The Princess Margaret Hospital (PMH), one of the world’s leading cancer research hospitals, found itself in an enviable yet challenging situation. The hospital had received a major financial gift to redesign its systemic therapy (chemotherapy daycare and transfusion) facilities. These facilities were both over capacity and in need of improvement, both functionally and aesthetically. PMH’s vision was to create a new space and experience that was truly patient-centric and world class. To do so, they required a better understanding of what patients experience and what matters most to them. There was universal recognition that achieving this goal would require new thinking and innovative methods.

Patient needs are often not well understood or satisfied, sometimes because even the patients can imagine only variants of the current system.

Fortuitously, a research team at the University of Toronto’s Rotman School of Management, led by the lead author (Brian Golden), had also received a gift from a corporate donor with a patient-focused mandate – to examine ways in which healthcare...
in Canada could be made more patient centric. The Rotman gift was made by MDS Inc. in honour of a senior MDS colleague who had recently passed away and who had received some of his care at PMH. That patient’s family and friends had the highest regard for the quality of clinical care at PMH but had been frustrated by a system that seemed to give short shrift to the full patient experience. The donor had explicitly requested that the Rotman team develop novel solutions for a system, starting at PMH, that had lost sight of the overall patient experience and instead focused more on the care delivery process. To PMH’s credit, its leadership recognized the opportunity and the Rotman research team was invited to work with their staff, physicians, patients and families to explore a more patient-centred approach using a technique new to healthcare but often used in the private sector – the Rotman Creative Design Process. This article describes the Rotman Creative Design Process and how it was collaboratively implemented by Rotman’s research team, PMH and their patients and families to redesign care. The results gave the hospital a “patient experience blueprint” that would shape subsequent improvement activities, from the design of physical spaces and new patient-centric services to the alignment of organizational systems and processes necessary to sustain any enhanced patient experience.

Patient-Centred Care
Healthcare organizations and systems in Canada have regularly evolved incrementally and, too often, unsystematically. This is not unique to healthcare. We see opportunistic organizational changes in a range of industries that lead organizations away from their central espoused goals. In healthcare, this has resulted in an accumulation of old and new processes that may better serve the interests of the systems’ permanent custodians, the healthcare professionals, than those of patients and clients. This is not surprising when one considers some of the design features of health systems: patients have few choices about from whom and where they receive care, patients are reluctant to criticize those who provide this care, and the information and systems needed to identify and correct a problem are often lacking or the solutions implemented are a band-aid treating a symptom but not the root cause of system underperformance.

In most instances, a system’s custodians have the best of intentions and assume that they are serving patients as well as they can, given available resources. Our experience in other organizations has suggested that patient needs are often not well understood or satisfied, sometimes because even the patients can imagine only variants of the current system – as opposed to entirely new approaches. Mindful of these challenges, we approached our goal with methods and techniques that have been successfully applied in private sector industries but largely neglected in healthcare.

The Practice of Design
Design can be usefully classified into two types – the more traditional analytical design and the approach developed in our work, creative design.

Analytical Design
For reasons of certainty and in some cases simplicity, organizations have historically favoured a more analytical or convergent design approach in which data are gathered and analyzed and a seemingly rational model results. This process relies heavily on logic and critical thinking. While common, it is important to recognize the limitation of analytical design; it works best when trying to optimize an existing solution. In other words, it is anchored in current reality and inhibits the most creative thinking needed to truly re-conceptualize the process of care. As Henry Ford noted, “If I’d asked my customers what they wanted, they’d have said a faster horse.”
Creative Design
The less commonly practised design method is exploratory or divergent in nature. As opposed to converging toward a solution at the onset of a project, this type of designer spends considerable time broadly re-examining what is and, more importantly, what could be. This entails questioning common truths, exercising curiosity and continuously reframing the problem from various perspectives. When it comes time to converge, practitioners of this approach rely more on intuition and insight – leading to the creation of multiple possibilities to be tested (e.g., “prototypes”) and evolved.

The Rotman Creative Design Process
Despite its organic quality, the creative design process must also be rigorous in order to distill often-chaotic and overwhelming amounts of data and ideas. Figure 1 provides an overview of the three-gear framework and identifies how healthcare leaders can begin the design process in their organizations.

