now knew for certain that the Leading by Design learning process would leave its indelible mark upon the mainstream practice of health and healthcare delivery.

Year Four: Broadening the Influence of the Leading by Design Project

Reflections on my practice –

A new awareness has come to me – within the expanding 'portfolio' of the Leading by Design project outcomes, there is now a sufficient body of evidence to support a focused discussion about the ability of the Leading by Design learning process to close this sustainablity gap that I have identified – the subject of my discussion with my Executive Committee in early 1999.

This new awareness has enabled me to shift my thinking: re-focusing the emphasis of the Leading by Design project from only being based upon the case study accounts of the participants, to a new and equally meaningful focus that is based upon specific topics – in this case, that of 'sustainability'.

Specifically, within the context of Leading by Design, the term 'sustainability' means that the improvements that have been made by the active exercising of 'health design leadership' to cultivate 'generative space' are improvements that continue to improve over time.

Generate new learnings from these reflections –

The second Learning Collaborative is scheduled to be held in London, in February 2008.

As I reflect upon my recent experiences, and the new learnings that I have gained from these – particularly in anticipation of my organizing the Learning Collaborative to serve as a most useful learning experience for all of the participants – my own practice has been informed, in my role as the project organizer, by my new awareness that I should plan our discussions to provide the space for both dimensions of the Leading by Design work to be discussed: (1) the case studies as well as; (2) a focused discussion about the evidence of 'sustainability' that we, as a group, are now producing.

Inform my practice with these new learnings –

This new learning, about highlighting our focus on documenting evidence of sustainable improvements to health and healthcare that we have achieved through our active cultivation of 'generative space', will – most likely – become the theme of year five of Leading by Design. This new learning will inform my own practice by providing a theme for the coming year's work, that seems to be emerging as – 'Sustaining and Documenting the Improvements that have been Achieved through the Leading by Design Project'.

5. The Future

As the Leading by Design project progresses through its fourth year, it is well positioned to expand the pattern that it has already established. Specifically, in its quest to expand this pattern, it will be addressing its ongoing viability as an applied research project; and its ability to successfully assert an impact upon the mainstream practice.

From my position of learning today, and prior to the new learning and understandings that emerge at the upcoming Learning Collaborative, the future Leading by Design activities will include the following, as they seem to offer a prudent path forward:

2008 -

Establish the fourth phase of the Leading by Design project – a 'prototype' project.

Establish the fifth phase of the Leading by Design project – a formalized learning program.

Continue to expand the influence of the Leading by Design project.

2009 –

Begin writing the 'generative space' book.

2010 –

Finish writing the 'generative space' book.

Present all completed Leading by Design case studies at an international conference and

publish the proceedings as a special issue of a distinguished academic journal.

Establish the sixth phase of the Leading by Design project –

the operationalization of the 'care-centred model' within a major provider system.

6. Concluding Reflections and Summary

The reflexive process of writing my own Leading by Design case study account has helped me to demonstrate the actual reflexive steps that this personal learning practice entails. Additionally, it has helped me to clarify a series of my own key learnings, and in doing so, it has enabled me to have a more strategic perspective on planning an intelligent network of future activities.

In my reflecting back, and in my imagining forward, I am – both - inspired by the progress that Leading by Design has made toward its goal and extremely enthusiastic about the future potential for the continued expansion of this work.

