**Reinventing the clinic?
Consuming hospital spaces
in the PFI era**

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Abstract: Since 1997, Labour has overseen a new hospital building programme in the UK that has been heralded by Tony Blair as part of a ‘new civic building programme that will rival that of the Victorian age’. These hospitals, primarily funded through the Private Finance Initiative (PFI), are depicted as setting new standards in healthcare facility design. In this paper, we examine the distinctiveness of these designs, exploring the rhetoric that proclaims them as offering new levels of clinical efficiency and patient care in a distinctly ‘non-institutional’ setting. Emphasising the homology between these designs and the (il)logics of the marketplace, we conclude that this new generation of hospitals is indicative of an important shift in the locus of healthcare from the world of the service user to the world of the consumer.

Introduction

Hospitals need to be well-designed, first and foremost for the patients, doctors and carers whose lives, livelihoods and welfare depend on them (HRH Prince of Wales, 2001: 58).

Is it a hotel? Is it a trendy bar? No, it’s a hospital (Purvis, in *The Guardian* 5 July 2001: 14).

The opening of the twenty-first century may come to be viewed in science and medicine as the dawn of a new therapeutic age. Following the mapping of the human genome and the possibilities offered by gene therapy for improved health, medical laboratories appear to be taking on a new significance as ‘healing spaces’. Perhaps, in this further molecularisation of the body (Rose, 2001), we are witnessing yet another shift in Foucault’s ‘spatialisations’ of the western medical gaze (Foucault, 1976; Armstrong, 1995). Whatever our position on this - and there are critical voices

(Conrad, 1999) - the return to prominence of the medical laboratory does provide an insight into the ways in which scientific and technological achievements influence the spatial organisation of healthcare.

The significance of new medical technologies has not been lost on geographers. For example, Cutchin (2002) reveals how telemedicine and Internet technologies are opening up opportunities for medical diagnosis and care. Going further, he highlights the potential of such technologies to gain access to, and alter the organisation of, specialist care. For other scholars, such changes point to a transfer of care from formal spaces such as hospitals to informal spaces such as those of the home and the community (Parr, 2002a; Williams, 2002; Fannin, 2003). Thus, for a number of commentators these advances are revolutionary in their implications, and point to new modes of medical care and intervention. For example, Armstrong (1998: 455) has suggested that the age of 'surveillance medicine' has hastened the post-war decline of the hospital, arguing there is no longer a justification for such bounded clinical spaces. The closure of many district general hospitals seemingly bears testimony to this (with Armstrong's comments made in response to the threatened closure of St. Bartholomew's Hospital, London in 1998).

However, in this paper we want to suggest that such technological advances should not distract from changes occurring in hospitals, which remain perhaps the most enduring and visible symbol of the National Health Service in the UK. In this respect, we focus on the Labour Government's ongoing hospital-building programme. Promoted as unprecedented in scale following years of neglect, this programme seeks to redefine the significance of acute hospitals as therapeutic

environments and emphasises that existing NHS hospitals are ill-equipped to deal with the healthcare needs of the twenty-first century. Accordingly, it involves the development of hospitals that are intended to offer new standards of in-patient care in a setting that is both architecturally and clinically distinctive. While the threat to hospitals - particularly the district general hospital - remains (see Brown, 2003), the hospital building programme implemented by the Labour Government implies an important shift in the organisation and delivery of acute sector services.

Rather than seeking to understand these changes solely in relation to ‘medical’ matters, in this paper we move beyond the medical to explore how hospital spaces are being reinvented to accommodate new practices and imaginations of care. Our paper thus begins by exploring the geographic literature that has critically explored the consumption of healthcare in relation to the health management techniques associated with ‘neo-liberal’ societies. In particular, we alert to the significance of the relationship between public health discourse and contemporary understandings of risk that impel individuals to be prudent and knowledgeable *consumers* of health services. In so doing, we necessarily engage with cross-disciplinary debates surrounding the changing design of clinical spaces, particularly the idea that they embody particular relationships between medical experts and patients. Arguing that these relations are being remade in the contemporary hospital, we thus contrast the Foucaultian notion of hospitals as institutional spaces at the heart of a disciplinary society with Bauman’s more fluid notion of societies controlled through the vicissitudes of the consumer society. In line with such ‘post-disciplinary’ accounts, we conclude that hospitals are being reinvented as *de facto* spaces of consumption,

where the logic of the institution is being superseded by the logic of the corporation (see also Kearns *et al*, 2003).

Consuming health: post-medical perspectives

In recent years, medical geography has shifted from its traditional twin preoccupations with the spatial distribution of disease and the provision of health services to encompass a variety of thematic concerns under the remit of a ‘new health geography’. While the novelty of this approach has been disputed (Kearns and Moon, 2002), one of the key foci of ‘post-medical’ geography has been an exploration of the embodied relationship of health, space and social well-being (Asthana *et al*, 2002; Kearns and Moon, 2002). A major conclusion of such work is that health needs to be understood as more than the absence of disease, with understandings of the healthy body intimately shaped by space and place (Parr, 2002b). Associated with this is the idea that centralised philosophies and collective practices of health are inflected by local concerns, with individuals negotiating discourses of health and healthism as they call on ‘expert’ medical knowledges in their everyday lives (Kearns, 1995; Lupton, 1995).

