The healing environment in our communities and healthcare settings: research excellence into practice

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As doctors, we know intuitively that having to live in depressing, dirty surroundings, with little fresh air or greenery may make people depressed or ill. But when funds are limited and staff are struggling to provide a good clinical service, considering the impact of the healthcare setting on patients is a low priority.

According to Abraham Maslow, an American psychologist, each of us is motivated by a hierarchy of needs, with the need to satisfy our most basic biological and physical needs – food, water, sleep, etc – taking precedence over our higher needs.[1] So patients and staff alike may have little interest in the colour of the paint or the pictures on the walls if medical equipment or medicines are in short supply. However, because of the government's Private Finance Initiative, over 40 new hospitals are in the planning stages or being built in the UK, giving us a golden opportunity to look at these issues and incorporate our understanding into the design of the new buildings.

The first healing environment conference, 'The healing environment, without and within', was followed by a book of that name published by the RCP two years later.[2] That first conference examined the ways in which the arts and humanities can affect health and well-being, and explored the links between the social environment, built environment and health. With an audience of researchers and practitioners from medicine, health and social care, urban planning, architecture, estates management, sociology, epidemiology and public health, the conference explicitly recognised the need for interdisciplinary collaboration, and offered a rare opportunity for an exchange of ideas across disciplines, creating a forum for participants to consider how to translate research excellence into practice.

Conference programme

- **The social environment and health**
  Sir Michael Marmot, Director, International Centre for Health and Society, University College London
- **The local built environment and health**
  Michael Mehaffy, Director of Education, The Prince's Foundation for the Built Environment
- **Keynote Address**
  HRH The Prince of Wales
- **Optimising design: making quality places for modern healthcare**
  Susan Francis, Architectural Advisor, NHS Confederation
- **A user's perspective on the healing environment: in search of the right questions**
  Michele Angelo Petrone, artist, patient and Director of MAP Foundation

Is it who you are or where you are?

Research into health inequalities over the past 20 years has illustrated that the physical fabric and design of community space can contribute to better social order and improved health.

Much of today's rhetoric in health is about individual responsibility and our ability as individuals to choose healthy options. However, where our parents live and their level of education also influences our own health. Therefore, to understand disease it is important to look at our environment – in its broadest sense – as well as characteristics of individuals. This includes the sort of housing we live in, whether we drive or walk to work and school, whether we have strong family support and good relationships with neighbours, and so on. In examining what it is about the environment that influences our health, it is clear that there is also an interaction between the individual and the environment. So, being in a lower socio-economic class matters more in one area than it does in another; for example, being poor in Brazil is worse than being poor in Lambeth. Put another way, if you are in the top social class, it does not matter much where you live in terms of your mortality or morbidity, but if you are an unskilled manual labourer, your mortality and morbidity will vary depending on where you live.

What exactly is it about an area that influences health? There is much interest in the idea of 'social capital'. Data that compare information from a group of people surveyed about what it was like where they lived and the health levels found in the data from the Health Survey for England, show that if trust and tolerance are low in an area, there is a greater likelihood of being in poor health.[3] There are similar findings for a sense of low attachment to an area.

Conversely, the research showed that people who had fewer family ties had better health. This is

believed to be because people of low social class tend to have high attachments with family, compared to people from higher social class who have a whole set of relationships with friends, work, church, political organisations etc. So more family ties suggest a smaller network of relationships and are likely to mean that you are living in a poorer area.

The conclusion is that neighbourhoods are more socially cohesive, and therefore healthier, if there is more trust, participation and attachment to the neighbourhood or tolerance within the area.

Unfortunately, in the design of cities we tend to look more at the physical issues such as the quality of the buildings and amenities. As Sir Michael Marmot said,

> *We tend not to think of building design in terms of social and psychosocial terms. We tend not to think about cohesion, trust and tolerance and sense of attachment to health. These all seem to be vitally important for health.*[3]

How can our communities provide environments that are conducive to good health?

The views of HRH The Prince of Wales on modern architecture have been much publicised. In his Keynote Address, he said:

> *Instead of seeing every building as an opportunity to make an ever more imaginative iconic 'statement' – and to indulge our egotistical ambitions – we must come to regard the characteristics of traditional architecture as not merely unfashionable political statements, to be thrown out with yesterday's rubbish, along with the baby and the bathwater – but, rather, as organically adapting creations over the passage of time, helping us to generate and regenerate places that relate to our essential humanity.*[4]

Such views, which have in the past frustrated architects and designers, are now more fashionable and supported by evidence. As Michael Mehaffy from the Prince's Foundation for the Built Environment put it, 'The challenge is to find healthy human places and to recognise the complex interaction of our environment and our health and to incorporate that into the design process.'

Whereas our recent history has placed driving at the centre of urban design, with work, leisure and home interconnected by cars, we are beginning to realise that by looking at the 'social capital' of an environment we can influence the health of a community. As HRH The Prince of Wales put it,

> *Well-designed places and buildings that relate to locality and landscape, that put people before cars enhance a sense of community and rootedness … They also create what can only be called beauty – and beauty is something the human soul needs and has been starved of throughout too much of the twentieth century.*[4]

Placing the patient at the centre of the design process

At a time when there is huge investment into building in the NHS, The Prince of Wales made a plea:

> *to be sure to place the patient, the human being, with all his or her psychosocial and spiritual needs, at the centre of the design process and not the technology or the imaginative abstraction first and then the people fitted around it.*[4]

Michele Petrone, a painter and patient, gave a moving insight into the importance of the environment of a hospital community, based on his own experience as a patient. As he put it,

> *The journey of illness and dying is not just medical, and places of healthcare are not just for medical provision … Where does a patient go to cry when he has been given bad news? All too often, patients are left to sob in corridors or in waiting rooms while other patients nervously wait for their news. In all the talk about doctors breaking bad news, we tend to forget that patients have to break bad news too.*

We know that on shared wards, privacy and dignity do not exist. How, for instance, is it possible to talk to a consultant on the ward round in an open ward, with only a flimsy curtain separating the patient from the other people on the ward, some of whom may have the same condition? As Michele Petrone said, 'Technically, we have made huge advances, but emotionally we are so backward.'