Gear One: Empathy and Deep Human Understanding
The objective of Gear One is to identify fundamental patient needs – to see the world through the eyes of the patients. As suggested in our description of the analytical design approach, traditional efforts to uncover true needs are constrained by past experiences. For instance, patients complain about a scheduling system that has them waiting for hours for laboratory work and results, but this critique is anchored in their current reality where patients take for granted that laboratory work must be done at the hospital and on the same day as their visit. What if it doesn’t? What if laboratory work could be done off-site, the results transferred into the patient record and, depending on the results, the patient could stay home and avoid going to the hospital altogether? To truly know what users needed, we looked beyond what was being said and saw with fresh eyes patient behaviours and experiences as indicators of patients’ real needs. To do so, we employed several ethnographic research methods, some originally developed in the field of anthropology.

Field Observation
We began with a classic observational exercise. Over five days, at different times each day, two researchers set up house to shadow patients and staff in situ. Typical observation sessions lasted two to four hours, and we ensured that we had different vantage points that corresponded to patients’ travels through the clinic. With notebooks in hand, dressed inconspicuously and intentionally not interacting with patients, we recorded observations answering a variety of questions, for example: What does the space look, sound and smell like? What are patients doing? Are they talking to each other? About what? Do they seem happy, sad, anxious? We attempted to record as much as possible and to avoid biases that might lead to the screening of information. Multiple observers helped mitigate such screening.

Engagement
Subsequent engagement exercises had team members experience a typical day in the life of a patient. Here we moved from passive observation to active participation, with the goal of empathizing with the patient. For instance, the researchers assumed the role of a “mock patient.” In the ideal, mock patients experience as much of the care process, from start to finish, as possible – short of the clinical care itself. In our work at PMH, casually dressed researchers were given instructions as if they were patients. For example, one mock patient showed up at the hospital not knowing where to go. When he finally found the appropriate clinic, he was told that he could not be seen without his hospital card and was sent to a different area to have one produced. There he waited for an hour before returning to sit for over two hours in a treatment chair typically used for chemotherapy. During his time in the clinic, he made notes about his own experience and those of others he observed. He returned the next day for another chemotherapy experience. Over the course of these visits, the mock patient recorded many useful observations:

- Waiting rooms are cramped and too warm; traffic overflows into hallways.
- There is congestion in front of the check-in and scheduling areas as patients show up early in the day for their appointments, regardless of their scheduled time.
- A lack of activities during waiting and treatment results in mental restlessness or exhaustion (i.e., tired from doing nothing).
- Patients are reluctant to leave the waiting areas for fear of losing their place.

The mock patient exercise, akin to the “mystery shopper” in retail environments, can be done by many organizations without bringing in outside researchers or consultants. However, if staff are used, we have found it helpful for these staff to come from another part of the organization so that they are not known to the staff and patients being studied.

Photo Journaling
The next stage was even more unorthodox for healthcare. Recall, the original focus of the project was to look at chemotherapy/systemic therapy treatment within the hospital. However, our initial field research and conversations with staff and patients showed us that patients do not think about their cancer solely in terms of receiving treatment – although that is how the system has been designed. Consequently, the research scope was expanded to “how patients live with and manage cancer.” This subtle yet dramatic shift allowed us to create a more holistic and
A richer picture of patients’ lives, which, in addition to treatment, include work, home and play.

Since we could not observe patients 24/7, a group of 20 patients and seven caregivers were asked to record their experiences living with cancer over a period of one week. They were each given a field kit that included a camera, a notebook and a set of instructions to document in words and photos key moments, good and bad. They were asked to consider questions such as these: “What is happening all around you? What rituals do you have to help you cope? What relationships are important to you?”

The notebook had several pages with a blank cartoon face pre-drawn, including a thought bubble above the face (Figure 2). Patients were encouraged to draw an expression on the face and to write a caption in the bubble to describe their thoughts and feelings at key moments in the experience (e.g., getting blood work, waiting for an appointment). At the end of the week, patients returned the field kits to a drop box at the hospital.

Our objective was to understand the high and low points (i.e., extremes) of the patient experience, ultimately generating new insights into what could be brought into the hospital environment and what should be eliminated. The photographic and journaling approach allowed us to collect data through the eyes of patients.

**The conversation had** an organic form, forcing the researchers to actively listen and continuously explore what was happening in the mind of the patient.

**Open Conversations**

A follow-up conversation was held between two members of the research team and each patient that was given a camera-and-journal field kit once he or she had completed the exercise. In the discussion, researchers began by displaying one of the patient’s photos and simply saying, “Tell me the story behind this photo.” These discussions, taped with permission, involved one researcher guiding the conversation and one taking notes. When points of interest were introduced in the story or prompted by a photograph, the researcher prompted, “Tell me more – why was that important? What else was happening?” As opposed to following a pre-planned, formulaic interview process, this conversation had an organic form, forcing the researchers to actively listen and continuously explore what was happening in the mind of the patient.