Within the geographical literature informed by such social (rather than biomedical) models of health, one avenue of investigation has been an exploration of how individuals respond to the discursive practices of the ‘new public health’. Simply defined, this is a state-sponsored movement that encourages individuals to be prudent consumers of health services by suggesting certain behaviours and lifestyles are inherently risky (Peterson and Lupton, 1996). Rather than being repressive,

however, such discourses are regarded as productive and permissive, encouraging citizens to take charge of their own health in the name of freedom of choice. This is, as Brown and Duncan (2002) note, an extremely effective form of governance, legitimating ideologies and social practices through seemingly innocuous statements about health risks. Indeed, under the burden of an increasing wealth of information about the dangers of poor diet, excessive drinking, lack of exercise, risky sexual practices and so on, it becomes the *duty* of the responsible citizen to monitor the lifestyle choices they make (Brown 2000; Joyce, 2001; Fullagar, 2002). The outcome is a population made acutely (and *anxiously*) aware of the risks permeating social life and their responsibility to exercise self-surveillance in relation to the norms laid down by the state and its health agencies (as Castel, 1991: 289, questions, ‘For what situation is there which one can be certain that it harbours no risk?’) This has led many commentators to suggest that the health knowledge constructed by ‘experts’ is crucial in organising all aspects of our embodied existence. Summing up, Parr (2002b: 245) suggests ‘individual body sites are...complex sites of risk assessment which are worked on by their owners to produce more culturally-appropriate material forms, as well as being inscribed with health and medical knowledges that are appropriated by self-made corporeal experts.’

What is being suggested here is that new regimes of self-care have emerged in response to the production and articulation of epidemiological knowledges of health and risk (Castel, 1991; Armstrong, 1995). Yet, as Lupton (1994) acknowledges, these intertwining notions – health, risk and self-care – need to be understood in the context of broader cultural practices. More specifically, an awareness of risk, and of the health-promoting benefits of a balanced diet, of physical exercise or of smoking

cessation, is only one of the reasons why individuals conduct self-care regimes: another is the link between healthism and the ‘ideologies of morality, asceticism, self-discipline and control’ evident within contemporary consumer culture (Lupton, 1994: 113). As in Bauman’s (2001) persuasive account of the links between consumption and the dissolution of modern state, it appears that the incalculability of risk and the insatiable desire that surrounds the maintenance of a healthy body is encouraging people to seek surety in the only place that seems to offer any guarantees: the marketplace (hence Rose’s, 1999: 86, assertion that we are ‘obliged to be free’ - to understand and enact our lives through self-gratifying consumer choices). This is manifest in increasing numbers of ‘reflexive’ and ‘discerning’ consumers visiting health clubs, gyms, holistic health shops, and high street chemists - as well as accessing health information through satellite television health channels, telephone helplines and Internet sites (see Kearns and Barnett, 1997; Smith-Maguire, 2001; Parr, 2002a; Williams, 2002).

Accordingly, the massive growth in health-related consumption is provoking a critical reappraisal of established geographies of health, with an increasing focus on spaces that have traditionally received little attention in the literature on ‘therapeutic landscapes’ (e.g. see Fischer and Poland, 1998, on street spaces; McCormack, 1999, on office spaces; Parr, 2002a, on the spaces of the Internet and Williams, 2002, on the home). Yet despite such studies, there is yet to be any sustained examination of how new discourses of risk and consumption are shaping the design of *clinical* spaces (including GP surgeries, day care centres and acute hospitals). Indeed, although the aim of the new public health discourse is apparently to make unhealthy and stressful spaces healthy, we argue in this paper that this necessarily includes

clinical spaces as well as the homeplaces, workplaces, communities and cities that have been the foci of most studies to date (Brown and Duncan, 2002). Hence, while we do not dispute Bunton and Burrows' (1995: 48) assertion that 'health and illness are no longer confined to clinical locations of hospitals, or to the relations between doctors and patients', we wish to offer a sustained examination of the way that health consumerism is shaping clinical spaces rather than simply making the obvious point that healthism is dispersed through the social body.

Hospitals as institutional spaces

According to Foucault (1976), hospitals evolve at the interstice between medical knowledge about diseases and the fleshy bodies of individual patients that harbour these diseases. Thus, in his famous account of the origins of post-Revolutionary French medicine, Foucault noted that hospitals underwent a significant transition with the emergence of new types of medical practice (see Philo, 2000). Though Foucault did not dwell at length on the architecture of these new spaces, he noted that they were informed by the twin principles of incarceration and panopticism that have been more widely-documented in the context of asylums and prisons (Philo, 1987; Markus, 1993; Edginton, 1997). Incarceration of the sick was deemed desirable given there was a twin need to protect the public from the dangers of illness while placing the sick in an environment where they could be managed and treated within an ordered space (Armstrong, 1998). Likewise, panopticism was a key organising principle given patients needed to be observed, probed and documented:

There, beneath the eye of the hospital doctor, diseases would be grouped into orders, genera and species in a rationalised domain...Thus conceived the hospital would make it possible to classify patients...without spreading contagion either in the hospital or without it (Foucault, 1976: 42).

The product of this medical gaze was a *de facto* distinction between healthy and unhealthy bodies, as well as between different diseases, with medical practices of intrusive examination (and later X-rays and body scans) being used to ‘gaze into’ bodies when the symptoms of illness were ‘invisible’: ‘Hence, the strange character of the medical gaze: it is caught up in an endless reciprocity. It is directed against that which is visible in the disease - but on the basis of the patient who hides this visible element even as he shows it’ (Foucault, 1976: 9).

In Foucault’s account, the centrality of the medical gaze in clinical settings placed medical experts and patients in a particular power relationship, with patients ‘seemingly looked upon as objectified sources of data rather than unwell individuals wishing to have their suffering alleviated’ (Philo, 2000: 16). Yet this unequal relationship was tempered by the series of moral assumptions that adhered to medical practice:

The domain of the hospital was an ambiguous one: theoretically free, and, because of the non-contractual character of the relation between doctor and patient, open to the indifference of experimentation, it bristled with obligations... If, in the hospital, the doctor does not carry out theoretical experiments, free of all obligations to their human subject, it is because as

soon as he sets foot in the hospital, he undergoes a decisive moral experience that circumscribes his otherwise unlimited experience by a closed system of duty (Foucault, 1976: 83).

