A clean, white world

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As a design historian, I have always been fascinated with the Grand Narrative of Modernism, and the relationship between Modernism and technology. Some people take Le Corbusier's 1923 framing of the house as 'a machine for living in' at face value and consequently see Modernism as inherently dehumanizing. This is frustrating, given that the very roots of Modernism lie in altruistic attempts to improve health and hygiene for all. The best teaching aid I ever found to get this message over came in the form of the 1995 Channel 4 documentary series Hidden Hands: A different history of Modernism, especially the second episode 'A Clean, White World'. It showed how the Modernist ideals of cleanliness and hygiene grew out of repulsion at the bloody mess of the Great War, followed by the horror of an influenza pandemic that took more lives across Europe than the war itself. It explained the Modernist designer's fascination with smooth (easy to clean) surfaces, and why Modernist architects produced large, white buildings with curved walls and metal rails that resembled nothing more than cruise ships, at a time when the only recommended treatment for tuberculosis was a relaxing cruise in the sun. Viewed in this light, it is impossible to see Modernism as a triumph of rational design over human comfort.

It is clearly and purely a coincidence that academic journals consistently receive a number of papers from different authors at the same time which address very similar topics but written from very different perspectives. The joy of this lies in the editorial process, where the juxtaposition of papers can create something greater than the sum of its parts. A joy tempered on this occasion by the complexity of the numerous and varied opportunities for such co-location that emerged from the articles selected for this issue. They all, though, refer in some way or other to this relationship between people and technology, and two refer directly to Modernist architecture.

First, Bates' article traces the vacillating currency of 'humanization' as a driving force in the architectural design of health care environments. Emerging as a recognized desirable aim after the Second World War, it became an international trend by the end of the twentieth century, both in the welfare states of Europe and in free market capitalist America as a reaction to rampant mechanization and technology. Second, Crocker and Leatherbarrow's article compares and contrasts four case studies of hospital design where the focu Modernist architects were leading the way in design of hospitals as 'machines for healing'.

The next three articles all address the beneficial use of new technology within a health care context. Veitch et al. explore new techniques for creating life-like models for teaching clinical breast examination. Starting from the premise that the more realistic the model, the better the skills developed by student clinicians, the multidisciplinary research team tested models consisting of rapid prototyped substructures generated from 3D scanned CAD data, overlaid with simulated tissues made from a range of silicones. The resulting highly realistic breast models enable better learning of examination methods, which are of high value in communities that may have little or no access to more expensive imaging or biopsy test techniques.

It has been shown that having a higher level of knowledge about cancer and more information about coping skills has a beneficial effect on patients. Evidently, technology can help to deliver this knowledge in an effective way. Iacobelli et al.'s article notes the disparity in symptom burden between Latina and non-Hispanic white breast cancer patients, and suggests the cause lies in the different levels of health care literacy. The team took a community-supported approach in developing a mobile phone app that overcomes language, economic and cultural barriers to provide suitable information and support for Latina patients following their treatment. Similarly, Stephenson et al. developed an interactive mobile phone app to help paediatric cancer patients to prepare for proton therapy, again empowering the patient by improving access to knowledge. Design thinking by the university–community partnership led to a focus on designing the experience over the design of the product, which was expanded to include a printed book, character and toy design.

The remaining six articles are all based on presentations given at the fourth Design4Health conference held in Melbourne, Australia from the 4th to 7th December 2017. Hosted by the Centre for Design Innovation at Swinburne University of Technology, the proceedings from the conference will be published online at www.design4health.org.uk.

The first of these, by Douglas et al., refers once again to the design of the hospital environment. Using a co-design approach and employing critical design artefacts designed specifically to provoke a response and initiate discussion, the research gathered users' individual stories and opinions to inform a design proposal to improve the often stressful and anxiety-laden space of waiting rooms outside intensive care units. Lo Bianco and Pedell similarly looked at improving user environments by using positive assistive artefacts. A design ethnography approach revealed that the 'official' home modifications for fall prevention were seen as intrusive, impersonal and 'cold', where the low-tech, home-made alternatives provided by family members were perceived as caring, personal and warm. Such simple objects as a hand-made handrail helped patients to maintain their independence. Taffe, Pedell and Wilkinson's article similarly explores a lack of engagement with existing, often stigmatizing home modifications, but, by contrast, considers much more high-tech, digital-assistive technologies as an answer. Co-designing with senior citizens end-users, and with input from ageing experts and design teachers, design students answered industry-set briefs to develop more inclusive designs to maintain personal independence.

In a different environment entirely, James and Olausson employed ethnographic methods including drawing, discussion and photo elicitation to research the impact of the physical environment on young offenders in special care homes. They found the uncomfortable, restrictive spaces disempowered and de-personalized the occupants, and that the addition of simple, personal objects could afford a reflective connection to 'a life elsewhere', outside of their four walls.

Kenning's article reports on participatory and co-creation approaches to design to enhance the quality of life of people with late stage dementia. A mix of ethnographic methods and art engagement provided designers with some insight into the embodied experience of living with dementia and led to the creation of user-centred, personalized health care products and services.

In the final article, MacLeod and Macdonald acknowledge the limitations of graphic design solutions developed remotely and with an outsider's perspective rather than achieved through close ethnographic observation and developed with the communities involved. Witnessing first-hand the devastating effects of a lack of malaria education, the authors used an ethical, co-design approach and learned from the locals to identify the messages about malaria that needed to be communicated and how to ensure effective engagement with the target audience.

This issue is concluded with Graham Pullin's review of a book also addressing visual communication in a health context. Elizabeth Guffey's Design Disability: Symbols, Space and Society traces the history of accessibility, the design of accessibility signage and the influence of disability rights movements. Pullin's engaging review finds the book in turn inspiring, fascinating, occasionally exhausting and sometimes frustrating, but concludes it is an important book that might provoke new directions in disability-led design.