Should we pay more attention to helping patients maintain a sense of social participation? Many people in hospital are not confined to bed, and though they may be ill, their lives outside hospital still continue. Why not provide areas to contemplate, or meet their families, or talk or even work?

Research is beginning to emerge that supports Michel Petrone's views: for example, that the view from a hospital ward may reduce the need for painkillers and the length of stay of patients who have had surgery.[5] Although it may be difficult to pick out one variable and prove a link with patient outcome, it seems clear that the more comfortable patients are, the more positive they are about both treatment and staff. Other research shows that 90% of staff believe that working in a poorly designed hospital contributes to increased stress levels.[6]

Incorporating art, architecture and design into health

> *I believe that our lives can surely only be enriched through the process of integrating the knowledge of other cultures and peoples with that of our own. The vast botanical expertise of many indigenous cultures; the beautiful and complex geometries of Islamic scholars, which are rooted in the deepest universal pattern of things; the intuitive environmental knowledge of tribes that live close to the land; the ancient medicinal practices of India and China. All of them, to one degree or another, have recognized the importance of the social and environmental context when it comes to health and disease.*[4]

The Commission for Architecture and the Built Environment (CABE) believe it may be helpful to think of four main design principles which are important in the planning stage of a new healthcare facility: efficiency, minimising risk, improving well-being, and the provision of access. Although it is difficult to comment on the high-level decisions made during the design stage for building new hospitals, it is likely that the design briefs

of new hospitals focus strongly on increasing efficiency, minimising risk and improving access. However, there is less confidence that improving well-being is sufficiently high on the agenda.

We know what can be achieved on a smaller scale. For example, the King's Fund's scheme, Enhancing the Healing Environment (EHE), has shown how good design can make a real difference, affecting the quality of life of patients, staff and visitors.[7] Launched in February 2000, the EHE is the largest single investment – nearly £2.25 million – that the King's Fund has ever made in London's hospitals. The programme was designed to encourage and enable nurse-led teams to work in partnership with service users to improve the environment in which they deliver care. It has two main elements:

- multidisciplinary teams, led by a nurse, and including estates and facilities staff, arts coordinators and, increasingly, patient representatives
- a £35,000 grant for each team to undertake a project to improve their patients' environment.

The evaluation of the scheme shows that there are significant long-term benefits from improving hospital settings, including reducing vandalism and violence, helping patients recover more quickly, creating a positive ambience and feelings of calm and well-being, improving staff morale and motivation, and helping staff recruitment and retention.

Using the creative energy of designers and architects together with a growing body of research knowledge, our future hospitals should provide inspiring, health-enhancing environments for generations of patients and professionals. It will be interesting to see if and when such advances are applied to community healthcare settings, where many front-line health workers still work in the poorly lit, poorly ventilated, gloomy rooms with peeling paint that the new hospitals have consigned to memory. As Florence Nightingale once commented, 'Little as we know about the way in which we are affected by form, colour, by light, we do know this, that they have a physical effect'.[8]

References

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2 Kirklin D, Richardson R (eds). *The healing environment: without and within.* London: RCP, 2003.
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6 Commission for Architecture and the Built Environment. *The role of hospital design in the recruitment, retention and performance of NHS nurses in England.* London: CABE, 2004.
7 Francis S *et al*, King's Fund *et al. Improving the patient experience: evaluation of the King's Fund's Enhancing the Healing Environment Programme.* London: Stationery Office, 2003.
8 Florence Nightingale. *Notes on hospitals.* London: Parker and Son, 1859.

letters
TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by email to: Clinicalmedicine@rcplondon.ac.uk.

Sex is dangerous

Editor – Professor Adler's article (*Clin Med* Jan/Feb 2005, pp 62–8) clearly describes the devastating effect of HIV/AIDS in certain parts of Africa. Professor Adler also draws attention to the mixed response of the South African government to the crisis in their country.

Since 2000, I have been working on and off in a rural area of South Africa, Hlabisa, that has been hit hard by HIV. Without trying to explain or justify what has happened here over the past few years, I would like to outline the current situation on the ground which, I think, is one of great hope.

Hlabisa is situated in northern KwaZulu/Natal. The sub-district has a total population of around 220,000 people; HIV prevalence is around 20% but rises to 40% in antenatal women.

Our hospital became accredited as a site for antiretroviral treatment (ART) in August 2004. We started our first group of patients on therapy in September 2004 and we now have 150 patients on therapy and are adding around 20 a week. At three months review, 13/14 of the first group of patients had undetectable viral load and a rise in CD4 count. The AIDS department of our hospital has gone from a place of despair to a place of hope.

We started giving therapy in one of the sub-district's 15 clinics several weeks ago, and, with no advertising, nine people came on the first day and 27 on the second.

Apart from these early programme successes, there seems to have been a change in the way people perceive HIV. With more openness, less stigma, and more people coming forward for HIV testing, there will be vastly increased opportunities for prevention.

Despite what has gone on in the past, I