To characterise this relationship as one of exploitation is thus misleading: it was not simply that doctors treated patients as bodies to be diagnosed, documented and appraised: there was always the desire to cure. Even so, the primacy of the gaze underlines that the relationship was unequal: ‘to look in order to know, to show in order to teach, is it not a tacit form of violence...upon a sick body that demands to be comforted, not displayed?’ (Foucault, 1976: 84). In this sense, such hospitals have been described as quintessentially institutional spaces in that they were designed to ‘restrain, control, treat, “design” and “produce” particular and supposedly improved versions of human minds and bodies’ (Philo and Parr, 2001: 514).

Isolating the spatial themes largely latent in Foucault’s work, Philo (2000) heralds *The Birth of the Clinic* a remarkable piece of medical geography. Unfortunately, Foucault’s ‘archaeology’ of the birth of clinical spaces in France at the turn of the eighteenth century has not inspired similar ‘institutional geographies’ of the emergence of such spaces in Britain (although see Gillespie, 2002). Nonetheless, it is clear that emerging discourses of self-care throughout the nineteenth and early twentieth centuries gradually replaced custodial medical institutions with more open facilities where patients were encouraged to participate in their own healing (see Armstrong, 1983). Yet the preoccupation with the medical gaze arguably persisted throughout this period: for example, British hospitals often sacrificed patient privacy in the interests of developing a ward system based on continuous observation and the

economical allocation of medical resource (Forty, 1980). As Armstrong (1998: 447) contends, the ward system allowed every individual patient to have ‘a recognised place in the institution of the hospital: an address in the form of a ward name and bed number’. In this sense, the hospital bed remained at the core of a system of medical management based on clinical observation of the patient by both medical and nursing professionals. Thus, hospitals have traditionally embodied a *politics of speed* where medical experts are mobile and patients sedentary. This reinforces Lupton’s view that hospitals are institutional spaces designed to create docile bodies by holding patients ‘in the grip of ever-more powerful discourses and practices of panoptic medicine’ (Lupton, 1995: 102). Maybe so. But even if this type of interpretation can be applied to the hospital of the nineteenth and twentieth century - a debatable point in itself - in the remainder of this paper we want to suggest it cannot be applied to the hospital of the twenty-first century.

Towards post-institutional hospitals?

Foucaultian takes on hospital spaces suggest they are ordered spaces of surveillance where diseased bodies can be segregated from society at large in a safe and hygienic environment. These twin principles have arguably informed hospital design throughout the history of the British NHS, albeit that increasing emphasis has been placed on the promotion of hygiene and patient recovery. For example, in the wake of concerns about the dangers faced by patients in hospitals (e.g. cross-infection, stress, noise, bed sores - see Armstrong, 1998), both the routines and built forms of hospitals were modified in the 1950s and 1960s to reduce the nascent risks to health faced by patients. A series of reports and publications at this time - most notably the

Nuffield Provincial Hospital Trust publication *Studies in the Function and Design of Hospitals* (1955) - advocated the maximisation of light, air and clean surfaces, adapting the principles that had characterised the much-vaunted Finsbury and Pioneer health centres in the 1930s (Gruffud, 2001). These ideas informed the innovative hospital designs that characterised the early days of the NHS: Francis *et al* (1999) suggest that distinctive clinical, social, and architectural ideas came together at this time to create the ideal of a vertical ward tower set on top of a horizontal block providing clinical and support functions. Colloquially known as the ‘matchbox on a muffin’, and influenced by hospitals built in continental Europe and North America, this design embodied modernity, efficiency, and an optimistic attitude toward technology and progress. Over the years, variants of this design were developed as and when costs and site constraints dictated: for example, the more flexible and low-rise harness schemes, nuclear designs and *Best Buy Hospitals* (introduced in 1967 and codified in a series of Hospital Building Notes) (Francis *et al*, 1999).

In this context, it might be argued that the Labour Government’s highly publicised hospital building programme represents merely the latest in a long-line of attempts to produce environments that do not simply render the body a knowable and treatable geography of organs, blood and cellular transmissions (Parr, 2000b), but also attempt to promote patient well-being and recovery (Williams, 2002). However, the programme has been proclaimed as representing ‘unprecedented’ investment in hospital building following years of ‘neglect’: when launched by the Secretary of State for Health in July 1997, it was described as the ‘largest building programme...in the history of the NHS’ (Department of Health press release

97/155). This programme - redeveloping around 25% of healthcare buildings within 10 years - has been enabled by the Private Finance Initiative (PFI), a mechanism originally introduced by the Conservative Government in 1992 to encourage private sector involvement in the provision of public services (Kerr, 1998). However, while no PFI hospital projects had reached financial close by the time of Labour's electoral victory in 1997, 64 PFI hospital building schemes have been introduced since May 1997 at a total capital value of over £1.1bn (DoH, 2003): of these, 21 are fully operational, 6 have work started on site, and the remainder are in various stages along the PFI process (see Appendix).

In basic terms, PFI allows NHS Hospital Trusts to solicit private sector consortia to design, build, finance and, in some cases, operate a hospital on their behalf, with repayment staggered over a thirty-year period (Kerr, 1998; Ruane, 2000).