The photo journaling in conjunction with open conversations generated a variety of patient stories. For instance, we heard about children making toys for their ailing mother in an attempt to “keep her company” while she was at the hospital; about pets and the healthy distraction of being responsible for them; and about daily rituals that helped patients escape from the pain and anxiety. Such stories became the foundation for the redesign of their experiences.

Consider some patient comments:

**Space:** “The blank walls are really austere. Sometimes when I’m getting chemo, I’m looking at a blank wall for seven hours. Sometimes they put you in a room without a window; it’s like being in prison.”

**Engagement:** “I once sat there for five hours not even knowing what was going on.”
You sit there with nobody coming and saying a word to you.”

Space: “Three chairs side by side, people listen to your business; it makes people close off – no privacy or comfort. I completely lose all the good feelings. The hallway is the March of Death.”

We also heard positive stories of how front-line staff made the ultimate difference in patients’ experiences, how friends and family selflessly gave their time to help and the many “workarounds” patients employed to make their treatment and lives more pleasant:

Family support: “He is extremely devoted; we are a very close couple. The support from my husband, my family, my friends has been unbelievable.”

Patient support: “When I’m waiting, I meet a lot of interesting people all the time. I’m very chatty, and they help me pass the time.”

Staff: “PMH represents the absolute peaks and valleys of the human emotional and physical experience – the nurses are just terrific – supportive as human beings in their care and contact.”

Need Finding:
Distillation and Synthesis
Once each interview was completed, the research team analyzed the interview data line by line and then gathered in a room with a large, blank whiteboard to draw a “mind map” (Figure 3) to identify common themes and ideas. To make a mind map, we drew a circle for each theme, with supporting information branching off again and again until exhausted. At that point a new central theme and branches were formed. The result of this process was the identification of core patient needs that were common to all patients regardless of type.

- To have support and connectivity to friends, family and staff – “Living with and managing cancer is tough. I need to feel supported and connected to the people around me.”
- To be engaged, physically, emotionally and mentally – “Life goes on hold with this disease. I need to stay active and engaged, physically, emotionally, mentally.”
- To be in the know and have a sense of control – “There is so much that I don’t know. I need to know what is happening, to have a sense of control in my life.”
- To heal in a humane manner (e.g., recovery of the mind and body) – “Treatment takes more than just a physical toll. I need to heal in a humane manner.”
- To have things be simple and effortless (e.g., to have things easy to get and do) – “Cancer adds another layer of

![Figure 3. Mind map](image-url)
complexity to my life. I need for things to be simple and effortless.”

All of these needs relate to the common themes of providing the patients with a sense of hope and reducing anxiety. In our experience, these needs are frequently unmet by systems that are designed primarily (or only) to provide optimal clinical care.

**Patient Personas**

Based on these five needs, the patient data and insights were consolidated into four distinct patient “personas” – characterizations of patient groups based on similar needs, attitudes, motivations and challenges in aggregate. These four personae represented the majority of patient archetypes and were used as a tool to describe the varied needs of patients. They would later, in Gear Two, form the base for the design of the ideal patient experience. They became “virtual test subjects.” As an example, “Pamela” emerged as a patient persona (Figure 4).

Pamela’s needs are the following:

- **Support and connectivity** – “My husband passed away, and I cannot do this alone.”
- **Engagement, physically, emotionally and mentally** – “I live alone, and my kids who have grown up can’t always make time for me.”
- **Personal empowerment and control** – “This disease has taken over my life, and I feel helpless.”
- **Humane healing** – “Cancer is not just physically but also emotionally and mentally debilitating; it’s all connected.”
- **Effortless simplicity** – “My life is already too complex and moves too fast. I worry about money, health, food and the well-being of others.”

The three other personae (see Figure 5) greatly helped personalize our discussions with the hospital project team, shifting conversations away from administrative processes and protocols and focusing instead on the patient (see sidebar “Three Additional Personas”). The personas also served as a valuable reference for staff when validating current and future initiatives (e.g., Could we imagine the persona using this? What would our persona say about this? How does it add value to the patient experience?).

