

AT HOME IN HOSPITAL? COMPETING CONSTRUCTIONS OF HOSPITAL ENVIRONMENTS

Peter Kellett and Peter Collins

Abstract

Large institutions housed in large buildings are frequently regarded as the antithesis of personalised, small scale, domestic, home environments. However the attribute of 'homeliness' appears to be used more broadly to describe places where people feel a sense of attachment, control and identification.

In a large multi-disciplinary study of a hospital re-building project in northern England a range of users were interviewed to ascertain their responses to the original older buildings and later the new purpose-built hospital. We found both staff and patients retained a strong sense of affection for the older buildings and frequently used the language of home to describe their responses. In contrast, the newer buildings were generally recognised as efficient but impersonal, lacking many of the positive qualities they were familiar with. In addition some respondents suggested that despite efforts to include art projects, the new architectural language was inappropriate for healthcare, believing that small scale, 'home-like' environments were more conducive to health and well-being.

The authors will draw on anthropological and architectural frameworks to analyse the data which consists of extensive interview transcripts complemented by photographs. The paper aims to understand the conceptualisations which underpin the various user responses and to offer a critique

of the design language of the current healthcare building programme.

Keywords:

Hospital design, conceptions of home, representations of space, design language, health.

Introduction: Competing Constructions of Hospital Space

In recent decades the social sciences have developed an increasingly dynamic conception of space and place. For example in anthropology, until the 1980s space and place tended to be represented as merely containers for 'culture'. The 'field' was generally depicted as a homogeneous, unified and more or less self-contained whole. The tendency in the 21st century is to conceptualise space and place as more dynamic: as a process which does not simply contain culture but which is partially constitutive of it. This tendency is a part of a wider trend in the social sciences which has seen a turn towards social constructivism. This is especially true in treatments of space and place. For example Sack (1997) and Casey (1987, 1998) have each argued strongly for a more active role for space and place in social life.

It is now commonly accepted that place and space are in no way 'natural' but are contingent, dependent on the thoughts and actions of human beings going about their daily lives. No place has to be the way it is. This implies that no place can be represented in just one way - more 'truthful' than all alternative representations. Representations of space and place compete in the field of meaning; in different circumstances different representations may gain ascendancy. Clearly, the representation of place which becomes 'accepted' draws on the voices of the powerful. In the case of hospitals the default, ideological or in Bourdieu's terms the doxical expression (Bourdieu, 1977), has tended to be underwritten by the biomedical model. This need not be the case. In this paper we hope to indicate the ways in which representations of the hospital (in the UK at least) are deeply contested. We aim to demonstrate that the hospital is polyvalent – with multiple meanings, each of which struggles to be heard.

We focus on the domestication of hospital space, on the ways in which the acute hospital is represented (amongst other things) as 'home'. It is worth noting that several significant writers place 'home' firmly at the centre of any understanding of space and place. Tuan, one of the most influential writers on the subject argued that in creating space and place, at whatever scale, all human beings are endeavouring to generate a certain homeliness (Tuan 1991). We will support Tuan's view in what follows.

Researching the Hospital

In the north east of England a new large public hospital, the James Cook University Hospital

(JCUH), was completed in 2004 on a single site based on the amalgamation of three existing smaller hospitals (Macnaughton et al 2005). It was commissioned by the local National Health Service (NHS) Hospital Trust and financed using a relatively new contractual approach- 'PFI' (Private Funding Initiative). The Hospital Trust is committed to delivering high quality 'patient-centred' care and aimed, despite the large scale of the building, to achieve a sense of intimacy for individual patients, and to encourage a sense of ownership of the hospital amongst the local community.

The hospital planning team believed that the solution to these challenges lay in high quality architectural design and the integration of public artworks into the health care environment. The project brief paid special attention to building design, therapeutic colour schemes, materials, lighting, space, and acoustics. The design features and colour schemes were intended to individualise departments within the hospital to help create a sense of intimacy and identity within the whole. Part of the budget was used to commission artwork for the hospital and a 'Healing Arts' Committee was set up to oversee this work, to seek further funding, and to fund artists' residencies creating works appropriate to this hospital environment. The theme of the voyages of Captain James Cook (who was born locally) has been introduced to link the hospital with the local area and to give the hospital a sense of coherence as a single building. The James Cook theme is 'quoted' throughout the hospital both in large, commissioned pieces of art and in small artefacts which are displayed in glass cases along some of the corridors.