Additionally, the private sector is encouraged to employ its managerial, commercial and creative skills to secure 'significant performance improvement and efficiency savings' (Treasury Taskforce, 1997: 9 cited in Ruane, 2000). In this regard, the PFI hospital building programme can be associated with broader trends that are changing hospital practices and transforming the ways in which the hospital as an institution, and the various actors associated with it, are imagined (Gaffney *et al*, 1999; Joyce, 2001). Notably, these include the privatisation and mercerisation of health care, which is serving to effectively blur the boundaries between the public and private sectors (Bunton and Burrows, 1995; Mohan, 1999). While largely implemented under the Conservative governments of the 1980s and 1990s (see Moon and Brown 1998; 2000) - through, for example, the creation of NHS Trusts, the establishment of health care commissioning, and the introduction of hospital managers - this

ideological commitment to the public-private partnership remains a cornerstone of UK health policy under Labour.

While various scholars have engaged with the PFI hospital building programme (often from a critical perspective, see Gaffney and Pollock, 1999; Gaffney *et al*, 1999; Pollock *et al*, 2001; Dunnigan and Pollock, 2003), our focus here is on the assumption, implicit within governmental discourse, that good hospital design, effective management and mercerisation are linked. Indeed, PFI has allowed for the heightened involvement of architectural practices in the design and building programme (including many with considerable experience in the private health sector, such as Nightingale Associates, WS Atkins, David Morley, von Stenburg and Avanti), with the resulting designs exhibiting more variation than was the case where hospitals were built to NHS specifications. This has allowed for the creation of hospital buildings that are arguably more sensitive to local context, responding to accusations that NHS hospitals have tended to be ‘placeless’ and even intimidating locations (see Kearns and Barnett, 1997, on hospital design in New Zealand). Simultaneously, PFI has ushered in new ideas about the layout and delivery of clinical services, with the creation of a fully ‘digital hospital’ being a commonly cited design aspiration.

However, to date, judgements of the quality of PFI schemes have been mixed. Several have already been upheld as innovative examples of good design, with Norfolk and Norwich University Hospital and Cumberland Hospital (Carlisle) having been nominated for the Prime Minister’s *Better Public Buildings* award in 2002 and 2001 respectively, and the ambulatory care centre (ACAD) at Middlesex

short-listed for the *Building Better Healthcare Awards* by NHS Estates, 2001. The Health Minister, Lord Hunt, maintained at the latter that:

The government has a strong record in health on promoting design quality. We recognise that how a building looks, and how it feels to work in have a major impact on patients, staff and visitors. Well-designed buildings are welcoming, safe and effective. Good design lifts the spirits, helps patients to recover, and inspires staff to give their best. Each scheme here today represents the means to achieving the quality we are aiming for in creating a national health service fit for the 21st century (Lord Hunt, 2001, cited at www.nhsestates.gov.uk/news_update/content/awards.html, accessed July 2002).

Despite this praise, there has also been much criticism of the first round of PFI hospitals, with the independent King's Fund claiming that Labour had 'entered a massive building programme without an assessment of future requirements and without transferring any substantial risk from the public to the private sector' (Walker, 2002). Sir Stuart Lipton chairman of the Commission for Architecture and the Built Environment) likewise described early PFI hospitals as 'urban disasters' which had not encouraged innovative design, had drawn on the expertise of a limited number of architectural practices, and involved inadequate public consultation (Lipton, 2001).

Despite such criticisms, there is in fact much that is distinctive about the new generation of PFI schemes, and, although they might be read by some as institutional

spaces of discipline and control (see Armstrong, 1995), we would argue that they are characteristic of a society where public service users have been refashioned as consumers, or according to the Labour Government, ‘partners’ (see also Kearns and Barnett, 1997). Consequently, we suggest they embody a fundamentally different locus of control, being based on the *seductive* control evident in consumer spaces rather than the disciplinary control of institutional space (see Bauman, 2000, on post-panopticism). On a superficial level, such arguments seem hard to sustain: most PFI acute hospitals are, like the district general hospitals of the 1950s and 1960s, large facilities offering a range of diagnostic services alongside specialist in-hospital patient care. In this sense, they remain places where specialist medical knowledge is produced and consumed, and where the sick and ill are kept in sanitary conditions under the watchful eye of medical authorities. Yet, a closer examination of the design of PFI hospitals – and the rhetoric that surrounds them - reveals evidence of a new, and distinctly non-institutional, logic governing health care (Kerr, 1998). Below, we illustrate this by highlighting the three key design aspirations of PFI hospitals: to enhance clinical efficiency; to contribute to civic life, and to provide restorative, healthy environments. While these ideals have a lengthy history in hospital design, we argue that the way they are manifest in PFI-era hospitals demonstrates that the ‘mall of medicine’ (Kearns and Gesler, 2002: 144) is the defining feature of contemporary healthcare.

Promoting clinical efficiency

Under the NHS PFI Design Protocol, companies seeking to be awarded DBFO (design, build, finance, operate) contracts must demonstrate that they have carefully

considered issues of clinical efficiency and functionality. Detailed floor plans must be submitted, together with clinical output specifications for each clinical area of the hospital (e.g. multi-bed rooms, single bed rooms, operating theatres, anaesthetic rooms, radio-diagnostic facilities, ITU bays, utility rooms etc). Additionally, bidders must demonstrate how they will facilitate ‘essential’ and ‘desirable’ clinical relationships. This means careful attention is devoted to flow management, with the physical movements of people, waste and medicine remaining fundamental in hospital design. However, the availability of new ‘smart’ technologies, scanners, monitors and computers means that consulting rooms and surgical theatres must offer new forms of functionality, whilst new clinical adjacencies (i.e. proximity of key hospital departments) are demanding the creation of new patterns of flow within hospitals.