7. Appendix

Figure 1. The Leading by Design Diagram

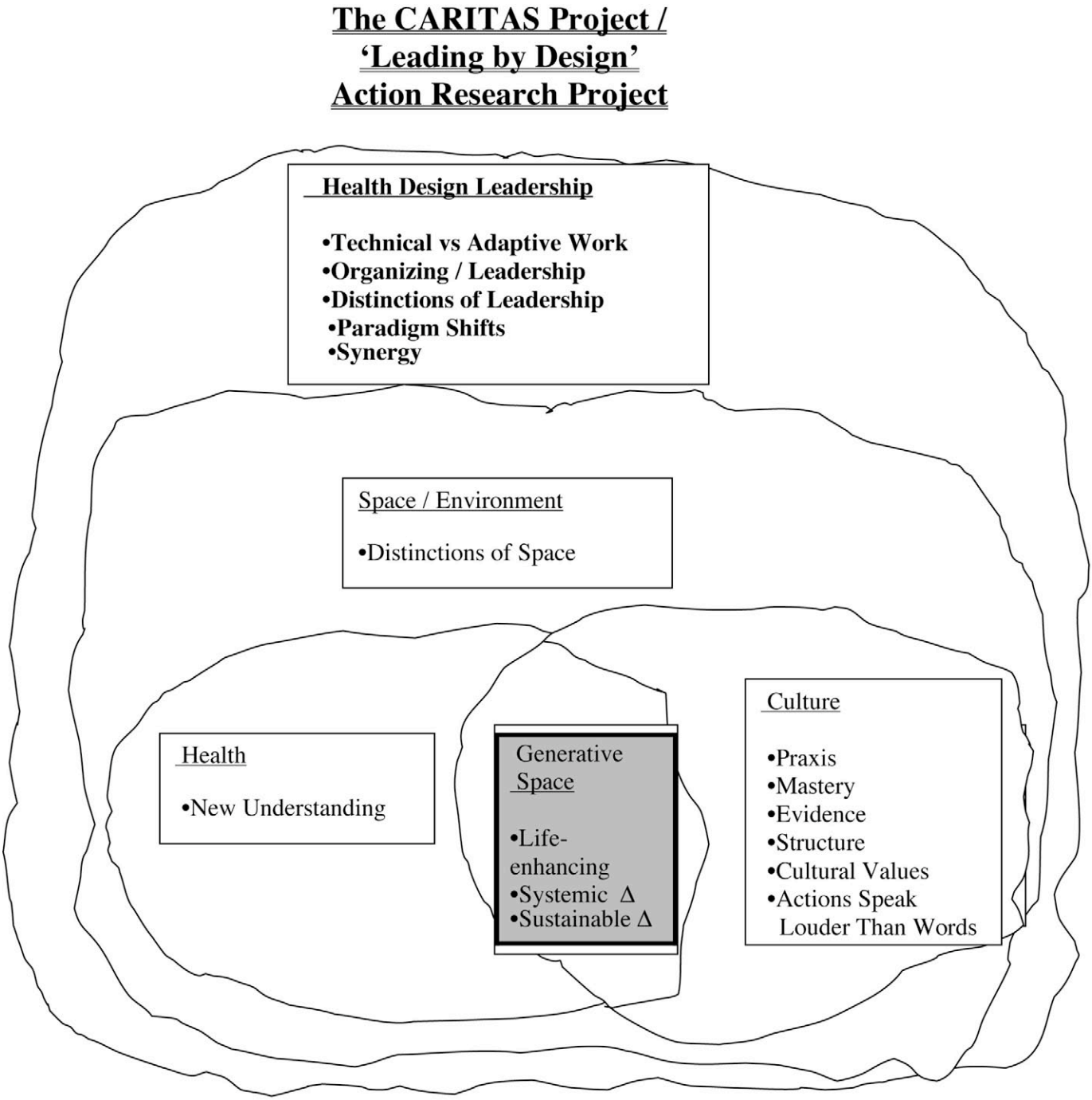

Figure 2. Working Definition of 'Generative Space'

As a means to develop a shared understanding of 'generative space', please consider the following as a working definition –

'Generative space' is a place – both physical and social - where the experience of the participants in that place is one that both fulfils the functional requirements of that place and it also materially improves the health, healthcare, and / or quality of life for those participating in that experience in a manner that they can each articulate in their own terms.

Additionally, and by its very nature, a 'generative space' is a place that progressively and tangibly improves over time.

The purpose of cultivating 'generative space' is to improve performance effectiveness. Depending upon the interests of the particular individual, the organization, or the community – the measurements of effectiveness will vary. However, in all cases, whatever these measures are – they will be used to encourage, support, and reinforce increasing performance effectiveness in health, healthcare, and /or quality of life.

The goal of understanding how to cultivate 'generative space' is to be able to produce it consistently, reliably, and predictably across the full range of life's contextual situations – including –

1. our personal lives;
2. our professional and organizational work; and
3. throughout the vast spectrum of our community engagements.