To evaluate the effectiveness of this approach a

detailed study of the new hospital environment (and for comparison, one of the existing hospitals – the Middlesbrough General Hospital) was carried out by a multidisciplinary research team (Architecture, Anthropology, Medicine and Art) from the Universities of Durham and Newcastle upon Tyne, funded by NHS Estates, the organisation responsible for overseeing quality in NHS buildings nationally. The research objective was to evaluate the extent to which a planned approach to architecture, art and design in a major NHS Hospital has a beneficial impact on patients' and visitors' experience of the hospital and on patient and staff well-being.

A range of methodological approaches were employed for different parts of the research. To

elicit information regarding the briefing process and explore how concepts such as 'patient centred care' were operationalised throughout the design and construction process, interviews were conducted with key players in the planning and design of the hospital: architects, managers, planners and senior clinicians who had advised on the design of individual departments. To facilitate comparison of responses to the contrasting environments, the study included pre and post-build phases using semi-structured interviews and a questionnaire survey with patients, visitors and staff. These were carried out in four inpatient units, six outpatient units and in selected general areas in one of the component hospitals (Middlesbrough General) as well as the new building.



Figure1: Entrance to the New James Cook University Hospital (Source: Authors).

We will examine what we call the 'domestication' of hospital spaces in the following eight sections which concentrate on different aspects of this complex process. Although the focus is on the polar types of 'hospital' and 'home', we suggest that 'hotel' can act as a helpful mediating category between them. Throughout the paper we draw heavily on extracts from transcripts of the interviews. We conclude by emphasising the importance of recognising the polyvalency of institutional spaces.

Competing Constructions of Hospital Space

From an extensive analysis of the project documentation it was revealing to learn about how the various decision makers and designers conceptualised their ambitions and aspirations. The language used was particularly revealing. One of the key briefing documents states that the aim of the new hospital is the:

...creation of a non-institutional and therapeutic environment in a manner which creates a cohesive and high quality image for the new hospital (MacNaughton et al, 2005: 38)

and the chief Executive stated that:

*...his vision of the hospital would be a place where patients would come in and it **wouldn't be like a hospital really** (Clinical Director).*

If not like a hospital then what would it be like? One recurrent theme which came out of the interviews with key decision makers was to try to articulate a place with particular qualities to which people could relate. In attempting to clarify this idea, reference was made to home-like qualities. A Divisional Manager stated:

*...the brief really was to make things as patient positive as possible ... and, you know we actually got it right for the patients – **homely**.*

But what do people mean when they say this? The extensive literature on home it is full of reference to place attachment, identity and status definition, processes of personalisation and connection (Dovey, 1985; Lawrence, 1987; Despres, 1991; Miller, 2001; Gullestad 1993; Tuan, 1977, 1991; Seamon, 1997; Heidegger, 1971; Bachelard, 1994; Rose, 1993; hooks, 1990; Young, 1997, etc.), which are usually focused on the domestic sphere, but can also relate to connection and identification with larger geographic areas or social groupings (eg home country, home city). Domestic dwellings would normally be regarded as the antithesis of institutional buildings and it is unusual to find the language of home used with reference to large institutions or organisations.

Unexpectedly, one of the central themes which emerged spontaneously from the responses during our interviews with (clinical) staff, patients and visitors centred on the degree to which the JCUH could be described and experienced as 'homely'. The ways in which hospital space might be (re)constructed as 'home' by those who occupy the space will be the central question pursued in this paper.

'Hospital' Becomes 'Home'

There is a close linkage between decoration, personalisation and attempts to achieve an environment which is commonly described as 'homely'. The ability to be in control of the environment is a key aspect of feeling at home (Dovey, 1985), and control of the environment

includes the opportunity and potential to engage, interact and even change it. Here two porters explain how children's work is used to decorate the wards.