It is helpful to consider the following experience at PMH that occurred prior to our involvement to see what can happen when the patient perspective is absent from design decisions. After substantial consideration involving numerous staff, one of the PMH clinics identified several possible chair types for the waiting room. Because patients spend much time there, the staff, led by a senior physician, wanted to ensure that patients would wait in comfort. Consequently, PMH staff “road-tested” these chairs for several days and identified the most comfortable chair. Regrettably, after all that time and expense, the patients did not find these chairs comfortable at all. The explanation? The PMH staff were healthy and had not lost the weight that cancer patients usually do. Healthy people did the testing, not the end users – frail cancer patients. Despite their best intentions, this caring PMH physician and his staff failed to keep the typical patient in mind. The use of personas makes unfortunate experiences such as this much less likely to occur.

**Gear Two: Concept Visualization Ideation**

Building on the identified patient needs, personae and a deeper understanding of the patient journey, 20 staff at PMH underwent a group ideation session. Oncologists, pharmacists,
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nurses, researchers and administrators were in attendance; were it not for scheduling challenges, patients would have been present also. The staff were divided into multidisciplinary groups, assigned a patient persona and journey and asked to imagine solutions to improve the systemic treatment experience while better meeting their persona’s needs. No constraints were given, to encourage a broader pool of ideas. For instance, staff were asked to consider other industries and practices (e.g., hospitality, tourism, health and wellness, media/music, virtual/online services etc.) as inspiration for the ideal patient experience.

In a span of 90 minutes, staff generated over 400 ideas that included such possibilities as personal secretaries, waiting room greeters, personal support staff, Zen gardens and relaxation pods. While many of the ideas themselves seemed far-fetched, the goals behind these ideas were often achievable with more practical solutions. For example, one team drew analogies between patient treatments and flying on an airline. Some patients have “short haul” treatments (e.g., less than 60 minutes) while others have long “trans-Atlantic” treatments (e.g., more than four hours). The team drew inspiration from business class flights in which luxury airline seating has evolved to achieve a fine balance between comfort (e.g., adjustable seating), entertainment (e.g., in-flight activities) and productivity (e.g., web access, work tools). This led the team to develop a patient experience around a never-before-seen, ideal chemotherapy chair.

Teams were also asked to be visual in their brainstorming. Instead of words on paper, participants were encouraged to draw, sketch or map-out their concepts. This exercise made the ideas more tangible, allowing for more robust discussion and practical idea development. The brainstorming session led to a myriad of possibilities for the new treatment facility and patient experience. The solutions did not rely solely on the treatment space but also on the purposeful delivery of patient-oriented services, activities, information and people.

Experience Design
Having elicited various possibilities, rough conceptual prototypes of the ideal patient experience were further developed in the form of visual storyboards. These were used to walk participants through an idealized yet realistic and improved patient experience.

Staff (at all levels) and patients openly discussed the pros and cons of the prototypes and suggested improvements for each concept. The prototypes were further refined and evaluated in an iterative fashion until the ideal patient experience was fully formed. By visualizing the patient experiences in a rough, unfinished format, staff and patients were more open to contributing feedback. In addition, the active solicitation of feedback from hospital staff gave them a greater sense of contribution and ownership toward the final outcome. What follows is an example of an idealized patient journey:

- At home, the patient checks her treatment schedule and books a treatment pod online.
- Through the use of a hospital valet service, her car is parked in a subsidized lot.
- Using the self check-in terminal, the patient is issued a treatment time and a text pager to allow her to stay in touch with clinic staff.
- Treatment wait times are displayed on electronic screens around the hospital.

FIGURE 5.
Three Additional Personas

Anton Ludic
Age: 25
Occupation: Student
Status: Single
There are not many younger patients (18–28 years old) at this hospital. Anton feels disconnected from all the other in-house patients. He has a somewhat reserved nature but has a very tight circle of friends and is always eager to help. He has been blogging about his treatment journey. Anton sees treatment as “just something that needs to be done and over with.”

Susan Arsenault
Age: 35
Occupation: Social Worker
Status: Single
Susan is currently in palliative care and undergoing experimental treatment. She loves to interact with new people and has many friends and family who always offer to help out. Although her work life and home life have dialled back significantly, she makes a conscious effort to do things for herself. She is very aware of the time she has left, and this causes her great stress.

