Are architects are the last people who should shape our hospitals?

Waxing lyrical at the end of my last editorial about the challenges to the profession afforded by increased regulation, I referred to the '…distinguished histories and attractive premises…' of medical royal colleges. As it turns out, this was an unwittingly apposite allusion, given that 2014 is the 50th anniversary of the current premises of the Royal College of Physicians (RCP) in London's Regent's Park. Some readers may know that the RCP was originally based at three sites in the City of London, all near St Paul's Cathedral, before moving to Pall Mall East overlooking Trafalgar Square, and finally on to its current location.

Architectural commentators regard our current building as a masterpiece, containing 'exceptional complexity within its confident form' as well as being 'well considered and well made'.[1] Given the RCP's somewhat staid reputation, I was interested to read that when interviewing a young Denys Lasdun[2] as the potential architect for the new building, our forefathers pointed out of the window, at South Africa House opposite, and asked if he would design something along those lines; in other words a classical, porticoed edifice. The short answer seems to have been 'no', and the end product reinforces that view, being described by influential commentators as '…a subtle and beautiful exploration in three dimensions of the old and new…'

Importantly for the theme of this edition of the *FHJ*, the RCP was at the time embarking upon a sustained engagement with the public on smoking cessation, the dangers of which were only becoming apparent at that time (the late 1950s). The proposal that the design and subsequent appearance of the new RCP building could help physicians to engage with the public on matters relating to their health was new to me, and I suspect that in its long and distinguished history the RCP has more often been accused of being inward looking, and concerned solely with professionalism and the interests of its fellows and members.

The idea that a building can be a statement of the intent of those whom it houses is intriguing, but not especially new, when applied to hospital design. Your editor is privileged not only to practise within the intensive care setting, but also as a respiratory physician. The National Insurance Act of 1911 compelled local authorities to establish hospitals for the treatment of tuberculosis (TB), and many of these began to emerge in the 1920s, to surprisingly uniform designs. Readers will recall that at the time no effective treatment could be offered to patients with TB, and even making the diagnosis represented significant difficulties. Koch's demonstration of the tubercle bacillus in 1882 meant that sputum examination was possible and, if positive, was diagnostically valuable. By contrast, radiology was unavailable until Röntgen's discoveries relating to the production and detection of electromagnetic radiation were translated into early X-rays (or Röntgen rays) in 1895.

However, even at that time it was known that if the patient was well enough and could afford to travel, transfer to a suitable climate was the preferred solution. Whether this was best achieved at high altitude (the alpine winter was very popular) or beside the seaside (the French Riviera had its attractions) was unclear, but 'therapeutic' success achieved in such environments resulted in the vogue for open air treatment in sanatoria. RCP aficionados may know that Sir Hermann Weber first advocated open air treatment for the UK in his 1885 Croonian Lecture at the RCP, although Brehmer had developed the first such institutions in Germany in the mid 1850s. By the early 20th century, local authorities were mimicking his approach in varying ways, and with appropriate local adaptation. Examples include the first purpose-built sanatorium for open air treatment in England at Mundesley in Norfolk in 1899, and the Papworth Village Settlement, representing the vision of Sir Pendrill Varrier-Jones (1883–1941). Following his appointment in 1915 as tuberculosis officer for Cambridgeshire, Varrier-Jones concluded that the welfare of patients with TB depended at least in part upon a nourishing diet and fresh air. The design of the wards at Papworth, still clearly visible today, was modelled upon the latest central European thinking concerning exposure to fresh air and sunlight. Your editor spends time at Harefield Hospital, which was selected by the County of Middlesex as the site for its sanatorium; the hospital opened in 1921. Patients were accommodated in pavilions and observation wards where the new patients were admitted while it was confirmed that they had TB. School rooms, nursing homes and eventually new curved buildings came to complete a site which had nearly 400 beds, its own water supply, electricity, farms and orchards, making it relatively self-sufficient for those who would spend many months or even years in residence.[3]