*And um obviously on the kids' wards there's all they've just put like all the like clowns and all over the walls. [...] I think so I think it makes it a little **more like homely** if anything. [another porter adds] I think it's just that **homeliness** ... I think it's important for them when they come in is to be in a good frame of mind which gives the doctor a better chance of finding out what the situation is.*

Here homeliness appears to relate to a relaxed, calm frame of mind which may be supported by reassuring design elements and interaction opportunities which may remind the children of home and everyday spaces, and by implications distract them from the reality of being in an institution directly associated with pain and illness. This is clearly evident in the lively colours and engaging motives which are found throughout the children's department in both the old and new hospitals. This echoes a similar approach taken to the décor of nurseries and schools which draw on design languages which are immediately recognisable as 'for children'.

In explaining the appearance of the older hospital (Middlesbrough General), an information officer keeps referring to the idea of achieving homeliness:

*They've just **decorated it to look homely**, really... it's a bit tatty at the edges, but that's ok.. I think it's .. er.. it doesn't look like a medical building at all, really... I think that's the way it is now, isn't it? They don't tend to paint everything white anymore.. which is probably a good thing. [...] Well, **homely** in the sense that woodchip isn't particularly **homely**..! It's.. it's not*

*clinical in that sense.. it's **homely** in the... you wouldn't need to be worried if you spill a cup of coffee on the floor! [laughs].. that's.. er... it's.. it's.. comfy chairs and tables.. and there's a coffee machine and... that kind of thing.. it's all there, really.*

This idea that 'hospital' could become 'home' almost entirely through design was a very common observation elicited from all of those interviewed. However, the extent to which this was brought off successfully at the JCUH remains debatable, as we shall see.

The Personalisation of Public Space

Many staff in the older hospitals were able to personalise their work environment. Two clerical staff in MGH explain what they have done in the context of their own office:

I suppose I've got my pictures and my computer and my little cuddly toy and..er... posters and things and calendars... and, er.. got my little man[?] up there.. to remind me.. my inspiration!.. yeh!! (female clerical)

Yes, we all have a desk and shelving space and filing cabinets.. so you can personalise that, to a certain extent. [...] I've got a calendar with men on it [quietly] [laughs].. in various states of undress which can't be seen from the waiting area, I have to say.. erm.. and another calendar with cats on it.. but other than that it's, it's impersonal. [The other secretaries] they look at my calendars! [laughs].. I don't think they have anything personal. [...] Some of the Consultants have pictures of family up.. and some... erm.. 1 or 2 of the secretaries have little cuddly things.. you know, things that you stand on your monitor.. but, on the whole, I think we're probably quite.. quite an impersonal bunch of people when we're at work! [laughs] (senior secretary)

Attitudes to personalisation vary. One senior clinician explained how in the future he would

not personalise his space as in the past because of how patients might interpret the presence of personal images and objects. Interestingly this coincides with a separation of offices from consulting rooms in the new building. This means that he will no longer meet patients in his office, but in shared (hence less personal) consulting rooms.

[These family pictures] have been there for twenty years I haven't taken them down I really should now. [...] there is a school of thought that believes doctors should not have photographs of their beaming children in their offices because the patients that are coming are patients and ... it's a reasonable argument. [...] I've never thought of it until a colleague told me about this about a year ago I think it is a reasonable. I wouldn't now if I was just starting out put photographs of my lovely smiling children up.

Patients, particularly those staying for long periods, appreciate being able to personalise their spaces. Here a nurse from a trauma ward explains the limitations of the new hospital where patients space and are discouraged from putting things on the wall. This appears to be partly because of the different contractual position of the hospital, which is no longer owned by the hospital trust, but by a private, profit-making consortium. They also have limited storage space.

Yeah they personalize [the bed area] with flowers and cards, but everything is in the locker, the very small locker, and there isn't a great deal on the table that they have their meals and drinks on, and they're always cluttered with their own personal stuff. So everything looks cluttered cause of the small room and the space that they have to personalize, and



Figure 2: Entrance to the Old Middlesbrough General Hospital (Source: Authors).

nothing goes on the walls. So again not enough room really.

It might be the case, however, that in dividing the hospital into wards which themselves consist of relatively small bays (usually of six beds) a kind of homeliness is created, the large scale remaining for the most part hidden behind the small-scale.