Associated with this management of flow in hospitals is a neo-liberal discourse of *speed* and *efficiency*. This emphasises the pressures of time on medical professionals, for whom speed and efficiency is seen as crucial to performance (Joyce, 2001). This is associated with new diagnostic and treatment opportunities linked to advances in biomedical and tele-radiological technology, which potentially do away with the need for patient and consultant to be physically proximate (Cutchin, 2002). With medical examination and diagnosis often occurring away from hospitals, such technologies potentially reduce the need for overnight stays, reducing the demand for bed spaces (see Dunnigan and Pollock, 2003). Yet at the same time, it is apparent that many established clinical adjacencies remain in demand, so that (for example) radiological departments need to be equally accessible to all wards.

Hence, the current round of PFI hospitals makes great play of the departmental connections and clinical adjacencies that ensure clinical functionality: ‘investment in quality means buildings that deliver services well - decent hospitals where people get better quicker...’ (Lipton, 2001: 32). For example, according to Gavin Pierce (in charge of commissioning the PFI project for Walsall), David Morley Architects has produced a theoretical layout that will act as a design exemplar to guide the redevelopment of Manor Hospital. This design consists of a new building unifying four different services (paediatrics, gynaecology, pathology and ambulatory care) so that clinical adjacencies can be created and patient movement between different buildings is reduced (Black, 2001). Likewise, Hove Polyclinic consists of a combined hospital and health clinic that ‘offers a much wider and more integrated range of complementary diagnostic and therapeutic services than usually found in a GP accommodation’. According to the NHS Estates Design Portfolio, which provides examples of best practice in hospital design, ‘one of the best features of the polyclinic’s architecture is that the organisation of elements within the overall plan is coherent...this provides an easily understood layout, where all spaces are excellent and consistent in their design qualities’

(<http://www.nhsdesignportfolio.nhsestates.gov.uk>, accessed July 2002).

The language of speed and efficiency is thus one that features quite prominently in descriptions in the plans for new hospitals. This language is used not only by the NHS, but by the architects and constructors building the hospitals (who have a vested interest in saying they are improving services). This suggests it is not simply about speeding up recovery (as therapeutic design and art are supposed to) but speeding up the *circulation* of patients. For example, the Middlesex ACAD centre

was praised in *Building* magazine because of its 'efficient layout'; 'the project was designed with patient flows in mind. Patients travel seamlessly through the main reception, diagnostic areas, operating theatre, recovery bays and discharge...the building has been designed to support the principles of ambulatory care, meaning that the patients move around the building in a logical sequence and at an appropriate rate, avoiding numerous and frequent queues' (Spring, 1999). This notion of efficient flow recurs in a Lewisham NHS Trust (2001) press release that describes their new clinical building as bringing 'services together under one roof so that patients can receive care and treatment seamlessly'. This press release also emphasised the speed at which people were getting treated: the mother of a patient treated in the new primary care unit was quoting as saying: 'This new suite is great. We both brought books to read in case we had to wait but we were in and out!'

It is here that we can discern an important distinction between the institutional hospital and the PFI hospital: while in the former the patient was sedentary and medical experts mobile, the latter is typified by a different politics of speed. This is a 'dromology' (Virilio, 1986) characterised by relative fluidity for both patients and medical staff: unlike the institutional hospital, that allocated each patient a fixed space, and placed severe restrictions on mobility and visiting hours, the PFI hospital apparently exercises its logic of control through less obvious and invisible means. While it might be dangerous to follow Virilio in implying that the physical is exhausted as a means of controlling and disciplining, this does begin to point to a very different locus of control, based on liquid, or 'gaseous' systems (Bauman, 1997). As Bauman argues, this is a form of control based on the codes and data trails that enable and disable, admit or exclude, accredit or discredit (see also Deleuze,

1992). Herein, exclusion and inclusion takes place through continuous, mobile forms of surveillance such as electronic tagging, the compilation of medical records and CCTV. In contrast to the institutional hospital, where immobilisation was the preferred form of disciplining, post-panoptic surveillance of mobile subjects tends to be the norm in the PFI era. A form of *generalised* surveillance, this creates a space that feels open rather than closed. Of course, the resulting hospital may not be as secure as its carceral predecessor (as numerous stories of patients and staff being attacked under the gaze of CCTV attests), but the trade-off of a significant level of security in exchange for removing constraints on mobility and ‘freedom of choice’ is a key characteristic of consumer society (see Bauman, 2000). In this regard, it is significant that PFI schemes are characterised by a form of control more routinely associated with retail or leisure spaces than institutional spaces, suggestive of the fact that hospitals are taking on at least some of the characteristics of spaces of consumption.

Promoting civic virtues

Another way PFI hospitals are depicted as being more efficient than ‘traditional’ acute hospitals is that they often involve an amalgamation of two or three hospitals onto one site. This leads to descriptions of ‘super-hospitals’, with many Trusts seeking to make economies of scale and efficiency by amalgamating in-patient and diagnostic facilities on one state-of-the-art site (typically devolving many out-patient services to local ‘one-stop’ health centres). For example, the Department of Health press release on the project at King’s College explained that ‘The main aim of the programme is to centralise the Trust’s acute services around its site at King’s

College Hospital, Denmark Hill so that all patients have access to the hi-tech facilities.’ It then quoted Health Minister Alan Milburn: ‘It is an excellent example of how public/private partnerships produce real benefits for patients and staff in the NHS. It will give patients fast, fair and convenient services.’ In Derby, the preferred option for reshaping health services is the development of a ‘superhospital’ on the Derby City General Hospital (DCGH) site. This hospital will have 1,200 beds, 35 operating theatres, 7,000 staff, a new £10m medical school, 3,000 parking spaces, ‘state-of-the-art’ equipment and electronic patient records, bringing together all the main disciplines of medicine, surgery, cancer care, diagnostics and therapy on a single main site.