Andrew Tam
Age: 46
Occupation: Auditor
Status: Married
Andrew is married with two daughters and used to lead a fairly active lifestyle in his community: volunteerism, coaching the local kids’ hockey team, fundraising etc. He’s been twice diagnosed with cancer and is relatively comfortable with the treatment process. He still works full time, but he worries a lot about his professional commitments and his ability to provide for his family.
• Computer terminals, entertainment and social activities are available while waiting.
• At the appointed time, she is taken into her pre-booked treatment pod, which resembles business class airline seating, including access to video and audio programming.
• Upon completion, she checks out at the self-help terminal and is issued a summary of her past few appointments.
• At home, she has access to discussion boards and patient support groups via the hospital terminal. She shares her latest thoughts and tips online.

User Feedback
The process of engaging users early in the design process is not common practice. Feedback is usually reserved until a final and fully formed product is created (e.g., a formal pitch or presentation). The challenge with this method is that significant changes are rarely considered this far into the development process. Frequently, the request for feedback is really just a courtesy and formality, and if it results in changes, they tend to be incremental and modest. By engaging users in the feedback process early and often, important insights can be heard before any significant investments or resources are committed. This allows for proper course corrections up front. As the design adage goes, “Fail early and often to succeed sooner.”

In our case, we presented the prototypes to patients and asked, “What works here?” “What doesn’t?” “What could be better?” The patient experience concept that rose to the top was based on the idea of turning lost time into found time. Patients often reflected on how their entire lives were put on hold in order to seek treatment and focus on beating the disease. This, combined with the fact that long wait times in a hospital are a necessary evil, painted a fairly bleak picture for patients. While the hours spent in treatment or waiting for test results were never going to go away, the ability of patients to convert those seemingly wasted hours into something more meaningful would substantially improve their experience. For example, instead of staring at a blank wall or television, they could share their experiences with others, engage in a new activity or heal in other ways (e.g., light therapy or meditation) to supplement the standard clinical care. By drawing inspiration from patient stories of their lives outside the hospital describing who and what supported them through their challenge, the team realized how the patient experience in the hospital could become an enabler of intellectual, mental, spiritual and social support, rather than only medical care. This reframing led to ideas that included social and private recovery areas, work and education resources, engaging activities, inspirational cues, peaceful and natural designs and new furniture.

Gear Three: Strategic Business Design
Gear One and Two activities are exceptionally useful at identifying patient needs and wants and for redesigning – in theory – an improved, patient centric experience. Challenges still remain as we move from concept to implementation, bridging the gap between the ideal and doable. Whether we’re contemplating a complete renovation and new treatment chairs or more straightforward changes such as reliable pagers, Internet-enabled iPads for entertainment and more comfortable furnishings, improvements to the physical space on their own are not sufficient.

Gear Three encourages us to consider the systemic challenges to enhancing the patient experience, which includes some changes within the hospital and some beyond. Others may require macro-system changes (e.g., funding) to ensure that the hospital and the health system are aligned to provide an enhanced patient experience (cf., Golden and Martin 2004). This is the role of Gear Three, strategic business design, where the focus is on ensuring that systems support enhanced design. Consider the following three observations made in Gear One and their Gear Three implications.

First, clinic staff typically performed their duties expertly but largely in isolation of earlier or later stages in the process of care. For example, physicians always found a patient waiting for them, but rarely did they know how long the patient had been there or whether the systemic therapy area was ready to receive the patient after the physician meeting. Once the PMH physicians were made aware of the wait time issue through observational reports from our team, many were keen to participate in initiatives to lessen the waits and improve the connections.

Second, patients frequently arrived at the clinic several hours before their scheduled appointment. Why? The simple answer involved parking. Nearby parking lots offer sizeable “early bird” discounts before 9:00 a.m. This, combined with volunteer-driven vans to bring groups of patients to the hospital and patients anxious to avoid rush-hour traffic, resulted in patients arriving very early. Caring staff then exacerbated the predictable waiting time problem by allowing the early patients to be seen on a first-come, first-served basis regardless of scheduled appointment time. The simple processes of field observation and engagement were required to identify this cause of delays for many, and suggested relatively straightforward solutions (e.g., showing staff how their well-intended efforts to minimize the waits of some increased wait times for many others; the need to collect information on waits and provide feedback to staff; scheduling more time-intensive patient treatments earlier in the day). These processes also revealed the value of providing the clinics with process improvement support, such as Lean

By engaging users in the feedback process early and often, important insights can be heard before any significant investments or resources are committed.
methodology (Fine et al. 2009; MacLeod et al. 2008), to introduce more effective scheduling techniques to minimize wait times. Such initiatives have the added benefit of uncovering other organizational inefficiencies.