Deciding the Decor

In the older hospital decisions about décor involved the staff of the particular spaces. In some departments this has continued and staff have had an input in deciding the colours and decoration of parts of the new hospital. Here a Sister (senior nurse) explains the process.

Yeah they if we ever needed painting or anything they always asked us and we get samples to look at. We all, you know, we decide, you know, say that 'll go oh I don't want that and yeah they're pretty good like that. [...] Oh we do because I've picked all the ones for the new [department] but I can't even remember what they are now 'cos it was that while ago! Colours and fabrics what you wanted on the walls yeah I've done that and it was me and my line manager ... the divisional manager we had all the samples all over and does that go with that. [...] I'm going 'no, we want it modern!'

Interesting that this person express a desire to achieve a 'modern' looking environment which will contrast markedly with the 'traditional' look of the old. An opposing interpretation is offered by a Prosthetics Manager who wishes to re-create the atmosphere of the old building. He here explains his expectations regarding the move from the old hospital to the new. He is making clear the need to 'domesticate' what he imagines will be a rather neutral, even

unformed environment and the frustrations in not being able to do this, because of PFI-imposed restrictions.

*Um ok I suppose you could say once you've looked at the pictures that's it you've looked at them but ... I don't know if we won't be able to personalise the building as we've done here. I would very much like to take [the paintings] to the new hospital... Well we've been told we're not allowed to put them up in there so there isn't really a lot of point, but I dare say they will go... It would make them **feel at home**.*

He goes on to explain in more detail the process of negotiation involved in decorating and fitting out the new facility (at the JCUH). His description begins with the process in MGH and then he explains how the new hospital is constraining possibilities for personalisation and decoration.

Well when we decorated this place um there were about three or four managers involved and we just sort of said you know wouldn't it be nice if we had this, this, this and this... these colours and it just goes from there. So you get wallpaper samples and colour samples um the carpet actually looked quite nice at one time before I think it's the damp that's gone in the concrete that's made it that colour. [...] Hmm well it was quite nice a light grey a neutral colour and the pinks of course because it's a ladies room I think ladies prefer pinks to blues and greens.

[and the pictures?] Well I brought a couple of them. Well they came from home and they were sort of pictures at home, where you think I've nowhere to put those what shall I do with them? So they were brought in here. [...] I've had a couple of people ask if they can have that picture of the horses. [laughter] I think rather than being in a very sort of white painted clinical environment yeah sure [...] the more relaxed they are the easier our job is.

This reminds us that the construction of space is always one of negotiation and that the decision-

making process is often contentious. In this context the balance of power has shifted during the change towards PFI building. Under this a new contractual process public buildings are designed, built and owned by private consortia who then rent the buildings to the local NHS Hospital Trust. This means that the occupiers/users are no longer the owners, and the building itself becomes an investment and source of profit. The change in funding from public to private impacts directly on decision making processes at even the most basic levels as it changes people's relationship with the building. Before it was unambiguously 'their' place, now it appears to belong to anonymous others. These issues of ownership (perceived as well as legal) are fundamental to the construction of space.

The Prosthetics Manager continues:

- we were allowed a little bit of autonomy in choosing the colours. [but] as for putting pictures and things up we've been told that we're not allowed to put anything up on the walls at all, that we have to put um a request in if something's to be put up on the wall and the service providers will send somebody round to put the picture up and will charge us for the privilege of doing it. [...] No it's PFI...the building is only rented ...so how that's going to work I've no idea as yet.

This is echoed by a physiotherapy assistant in the same department. She emphasises the importance of making the place welcoming for patients as well homely for both staff and patients. Again this is about control of the work place by those who use it.

Well um I think on ... pictures on the wall but apparently they don't agree with that ... Well so they so people's saying...it was said that um they didn't think it was appropriate. [...] Well I think it looks nicer I mean in the corridors they've got plenty of pictures and things... Which looks nice, so why not in the department? [...]