To some extent, this coalescence of clinical services in a single facility contradicts suggestions that acute hospitals should avoid the dehumanising scale associated with the post-war Welfare State building programme (indeed, no less a critic than Prince Charles - appointed national ‘tsar’ for hospital design in 2001 - suggested that the district general hospitals of the 1960s were ‘culprits of stark brutality’). To avoid such accusations of massification, recent PFI projects seek to create the illusion of human scale through a variety of design strategies. These include, *inter alia*, the promotion of low-rise development (such as at Clevedon, where a pitched roof has been used), breaking a large monolithic block into multiple wings, often around a central courtyard, and providing multiple entrances and exits. The fact such strategies are being adopted nevertheless points to contradictions between clinical notions of efficiency, whereby collecting clinical services together may be viewed as the most efficient use of medical resources, and patient satisfaction, which is deemed

to result from general satisfaction with the hospital environment as much as from promptness of service (Kenny and Canter, 1979).

Such ‘hard’ and ‘soft’ design considerations are thus incorporated into NHS Estates’ AEDET – Achieving Excellence in Design Evaluation Toolkit. This invites designers to consider the urban and social integration of the hospital building, including its contribution to a sense of place; siting; neighbourliness; town planning; community integration; and ‘character’. However, the way such criteria have been interpreted varies widely, and often depends on whether the PFI project is for a new city-centre landmark facility or an extension or refurbishment of an existing site. In the case of the former, and in keeping with the Prime Minister’s civic building crusade, buildings that make an explicit statement tend to be favoured, whereas in the latter case more importance may be placed on contextual compatibility. For instance, Spring (2001) claims that the ‘huge’ new Chelsea and Westminster hospital ‘fits with relatively little disruption into the surrounding townscape of Victorian four-storey brick terraces’ but felt that it had been somewhat marred by a large fabric canopy on the front of the hospital which gives a ‘dowdy image’. George Demetri, on the other hand, explained that you couldn’t ‘miss’ the Birmingham children’s hospital which was a vibrant contrast’ to the hospital next door. Moreover, he felt that ‘combination of toy town hospital fairytale castle must be seen as wholly appropriate outcome’. For children, the idea that a hospital should appear unthreatening and even exciting remains an important consideration, yet this ideal is one that is becoming paramount in all hospital designs as the rhetoric of de-institutionalisation becomes widespread. For example, Duncan (1999) describes Leeds PFI hospital as turning ‘a potentially intimidating encounter into one of

comfort and reassurance, creating a place unique to the city and offering the eye something of character and beauty wherever it turns'. She also draws attention to the fact the use of materials in the building – especially the red and blue extruded bricks – 'are in keeping with the Leeds tradition.' Considerations such as dispelling the clinical feel of hospitals, making them appear welcoming and contributing to civic pride thus inform the design of entrance blocks that are intimate in scale, feature welcoming atriums, have clearly defined entrances/exits (often marked by distinctive canopies) and incorporate colour and art. Again, the fact that these design features are also characteristic of commercial developments - offices, malls, airports, cinemas etc - underlines the way in which the distinction between clinical and non-clinical spaces is being recast as the relations of health, risk, society and space shift in important ways.

Promoting healing

As we have outlined, the assumption hospitals are therapeutic spaces was questioned by Foucault (1976), with his analysis of the institutionalisation of disease highlighting the medical profession's preoccupation with bodily surveillance and containment rather than with creating humane environments. Notwithstanding its importance in highlighting the knowledge/power nexus within the micro-spaces of the hospital, numerous limitations of his 'archaeological' analyses can be highlighted. These include a narrow interpretation of knowledge - one that overlooks the agency of the patient - and a limited interpretation of power based on instrumental control (Philo, 2000). These weaknesses are particularly significant within a contemporary context in which conventional notions of hospitals are being

reconsidered and patients are increasingly conceptualised as ‘knowing’ consumers.

In examining the new building programme there are therefore opportunities for a critical re-engagement with the notion of hospitals as therapeutic spaces by building on, but also moving beyond, Foucault’s restricted interpretation of knowledge and power in clinical spaces.

In this sense, we can draw attention to the ways in which seemingly functional architectural spaces are being replaced by *playful* spaces that ape many of the characteristics associated with corporate and commercial space. These design interventions, particularly apparent in some of the interior design solutions adopted in PFI hospitals, are ostensibly intended to make hospitals less stressful, more pleasant environments (indeed, talk of multi-occupancy wards is disappearing as designers seek to evoke a ‘hotel-like’ ambience, often fostered through single-occupancy wards). Unlike clinical solutions, internal modifications designed to improve the sensory environment have often been commented on in the architectural press, where therapy is discussed mainly in terms of art and interior design rather than in terms of clinical efficiency. However, it is apparent that innovation in interior design is most associated with specialist in-patient facilities rather than in the acute sector at large: children’s hospitals, cancer care units, psychiatric hospitals, and immediate health cares centres in particular. For example, at the Local Secure Capital Project, St Bernard’s Hospital, Nightingales have developed ‘innovative interiors using strong colours and unusual furnishings to make a bold and cost effective departure from traditional hospital design’; at the Mental Unit at St Mary’s ‘roof lights are used throughout, creating a sense of space and freedom despite the need for careful security’, while in Newham, colour-coded wards with soft

furnishings, skylights and stripped-pine ceilings have been designed to provide a more domestic feel for a mental health facility (see Gesler *et al*, 2003).