Third, the value of the organization-as-system perspective was seen in another example that goes beyond the walls of the hospital. Prior to patients receiving a chemotherapy treatment, blood work and a physical examination are required to confirm patient readiness. In our interviews with patients, many revealed that they would like to have their blood tested at a laboratory close to their home, have the results transmitted directly to the physician or electronic chart at PMH and receive a follow-up phone call for review. Their hope was twofold: (1) if the results showed that they were not ready to receive treatment, they could avoid a trip to the hospital entirely; and (2) if the results did show a readiness for treatment, the patient would not have to rush to the hospital, wait at the blood laboratory and wait for the results, and could instead proceed immediately to the treatment stage.

While such changes may not be possible in some cases, patients were keen to explore this possibility as technology and information technology capabilities advance. In some places, it’s happening already: Sunnybrook Hospital has recently introduced MyChart, an “innovative electronic health access service [that] lets patients check laboratory results, review their prescriptions, see ultrasound images and connect with their physicians” (Ogilvie 2011, January 23). PMH is also leading in this regard and introduced last spring an online portal for breast cancer patients to access laboratory results (at the moment, only laboratory results from Sunnybrook/PMH are available on the portal [i.e., not from outside laboratories]), imaging reports and educational resources (Ogilvie 2011, January 23).

Finally, we need to raise the issue of costs (and non-obvious benefits) and be mindful of a dubious assumption that may bedevil attempts to improve the care experience. Too often we assume that better experiences are costly and come at the expense of operational performance. Redesigning with the personas top-of-mind, we have been able to identify numerous experience improvements that did not substantially increase total costs or sacrifice operational performance, and may even lessen costs (e.g., improving patient flow, eliminating patient visits when they are not ready for treatment).

Of course, other changes will be costly. Such changes, given current hospital funding, may require the support of private philanthropists, such as the gift that PMH received. Alternatively, we may be on the cusp of substantially changed hospital funding schemes that differentially reward hospitals for the volume and quality of care provided (not only clinical but based on the full patient experience). Under such a funding regime, hospitals would have the economic (rather than only the moral) incentive to provide a more patient-centred experience. To date, economic incentives for patient centredness have been lacking, and, thus, it has too often fallen off the radar screen of healthcare providers.

And of course, not all benefits have a clear dollar value. Besides increasing patient satisfaction, we expect to see an improved experience for staff. Most staff we worked with wanted to find a better way and often relied on workarounds to assist patients. However, we should not rely entirely on the workarounds and the staff’s caring nature. Doing so pits individual and staff will against system and organization won’t, and that’s a recipe for failure.

Conclusion

When this journey first began, the research team and hospital staff had little idea about what patients truly needed and what was possible. By working with patients and their families and creating an environment in which they could start to imagine what was possible, we were able to develop a plan for a substantially enhanced patient experience. Some of the key lessons from our experience warrant emphasizing, especially for readers interested in implementing the Rotman Creative Design Process in their organizations:

• **Gear One.** Patients and clients, when asked what they value most in a caring experience, often articulate only modest departures from their current experience. To truly understand what they might value more, it is vital to examine their actions (i.e., what they actually do), listen to their stories (i.e., what they have done in the past, what they struggle with) and develop a deeper sense of empathy for the patient. This allows health leaders to better infer core unmet needs, many of which are unimaginable if we anchor on current experiences.

• **Gear Two.** Prototyping possible experience (e.g., by building a paper mock-up of a space or creating a storyboard) can help bring the experience to life in concrete terms. Doing so allows for critical user reaction and subsequent modifications.

• **Gear Three.** A system infrastructure that enables, supports and scales the solution, and hence the patient experience, is critical to sustainable organizational changes. Consider whether the current organizational or operational systems support the improvement ideas.

Based on our time with patients and staff, it was clear that the patient experience encompasses much more than the specific product (e.g., chemotherapy drug) or service (e.g.,
While PMH always understood this, it took the creative design approach to have this long-held insight inform changes about how PMH worked. Health leaders must be humble enough, as they were at PMH, to recognize that their expert clinical care is not all the patient values.

**Update**

For those interested, a multimedia video capturing the richness of the stories and the complexity of the envisioned new patient experience was made available for staff, donors and patients involved in this project (available at http://vimeo.com/18758890). The findings and presentation of the research became the foundation for a subsequent architectural design competition at PMH. The winner was chosen based on the ability to capture the spirit and essence of the design brief and to create the ideal patient experience. Final completion of the construction is slated for the end of 2011.

**References**


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