Architecture and general practice

Improving new healthcare buildings for those who use them perhaps hinges on two key areas. Firstly, how medical professionals interface with design professionals and second, how these buildings are procured.

Health care is a procedurally-anchored activity especially in today's litigious and insurance-driven environment. Crucial decisions are made and are well protected by protocol.

In architecture, protocol is increasingly present but the root mentality is different. Fundamentally we do not maintain preordained entities but make new ones (albeit infinitely less sophisticated) and we are trained from the outset as creative agents. There are bodies of hard scientific knowledge which impinge on what we do, how materials perform in fire, how to splice a joist, but the architect's decisive role is their synthesis with other information in the messy whole that is a building.

This was highlighted by Rice *et al's* paper on architecture in health.[1] We architects also develop an eye for the signs of deeper malaise, and the investigative tools brought to bear on this issue, akin to someone using a screwdriver to split a stout log, attracted attention. To quantify the effects of modifying aspects of a (typically rather nebulous) social, spatial, and aesthetic balance the authors use the methods and indices of medical research.

Medical research methods are geared up to substantiate or refute a hypothesis with sufficient rigor to allow its results to be proceduralised. In architectural design one can hardly look up the correct drug to prescribe for a particular problem and yet the authors seem to fall into the trap of attempting just that. The symptoms of their disorientation on foreign soil are clear, an uncertainty of argument epitomised by an assumed common view of 'art', in this context curiously lumped in with aquaria: 'There is support for the role of art in healthcare facilities, for example, contemplation of an aquarium before dental surgery has been found to reduce patient anxiety during treatment'.[1]

I point out the above, slightly mischievously, not to denigrate the article but to illustrate the aforementioned paradigmatic differences which must surely be addressed before we can effectively work together. I suspect doctors are prone, by nature or nurture, to seek different solution types to architects. A search which, if formalised as qualitative research will almost certainly be in vain.

Further, I suspect that the health service as an institution, with it's heavy reliance on procedure, will always be vulnerable to a misplaced confidence in quasi-scientific evaluation of building design — be this arrived at by the analysis of time-and-motion or the statistics of surveyed opinion. Because the method lends apparent authority, the results will tend to promote groups of 'tested' design solutions to the status of protocol. The logical consequences are eventually generic building designs; bad in two ways.

Firstly, as this article illustrates, there are huge limitations on what can be evaluated by such means. Certainly there are easily-documented technical specifics to primary healthcare buildings, for example, infection control and accessibility, but good, appropriate design is a vital, subtle area where it is far harder to pinpoint the crux of success or failure.

If I were very ill, however, I should nevertheless like to be in a beautiful space. That means the proportions, the cill heights, the wall finish, the acoustic, the location of the door in the room, the light ... But you cannot define that on sheets of A4 and hand it round the estates department. It is notoriously difficult to legislate for good design — witness the Local Authority Planning system. Generic guidelines are at best a low-grade safety net.

Second, I believe the presumption should be against generic solutions. There are three criteria groups to balance in an architectural solution — the location, the people, and the building. Even if for expediency the schedule of accommodation remains the same the location and people will always have shifted, from time to time, from place to place. Once one has mastered the technical background to a particular building type our activity as architects is analogous to 'spinning a yarn'. A story is told and perhaps at some point retold but, if it is to have any vitality, will never be the same for every theatre or audience.

Generic solutions are admirably suited to the unseemly haste of large scale, contractor-driven procurement currently ravaging the public services. A process of bulk-buying on credit in which one must seriously question the true location of motive. Such systems are only too eager to predicate generic solutions on apparently scientific bases. In these circumstances, it becomes doubly hard for the less easily quantified (read short-term remunerated) aspects of architecture to secure investment. One hopes that at least smaller primary care facilities will remain beneath the radar of the big procurement beasts.

Buildings for the physically or emotionally vulnerable have a particular responsibility to demonstrate fine, humane architecture and they should be designed by those who are good at it with adequate time and investment. All the factors currently in the ascendancy in both briefing and procurement — efficiency, 'safe pairs of hands', accountability, liability — favour experienced technicians over creative architects and generic buildings over considered architecture. Medical professionals need encouragement to resist the over-emphasis of these factors and perhaps also their own natural tendencies in that direction. We require good translators at the interface, familiar with both professional environments, but the results can be refreshing.

If it is within your influence, engage the best architect you can, brief them well and listen to their advice. Every time.

Rod Kemsley of studioKAP architects

REFERENCE

1. Rice G, Ingram J, Mizan J. Enhancing a primary care environment: a case study of effects on patients and staff in a single GP practice. *Br J Gen Pract* 2008; **58**: 465–470.

DOI: 10.3399/bjgp08X319567