Beyond mental health facilities, art and colour in hospitals are most associated with Children's hospitals and wards. For instance, professional artists Michelle Dawson and Pat Derrick held a series of workshops on the psychological ward at Colchester General Hospital in 2001, where children worked on designs based on the themes of the natural world, animals and the four seasons. Consultant clinical psychologist Dr Chris Lawes said artwork which was intentionally child-focused could encourage children to talk: 'It's not a question of decorating one of the consulting rooms, a corridor and waiting room simply because they need a lick of paint - but of introducing artwork which will be used therapeutically...As far as I can find out, this will be the first time it is being considered to help children needing psychological support' (cited in Spring, 2001: 31). At North Tyneside children's hospital, planes of colour were added to the outside of the building and project from the face. Artwork is also incorporated into the design, with castles, fish and planets decorating the interior. All the designs are maintained into the floor finishes and colour themes are evident in crash rails, skirting and fabrics. An artist was commissioned and came up with the design of a flock of swallows, which swoop over the main entrance and are reflected in the main entrance floor finishes. Similar designs have been introduced at the Birmingham Children's hospital and the Leeds' Hospital Jubilee Wing, where the artwork inside the building was seen to have had a demonstrable impact on patient recovery: 'In one particular ward recovery times have fallen by a day, with a parallel reduction in medication...Health ministers, please note!' (Duncan, 1999).

The idea there might be a link between design and patient satisfaction is thus hinted at - yet not explicitly developed - in the literature on art in hospitals. This is also the case in debates surrounding the use of gardens as therapy. For example, Maybourne Projects designed a PFI 28-bed ESMI including a Memory Trail as therapeutic activity for patients. It included a perfume garden among other sensory triggers, with communal rooms located around this healing garden. The Bristol Royal Infirmary Children's Hospital was similarly rebuilt with an outside play area. Alan Milburn, in his speech to the *Better Patient Environment* conference (November 2001), argued that such specially-designed children's facilities recognised the importance of 'tailoring design to meet people's needs', suggesting that 'the important thing for us is to recognise that consideration of the impact on patients of the design of buildings does not end when the child becomes an adult.' The only general hospital that has been highlighted in the press as having outdoors spaces to encourage healing is the Edinburgh Royal Infirmary for which DLP had designed 18 courtyard spaces 'to add to the healing atmosphere' (Baxter, 2000). Nonetheless, notions of bringing the 'outside in' are becoming more obvious in the development of sun-drenched atriums and skylights as standard design features. Less standard perhaps, is the Newham Hospital roof re-development that provides one of the first examples of 'sun-pipes' in the country. These 'sun-pipes' carry natural light 12-15 metres into the building, not only potentially providing overall savings of more than 80% in energy costs, but also helping to alleviate alleged Sick Building Syndrome.

Consumerism and the health cultures of PFI

Despite the tensions between different notions of care, this brief review of the PFI hospital building programme has suggested the contemporary design of acute facilities in the UK is seeking to combine emerging concerns with contextual compatibility, civic pride and patient access with long-standing preoccupations with clinical efficiency and healing. Such design features are seen by some to distinguish these hospitals from the welfare state hospitals of the 1960s that Prince Charles described as ‘culprits of stark brutality’ (Mathiason and Summerskill, 2001). Hence, the new generation of PFI hospitals is not only aesthetically-distinctive, it also *feels* different. The creation of a ‘non-institutional’ ambience is clearly crucial here: time and again, descriptions of new hospitals emphasise that it is important to eradicate the clinical atmosphere that patients find intimidating. For example, HLM’s description of South Tees Acute Hospital explains that ‘a central mall interlinks new and existing accommodation and forms a transition between internal and external environment. It also offers the opportunity to incorporate café and retail spaces and the display of artwork which all contribute to a therapeutic environment’ (www.hlm.co.uk/tees, accessed April 2002).

This idea arguably began in the mental health sector, where de-institutionalisation and the move towards homely, domestic-scale day care centres rather than ‘forbidding fortresses of locks and chains’ began in the post-war years, gaining pace in the 1980s (Moon and Brown, 1998). Today, however, it is a discourse that permeates the NHS, so that synchronous with the reinvention of district general hospitals as ‘super-hospitals’, GP surgeries are being replaced by user-friendly ‘one-stop health shops’, with cold, clinical reception areas replaced by the ubiquitous bright, airy atrium (often incorporating showpiece artwork). A press release for

Ipswich Orchard Medical Centre makes bold claims about the way these recast GP surgeries will serve users:

Colours for the building were chosen to promote a feeling of calm and well being, with the primary objective being to put patients at their ease the moment that they enter the premises. It is hoped that by creating a tranquil environment, the patients will be relaxed by the time they enter the consulting room and are so able to communicate better with the consultant. Thus they receive a more effective consultation... (NHS Estates Design Portfolio web site, <http://www.nhsdesignportfolio.nhsestates.gov.uk>, accessed August 2002).

In a society where healthcare is regarded as a product, and health as a commodity, the fact that hospitals and surgeries seek to recreate the leisured ambience of the shopping mall is perhaps not surprising, but certainly marks off contemporary clinical spaces as distinct from their predecessors. Allowing familiar icons of consumption (e.g. McDonalds and Starbucks) into many PFI hospitals is yet another symptom of this, despite the mixed messages that this might send about the importance of maintaining a balanced diet (see Kearns and Barnett, 2000, on 'McHospitalisation').