*Maybe maybe ... once the um cracks maybe start appearing and oh we'll hang a picture up and hide that do you think! [laughter] ... It is like a **second home** isn't it? It's, I think you know people should be able to put a few pictures up and whatever. [...] And make it look **welcoming, and homely.***

Workplace as Home: Colleagues as Extended Family

Not only the place, but colleagues themselves are reconstituted as a part of the hospital as 'home'. This tendency is described by a Ward Sister who not only talks about the workplace as a home, but her colleagues at the MGH as an extended family:

*I think the staff are very **homey** as well ... I mean certainly I do. This is my **second home**. I've similar feelings I think about being here to my home environment. If people um criticise the ward you tend to take it very personally. I feel the staff work very much as a team and it's almost like an **extended family** um in that you trust them... you put a certain level of trust and faith in the rest of the staff and in the patients that come backwards and forwards that you develop a relationship with them and it is almost like an **extended family** you feel very protective towards them.*

The overt connection between the work place as a 'second home' and colleagues as extended family members is logical and consistent. It is a clear example of how the relationship between people and place, between environments and those who use them can be conceptualised as mutually interdependent. In the case of home, Dovey (1985:34) defines this relationship as 'as an emotionally based and meaningful relationship between dwellers and dwelling places'. What we see here is the domestication of what we would otherwise regard as institutional space.

This appears to be possible as the people treat colleagues as family in which values such team, trust, faith and protectiveness are reinforced and celebrated. Through this process environments with home-like qualities are created and sustained.

This raises one of the key challenges of this research project. Not only were the buildings changing but because of the amalgamation of the three constituent hospitals and the changing contractual position, many work practices and organisational structures were inevitably changed too. With the move to the new building the 'emotional relationship' between the users and the spaces needs to be re-formed in different circumstances. In some places it appears to be seriously fractured,

but we may conjecture that with time new relationships and patterns of engagement will develop. Our study was done shortly before and after the move, and the interviews were full of nostalgia towards the 'lost home' of the older hospital.

'Public/Private, Work/Home'

For patients, as well as staff, the ability to understand hospital in terms of home, to see public space as private is central to their sense of well-being in hospital. For some patients the close positive correlation between the approach of the staff and the appearance/characteristics of the building has been changed by the new hospital building. A female chemotherapy patient describes the response of her mother in



Figure 3: Sitting Area on Main Corridor, James Cook University Hospital (Source: Authors).



Figure 4: Foyer Area with Hanging Glass Sculpture, James Cook University Hospital (Source: Authors).

law who regularly accompanies her to the new hospital.

She said, when we came to this one, it's different to the other area, she said it's more plain, even said the words 'clinical, more clinical than the old place'. Because as soon as she went in the old one, she thought, oh this is friendly.

Interviewer: So the friendliness wasn't just to do with the people then?

Oh, no. It felt more... What words would you use to describe? It felt more welcoming really. I mean, like I say, loads of times, the girls [secretaries, nurses etc] haven't changed, it's nothing to do with them, it's just the, because even the mother in law and John says, the girls haven't changed.

As we noted earlier, there can be no homogeneity

in people's perceptions of hospital space. For some the JCUH is, quite simply, 'cold and clinical'; whereas it is 'homely' for others. It depends partly, of course, on the ward in which they are placed. The wife of a patient in the new trauma ward was much more positive in her assessment. She refers to homely qualities in the new building:

*In the ward they were **very homely**. Very homely. But everywhere you went in the hospital, there were very nice people. Very nice surroundings.*

Interviewer: You said you felt at home. In what sense? Was that largely to do with the people?

*Everything really. It was relaxing really. **It wasn't like a hospital**. It was relaxing. [...] There were pictures on the walls. Art and plants in the corridors. Chairs all the way up the corridors. So if a patient got tired they could sit down. ...But they weren't like ordinary chairs.*

They were comfortable like two-seater sofas.

This raises the question regarding the extent to which individuals are predisposed to conceive of the JCUH as 'home'. A similar positive response was elicited from the mother of a patient, who explains how the new hospital is such an improvement on the old, precisely because it felt less like a hospital.

And I was interested to see the range of artwork and prints and styles and things along the walls so... I felt it very homely, welcoming, friendly, less like a hospital. [...] It didn't smell like a hospital and it didn't look like a hospital. I felt I was somewhere welcoming and helpful.... Take your worries away.

As expected, patients varied in their responses. Here a female chemotherapy day patient describes the new building as clinical and is very critical of the absence of daylight in a quiet room.

