Ideal States: Towards a Joint Knowledge and Operating Framework for Design and Medical Practices

www.idealstates.co.uk

Alastair Macdonald

e a.macdonald@gsa.ac.uk
t 0141 353 4715

The Glasgow School of Art

OVERVIEW

CURRENT COLLABORATION BETWEEN THE FIELDS OF DESIGN AND HEALTHCARE USUALLY EXPEDITES PARTICULAR TYPES OF SOLUTION, E.G. MORE 'EQUIPMENT' OR 'DEVICES', USED BY THE PROFESSIONS ON THE PATIENT. WHAT VALUE CAN DESIGN THINKING, PROCESSES AND METHODS, IN COLLABORATION WITH HEALTHCARE, BRING MORE BROADLY TO BEAR ON THE DYNAMIC PATHWAYS OF INDIVIDUALS EXPERIENCING AGEING, CHANGE IN HEALTH, ILLNESS AND DISABILITY?

Activities

The Ideal States cluster held a total of six workshops to bring together practitioners and academics in the fields of healthcare, human factors and design. These workshops ranged from initial orientation (who does what and how), exploring quality of life (involving older or disabled people's and carers' views), exploring the relationships between people, design and healthcare, to mapping design into healthcare pathways. An important aspect has been to understand not only what is mainstream in all fields but what is current and emerging debate in the respective fields. Although grounded in the particular health-related issues of western Scotland, the intention was to gain generic insights for broader application in other situations.

Insights

The common ground between all three main disciplines was originally thought to be person-centric: in fact our findings revealed that healthcare traditions sustain a pathology-centric approach. Although design, human factors and healthcare each have their own processes and methods, central to all is the idea of the journey or pathway that individuals follow, or choose, in their progress through a disease or to recovery: it is the focus that is different. It has been useful for us as designers to understand just how empirically healthcare specialists think and act. Often they may have to act in an area where definitive evidence is lacking but they will understandably not introduce a significant change in practice without the evidence and proof that it will provide better treatment, or recovery, or prolong life or improve the quality of life, which provided a useful foil to the more speculative approach that designers can employ. Our goal was how to develop and visualise patient-centric views, and how to understand and map the complexity of the experience of receiving healthcare at all its stages. At each point, design can mediate between patient and his/her relationships with the other individuals involved (family, healthcare specialists, community and social support), between the patient and the environments encountered (home, clinic, transfers, hospital, community), and between the patient and the types of care and treatment they might receive (primary, secondary, and tertiary) to improve efficacy and quality of life. Given a clearer understanding of the existing scenarios, how can design thinking be utilised in contributing towards improving healthcare pathways and lifestyles, to ameliorate declining levels of health and life expectancy?