The theme here is clear. Not only is hospital design influenced by the need to provide physical facilities of a type and nature that can facilitate recovery (as in the TB sanatoria) but also by the wish to provide reassurance and comfort to those in distress. This requirement might at times apply not only to patients but also to hospital staff. Your editor has encountered a number of times in his working life extended lamentations for a late 'Royal Infirmary' or similar, bulldozed before it fell down and replaced with what at the time was seen to be modern and wholesome hospital accommodation. The way in which such new builds have deteriorated and found not to be fit for purpose after only two or three decades, rather than

centuries, may reflect the much more rapid recent evolution of clinical medicine, rather than deficiencies of architecture or building. The more intense pace of life (no farms now in hospitals treating respiratory cases), turnover of patients (none expected to stay more than a few days) and pressure on beds (reduced by around half in the past 20 years) have all put paid to the concept of the extended hospital community. The Future Hospital Commission recognised this implicitly, by including a workstream looking specifically at the built environment, led by the RCP treasurer, Professor Linda Luxon. The debate within that group was intense, and brief summary answers to the questions raised could not be easily incorporated into the Commission's final report. We therefore devote the focused section of this edition of the *FHJ* to this theme, and Linda has selected experts involved in the original work to record their ideas. I hope that these are complemented by contributions from figures with significant national and international reputations in this field.

It therefore seems clear that as clinicians we need not only to nurture the natural environment in which we are privileged to live, but also to influence the design of the built environment in which we work. The way in which we feel about ourselves as medical practitioners, and our ability to carry out our tasks to the satisfaction of our patients, depends upon such engagement. This concern can and should extend to the buildings within which we try to improve our standards of practice. As far as I know, we are not seeking new RCP premises to replace those so ably created by Lasdun, but our new president and senior RCP officers are rightly questioning how we should use them; should we for example be promoting their commercial exploitation merely to sustain them in their current location? The beauties of Regent's Park are, in the words of a former distinguished registrar, '..a long way from the realities of the Midlands and North of England…' where many of our fellows and members spend their professional lives.

We are heavily influenced by the circumstances within which we work. We know that fellow professionals can and are achieving wonders in helping patients in the most primitive accommodation and circumstances around the world. I suggest we should not only be grateful that most of us are not trying to practice under conditions of open warfare, flood, fire and famine, but should also make the very most of our (for the most part) privileged clinical and professional environments. I hope that the contributions contained in the current issue of the *FHJ* reinforce this message and broaden our thinking. ■

Timothy W Evans

References

1 Moore R. The Royal College of Physicians – just what the doctors ordered. *The Observer*, Sunday 7 September 2014.
2 Moore R. *Anatomy of a Building*. RCP, 2014.
3 McCarthy OR. The key to the sanatoria. *J R Soc Med* 2001;94:413–7.

EDITORIAL Future Hospital Journal 2015 Vol 2, No 1: 4–7

Infrastructure – the key to healthcare improvement

Author: Linda Luxon[A]

Introduction

In this issue, we focus on the infrastructure workstream of the Future Hospital project, and notable figures provide their perspective on the built environment and specific elements of healthcare infrastructure, including architecture, design, commissioning a new hospital, sustainability and information technology, both in the UK and overseas. Particular thanks are due to Tom Downes for editing this special section.

Infrastructure must integrate the hospital, as the centre for acute and inpatient care, into the broader health care system,[1] and should facilitate the seven domains of quality[2] – patient experience, effectiveness, efficiency, timeliness, safety, equity and sustainability. Infrastructure includes the built environment and supporting elements: equipment, access, information technology (IT), systems and processes, sustainability initiatives and staff. Overall these interwoven facets should enable patients to move seamlessly, with their privacy and dignity maintained at all times,[3] from initial referral through local hospitals to specialist tertiary centres and discharge to appropriate care (home, care home, or community hospital with intermediate care), whatever the age, disorder or social circumstances of the patient.

Infrastructure is a key pillar supporting the fundamental aim of promoting improved standards of care and wellbeing for all patients, together with a good experience of the health

Author: [A]Treasurer, Royal College of Physicians, and chair of the Future Hospital Commission Infrastructure Workstream