Yeah, really. I think they could've thought more about, I suppose the décor could have, it's very clinical, very white. I suppose you can't put wallpaper in, can you?. It's quite small, no windows and if you shut the door, it's very claustrophobic. I came in with my husband and we came out again, because it was just... like you're in a coffin before you're in one. Yeah. I just can't get my head around that there's no window.

This patient appears to be counterpoising the 'clinical' with the 'homely' and clearly perceives the former in negative terms. A similar point is made by another patient who explains how she feels uncomfortable with the scale of the new building, again drawing on her previous experience as a point of comparison:

I think it's more comfortable going into Middlesbrough General as a visitor than it is [James Cook]. Uh I think it's cold in there isn't it. [...] I don't know I just I always

felt quite at home in Middlesbrough General, bit scary [James Cook]. ... It's just so big it's just ... I can't explain what it is it's too big.... The corridors are so wide and so long and it's you walk a mile down the corridor to get to a little ward and then you go to another ward at the other end of the hospital you've got that walk again. ... It's just so so big.

Scale is an important marker among our respondents. As alluded to above, the 'homely' is associated with the 'small', small buildings, small and simply designed wards, small work teams. A senior clinician/ divisional manager appears to be aware of these sentiments:

Um it's seen as the General being small friendly, bit old fashioned quite a few people are a bit worried about the high-tech at James Cook

Patient Control of Environment

It is recognised that the ability to control aspects of your situation is a key factor in patient comfort and levels of satisfaction, and certainly a characteristic of home environments. Here an elderly male patient explains how in the Middlesbrough General Hospital (MGH) he is able to control the lighting and temperature:

Sometimes you get in here and it can be so bright and you just wanted a you're tired and you just wanted to rest your eyes sort of thing and it's nice to be able to switch these off ... and then you've just got that these side lights which give a more muted sort of thing ... and it's really nice to be able to have either the sun shining in ... and some and like this, this person who's sitting here ... Has switched it off and it makes a tremendous difference to the temperature in the room. The amount of sun that's shining in it really does the temperature in the room can really soar with the sun and a lot of people. I opened a window over there this morning it's nice. [...] It's lovely to be able to have the windows open

slightly and sort of adjust your fresh air...um because you're here for quite a while.

This is possible also for patients in the new hospital.

When we did actually open the windows to get the fresh air in, you know, especially in the morning you want to let the fresh air in. [...] Yes. There was easy access to opening and closing up the windows. Obviously there's no way I can adjust the temperatures. (male patient, mid 40s)

And there was a little bit of light on the ceiling for staff to walk in and check you in the night and they wouldn't have to disturb you. [...] Yes. I thought it was very well thought through. [...] Yes, you could [control it]. Yes. Very easily. There was like a buzzer you could ring for help or assistance. The television, the speakers, earphones, you could listen to a radio or TV through the earphones and things like that. You had all that controlling and the nightlight, you controlled that. [and the windows?] Yes. They could be opened. Yes. (male patient trauma ward).

These are encouraging responses. Although there are aspects of control which must inevitably be controlled institutionally, it appears that at this scale the designers have been able to create responsive environments which allows many patients to retain control of their own places, thereby re-creating some of the conditions of home.

'Hotel': Between Home and Hospital

A number of respondents have already remarked that the imagery and atmosphere of the James Cook does not conform to traditional expectations of a hospital. This was the stated intention of the key decision makers, but they were less explicit in defining a new 'non-institutional' environment. It is therefore

illuminating to examine the responses of the different users. One particular building type – the hotel- re-occurred frequently and perhaps we may regard it as a mediating category, being an institutional building which shares many overlapping qualities (and functions) of home. This is certainly true with regard to control over environments, where we may regard the 'hotel' as an intermediate category between home and hospital. Many people compared the new hospital to other building types, partly because of its visual appearance, but a few used other senses to comment on the changed environment. For example the mother of a patient contrasts the new hospital with one of the older hospitals:

It smelled like a hospital ... The James Cook doesn't. I don't think. The corridors are light and airy. Cream coloured walls. Nice green areas. I just think it's like I've gone to a hotel rather than a hospital.

