A sense of place

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I'm writing this Editorial sat at my laptop, away from my office as I have been for some time now. My home has become a more or less permanent place of work – exactly as predicted back in the 1950s when remote computing first became possible. As boundaries continue to blur between places of work and leisure, I am thinking about the notion of place and its meaning. A sense of place is defined as the intrinsic character of a place, or the meaning that people apply to it. This operates at a number of levels – personal attachment, regional awareness, national identity and societal belonging. This notion, though, also suggests a necessary demarcation between places – a separation between one place and another. Yet as we know, for a number of reasons in today's world, what happens in one place can have huge impact in another, and in some ways, no place seems to be totally isolated.

This line of my thinking is perhaps due to a number of big issues currently occupying a lot of people's thoughts. The climate emergency is one example. No matter how one person or even one country changes their behaviour, the effects of unsustainable activity by anyone are global. Pollution and waste do not remain within the country of origin but are spread around the world, either by nature or mankind. Ice melting at the poles raises sea levels everywhere, air-borne particles are blown from one country to another by winds, and micro-plastics find their way into every level of the food chain. Of course, the other big issue currently spreading around the globe is COVID-19. The initial outbreak in China could never hope to be contained within one place and has affected the whole world. It was not even clear at first exactly in which ways the virus was transmitted as it travelled from one place to another. On a possibly lesser note, like many others at the time of writing, I am nervously clicking between tabs on my browser, following the live results of the US Presidential election. Biden in the lead, but not that far ahead of Trump; everything to play for, and nothing can be taken for granted. Never before have I had such concern over what happens in a political election in another country, but the last four years of Trump's administration has clearly shown the massive affect that one nation's economic actions can have on every other nation; how closely connected we all are in modern society, despite being in very different places. Of course, this last example should be decisively resolved by the time this editorial appears in print, and we will know one way or another who will be leading America for the next four years. Climate change and COVID-19, though, will take considerably longer to tackle.

So, It seems that the idea of there being a right place for things to be is more fluid than it perhaps has been, which brings me to the topics of the papers in this issue of Design For Health which all in some way are concerned with the places occupied by the two different disciplines of design and healthcare: either the place of design within healthcare practice, or more directly the design of places for healthcare.

In the first article, 'Experience Based Co-Design in Healthcare Services', the authors Ramos et. al. analyse the barriers and enablers of Experience Based Co-Design, an approach which aims to improve health care services through adopting a collaborative co-design approach bringing patients and staff together. Previous studies have highlighted the importance of the role of the Facilitator and the involvement of senior clinical staff in making such co-design activities successful, and have also realised the weakness of the approach in the extended time and costs involved, among other barriers. Using semi-structured interviews with a number of past Facilitators of EBCD projects with the results coded and themed, the authors assessed human barriers, organizational barriers, the

Facilitator role, and organizational support to complement the existing literature on EBCD and hopefully encourage a broader adoption of the method by health services.

In the article 'Designing a diagnosis? Reflections on design, medicalization, and mild cognitive impairment', Collier et.al. explore how design processes and practices can be involved in constructing new medical diagnoses. Using a case study of a website design project on how to live well with Mild Cognitive Impairment (MCI), the authors ask if designers might inadvertently contribute to the process of medicalization by accepting sometimes contested medical constructs as 'givens'. Data for the project came through interviews and co-design workshops about living with MCI, and it is realised that the act of making a website to support those living with the illness served to further validate the condition, raising concerns about how such projects are carried out and pointing perhaps to a required rethinking of how design for health projects should be conducted.

The case study 'Myhealth – Developing accessible health materials with men with intellectual disability' by Bollard and Magee also addresses design artefacts in a healthcare setting. The study describes the development of a web-based platform 'Myhealth', aimed at men with communication difficulties and autism. The web-based platform built on the experience of an earlier project which used a co-creation approach to the design of a set of men's health postcards. Adopting an inclusive design approach around the issue of linguistic clarity resulted in the development of physical and digital versions of materials that are accessible and valuable to all men, not just those with ID.

Rowe, Knox and Harvey' article 'Re-Thinking Health Through Design: Collaborating in Research, Education and Practice' constructively proposes that commonly used theories, practices and ways of thinking in design practice could be usefully applied in order to help meet the increasingly complex demands within healthcare. Using the examples of three research projects in healthcare employing design practices, the study addresses how designers could facilitate better experiences around death and dying; how design might teach the use of design tools and processes by non-designers in a medical context; and how design thinking would improve performance and information delivery in health design. The authors note the similarities between design practice moving to place the end user at the heart of the design process (user-centred design) and healthcare practice moving to position the patient as the focus of medical regimes (patient-centred care).

Zitkus, Harris, Miles and Astin's article 'Design to Improve Patients' Sleep Experience in NHS Hospital Wards' is concerned with the design pedagogy of moving students between places. It reports on an attempt to enhance the learning experiences of product design students through exposure to 'real-world' design challenges in healthcare settings. In an example of research-informed teaching, students became closely engaged with the projects through a three-stage process of selecting the problem, engaging with an unfamiliar scenario, and involvement with stakeholders. The results of the study usefully point to ways in which the challenges of setting healthcare projects for students might be overcome.

Moving from the place of design within healthcare practice to the design of places for healthcare, Colley, Zeeman and Kendall show 'How the built environment matters in recovery after neurotrauma.' The article reports on end-user experiences of rehabilitation after brain and spinal cord injury in order to inform design thinking around future rehabilitation environments. Qualitative research within a brain injury unit and spinal injury unit revealed that the design of such environments could either directly promote or hinder recovery. Moreover, analysis of the interviews with end-users pointed to a number of factors that should be taken into account when designing future neurorehabilitation settings.

In a very similar vein, Majd, Golembiewski and Tarkashvand's article 'The psychiatric facility: how patients with schizophrenia respond to place' builds on previous case studies that confirm that the design of healthcare settings impacts on both staff and patients' quality of life and recovery processes. This study examined a mental health facility in Iran, which might be considered 'old-fashioned' by the standards of highly-developed countries, but which is nevertheless typical of many facilities still operating around the world. The research showed that the design of the environment played a significant role in patients feeling a sense of control, privacy, autonomy and a sense of purpose and meaning to their lives.

Finally, we come to 'Reframing loneliness through the design of a virtual reality reminiscence artefact for older adults' by Veldmeider, Wartena, Terlouw and van 't Veer. This time, the focus is an imagined place: as the title suggests, this article describes a project to design a personally tailored, virtual reality experience for older people suffering from feelings of loneliness. Rather than only attempting to expand the users' social connectivity, the researchers aimed to employ reminiscences of individual users' past lives. This is usually done through the use of analogue sources such as old photographs, television programmes and music, but the research shows that Digital Reminiscence Artefacts demonstrate a range of advantages in terms of immersion, communication and engagement. The results conclude that VR can contribute to the development of problem-solving skills, improved memory retention and better manipulation of information, especially if the VR experience is tailored to the personal reminiscences of the end user.

All these articles celebrate the potential benefits of a shared place for collaboration between design and healthcare. The possibilities are exciting and seemingly endless (unlike, thankfully, the US Presidential election).