This observation is also reinforced by perceive changes in organisational culture implied by the new building. The parent of disabled teenager commented:

*Well it's a work place you know it's a lot more it's a fact-it's a you know a **people factory** a lot more isn't it.*

This idea is expanded in the comments (made prior to the move) of a female clerical worker, who also raises the issue how people will adjust to the new place. Will increasing familiarity lead to more positive responses and a greater sense of ownership?

*The other one's a bit intimidating.. it's massive and.. and.. you can't get parked. [...] I remember it being built.. and we used to call it 'the **chicken factory**'.. cos it looked like a **factory**.. metal rigs... and it's just got bigger and bigger ...since then.. and I think*

people find that a **bit intimidating** .. it's very difficult for people that have worked here for a long time.. have got used to it and are familiar and all that... even if it is a bit tatty and grubby at the edges... and it's also difficult for patients that've been coming here for, you know, ..decades or.. and it's more difficult for them to change.. I think for people that are coming.. to use the service first.. I'm not.. not quite sure how they'll react .. erm.. it'll be normal for them, won't it, so..? .. it's still very... I don't know it's.. it's like... **like the Metro Centre** [very large shopping mall].. but upside-down and jiggled up, isn't it, really!! You can't find anything [laughs]..!! and they have fabulous maps everywhere, don't they?.. and great big signs advertising everything and you still get manage to get lost in the Metro Centre, don't you?!.. this is like that except.. a hundred times worse, really.. and you're ill!! [laughs]

This reference to shopping malls was made by a number of respondents and others suggested that a hotel reception area was a more accurate analogy:

*I did, I thought [the globe] was nice. That was outside the glass, the whole glass entrance. I thought it was quite impressive. It was almost like you were going into some sort of fancy ... As I say it felt more **like going into a hotel reception** than it did going into a hospital. (Mother of child patient).*

A clerical officer relates this to her experience of another local hospital:

*I went to North Tees my sister was in there a couple of weeks ago and you walk in I thought this is lovely **like a four star hotel** and it was. [...] Oh yes four star environment [...] cos there were carpets on the floor there were uh goldfish.*

For a male patient, the new James Cook building is more like an art gallery or airport, and he does not believe this appropriate:

It's a hospital, it's not an art gallery. [...] Have the art

*gallery part of it where it needs to be, where you're actually going to be sitting. How are you going to see it lying in a hospital bed? [...] I tell you the first time I actually went down and looked at the place. It looked like one of these **new designer airports**. [...] If you showed me a photo of that atrium inside, I would've said **modern art gallery**, airport. The last thing on my mind is hospital. [...]*

*I've talked to people who said they hate it because, like older people, it's too much. I don't like that. It looks brilliant as a **piece of art**. It's not there as a piece of art. It's more like going to airports all over the world. Breathtaking when you get inside of them, but just a way, a means of making it look good.*

Perhaps the most revealing part of the same interview is when he describes how the new building suggests different codes of behaviour. He is unsure about the behaviour which might be appropriate in the new space. This is the very opposite of an environment in which people feel 'at home' and sense they are in control.

Why are they there? This area, the biggest area, the atrium as you walk in, it's got some sort of plaque or something saying it's some sort of communal meeting area for discussions of this, that and the other. If it's a meeting place, yes, but the only people who are actually going to meet there are actually reps. We actually saw people sitting there eating their lunches.... Just eating sandwiches. It's not a place to eat a sandwich. Who are these areas designed for? Are they designed for visitors or staff or inpatients? There's no clarification, anything, you know, are you allowed to eat sandwiches?

Interviewer: Do you think you need permission?
Yeah, that's the sort of thing because you're looking at, it's all leather seating. You think to yourself, oh this cost a fortune these seats, and if I come here as a visitor you're thinking, oh I can't get in because it's another 10-15 minutes before open time. Right? If I sit in these seats is a big security guard going to come and go at me, 'Get off there, it's for staff.'

Conclusions

The construction of space is complex. Although buildings as physical entities may apparently remain static, the spaces within are in a continual process of change, negotiation and contestation. Meanings are constructed and re-constructed by individuals and groups to reflect and reinforce wide-ranging values within broader society. We have seen how the response of individuals to the new hospital has varied considerably. This raises a question regarding the extent to which individuals are predisposed to conceive of the new hospital as 'home'. There is certainly a tendency for interviewees to draw attention to the ways in which the hospital is more or less like home. It would seem clear that for patients 'home' should provide the model on which hospitals are based. The extent to which this is possible will vary with circumstances. For instance, the JCUH was conceived of and built as a flagship hospital with the ambition to represent the global aspirations of Middlesbrough and perhaps the area of Teesside more generally. The hospital is large (over 1000 beds) and struggles for the most part to transform itself into 'the homely'. For instance, consultants are far more likely to draw attention to the 'high tech' medical facilities which facilitate the more successful and rapid treatment of patients.

Bourdieu's work (1977) on social capital reminds us of the role of class in articulating distinctions, and in this context it appears that social class may be a significant variable in the construction of space. Particular design languages are identified, appropriated and legitimated by different social classes in distinctive ways. For example, the contrast between the friendliness of the old with the perceived impersonal nature

of the new is interpreted in these terms by a clerical assistant (prior to the move) who suggests that the new hospital is more 'upmarket'. This is clearly suggestive of class distinction:

*Erm.. this would have to be like a personal opinion... I think that this [older] hospital... is not as impersonal and... I feel as if ... we have more time with the patients.. I think, although it's an old building, it's big and it's spacious... and you can find somewhere to sit, if you do want to sit on your own... there is always somewhere where you can sort of find a corner to sit in and.. you know.. get away from it if you want to or.. you know.. go and join in, you know, wherever. From my experience of only going over to James Cook... it's just seems that there's so many people there and **it's so big and impersonal...** everyone seems to be dashing about and the places seem.. although the décor with the paintings and what have you are, you know, **very upmarket** .. it all looks very nice.. but it does seem as if.. **it's impersonal**.. I don't know, there's nothing.. it doesn't seem to have ... **friendliness**.*

Although the issue of class is clearly relevant it is beyond the scope of this study. This paper has aimed to demonstrate that the 'hospital' is polyvalent with multiple meanings, each of which struggles to be heard. At the centre of this battle of contested meanings is the uneasy relationship that exists between 'home' and 'hospital'. It is unlikely that such tensions will be easily resolved. In practical terms, we would want to draw attention to the naivety of some planners and managers who assume that they can predict the way in which hospital space will be interpreted by users. This naivety should, in our view, be replaced by a humble inclination to accept the inevitability of diverse responses and simultaneously recognise the value of 'home' as an important signifier and base-line environment against which other, more public, environments are compared and evaluated.

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Peter Kellett

Dr Peter Kellett studied architecture and anthropology and teaches at the School of Architecture, Planning and Landscape at Newcastle University. His main field of research is in housing, especially the environments created without professional support. Some recent publications include 'Housing and Home-Making in Low-income Urban Settlements: Sri Lanka and Colombia' (with Dayratne R) Journal of Housing and the Built Environment, Vol 23, No 1. (2008); 'The Construction of Home in the Informal City' chapter in Hernandez, F., Millington, M. and Borden, I. (eds.) Transculturation: Cities, Space and Architecture in Latin America, Amsterdam and New York: Rodopi, 22-42 (2005). A new book (edited with Hernandez, F.) is due out in 2009: Rethinking the Informal City: Critical Perspectives from Latin America Oxford: Berghahn. He can be contacted at p.w.kellett@newcastle.ac.uk

Peter Collins

Dr Peter Collins teaches social anthropology at Durham University. His interests include religion, narrative theory and issues relating to space and



*place. During the last five years he has been involved in inter-disciplinary research projects based in acute hospitals in the North East of England. He has published widely in these areas and his most recent publications include, *Locating the Field: Space, Place and Context in Anthropology*. (ed. with S. Coleman) (Oxford: Berg, 2006) and *Texts and Religious Contexts* (ed. with E. Arweck). (Aldershot, Ashgate, 2006) and *The Construction of Place as Aesthetic-therapeutic*. In *Therapeutic Landscapes* (ed. C. Williams). Aldershot: Ashgate. He can be contacted at p.j.collins@durham.ac.uk*