Consequently, the ideologies and languages of consumerism that have long been evident in the private health sector (see Kearns and Barnett, 1997) are now widespread in the NHS acute hospital sector. In many cases, this is blurring the distinction between private and public facilities (for example, Powell, 2000,

describes the Middlesex ACAD centre as an ‘icon of Blairism’ because it ‘has been used to promote the idea of a consumer-led, commercially underpinned NHS’ with its ‘BUPA hospital atmosphere’). Significantly, the adoption of a language whereby patients and users are depicted as *customers* is prevalent among stakeholders in the NHS sector:

Design and thinking surrounding healthcare needs to be reinvigorated. We are still designing and building buildings that look the same as they did 30-40 years ago. We still have waiting rooms and consulting rooms but society has changed. We have consumerism and increasing demands from the patient. Patients now understand what they want and are no longer submissive, but we build architecture that [*regards them*] as submissive (Peter Wearmouth, Chief Executive NHS Estates, http://www.nhsestates.gov.uk/patient_environment, accessed May 2003).

Powell (2000) likewise sees consumption-oriented hospital design as being driven by patients ‘who have discovered airport departure lounges, ski villages and Ikea’ and ‘won’t queue for an old-fashioned NHS’ (cf. Salter, 2003). Yet this reading of hospital design changing in line with consumer demands is overly simplistic. Instead, we need to acknowledge the more fundamental shifts in the nature of society that are obliging public sector institutions to take on many of the features associated with commercial ventures - for example, risk-taking, customer-satisfaction, marketing, cost-cutting, promotion. These shifts, in turn, are associated with the liquidation of the modern state (Bauman, 1997) and the triumph of a consumer society where social order is negotiated in the marketplace. The fact that hospitals

have come to resemble commercial buildings - and are being developed by commercial property developers with expansive portfolios of supermarkets, malls and leisure parks - is, we would argue, indicative of the way that healthcare is being reinvented and re-imagined in the consumer society.

On one level, our interpretation suggests we are witnessing the ‘death’ of the clinic: the diffusion of healthism into a multitude of spaces means that commercial settings are taking on some of the functions and forms associated with the clinical sector, and *vice versa*. This implies that it no longer makes sense to speak of ‘discontinuous, exclusively medical spaces’ (Foucault, 1976: 42) - nor for that matter, spaces where the medical gaze does not reach (see Parr, 2002a, on new spatialisations of health care). Yet we need to tread warily here given that the distinction between unspecified social spaces and clinical spaces has not dissolved completely: hospitals retain certain characteristics and functions that set them apart from other social spaces. Perhaps we should instead follow Philo (2000: 16) in arguing for a ‘double social and medical geography’ where understandings of the healthy body ripple out from hospital spaces to inform the understandings of health and well-being played out in other (everyday sites) of consumption. In turn, these understandings return, albeit in revised forms, to inform the design of clinical spaces.

In this sense, it is perhaps too soon to discard Foucaultian notions that focus on the institutional geographies of clinical spaces, as these spaces are still involved in a process of normalisation (i.e. producing healthy, desirable bodies). However, the means by which hospitals produce such social and bodily norms has changed greatly since the eighteenth century, when hospitals were forbidding spaces in which the

gaze of the medic imposed considerable social and spatial order. Clearly, there is a need to dispense with ideas that the control imparted in hospitals relies on the panoptic logic of the workhouse or factory: instead, it is useful to bring later Foucaultian ideas about governmentality (literally, ‘the conduct of conduct’) into dialogue with ideas about the control imparted through the consumer society, where a failure to acknowledge and act on information on health is to risk becoming a *flawed* consumer (Smith-Maguire, 2001). The design of hospitals is not incidental in this process, even if the mechanisms of control are not as visible as in the past, being based on a logic of generalised surveillance rather than panopticism. Applying Foucaultian methods to excavate the forms of power/knowledge embodied in new hospitals is still a valid exercise, therefore, so long as one accepts that physical constraints and panoptic architectures have given way to architectures of seduction and dissimulation (Bauman, 2000).

Conclusion

This paper has identified NHS hospitals as distinctive social spaces that have traditionally been conceived as being at the apex of systems of medical care in the UK. While this centrality is being challenged by the emergence of ‘surveillance medicine’, this paper has suggested there remains a pressing need to explore how changing notions of health and well-being are informing the design of acute hospital spaces (and not just those new ‘landscapes of care’ emerging beyond the clinical sector). Bauman (2001: 24) has suggested ‘there is a nearly “perfect fit” between the characteristics of commodities the consumer market offers, the fashion in which it offers them, and the kind of anxieties and expectations which prompt individuals to

live their lives as a string of shopping expeditions'. In this paper, we have begun to show that there is a similar homology between the design of PFI hospitals, the forms of healthcare they provide and the vicissitudes of a consumer society that obliges us to seek surety in the marketplace. Of course, the fact that PFI hospitals ape the appearance and ambience of spaces of consumption is just one of many signs that health services are being integrated into the world of the consumer rather than the world of the service user (Kearns and Barnett, 1997: 172). Recent moves in the NHS towards mercerisation and financial accountability are also highly significant here, with the language of consumerism permeating not just the hospital building programme, but the whole system by which healthcare is delivered through a restructured welfare state.

In a society where health is individualised, and notions of well-being are most commonly exhibited and brought to people's attention in the realms of consumer culture, it is perhaps not surprising that hospitals are changing, and no longer represent bastions of medical expertise where the gaze of the clinician is prioritised over the creation of a comfortable, consumer-friendly environment. The PFI building programme brings these issues into sharper relief, suggesting that acute services are now designed with very different conceptions of users as customers rather than patients. Highlighting some of the contradictions evident in this process - specifically, the tension between clinical efficiency and the creation of patient-friendly user environments - this paper has suggested that the new PFI hospitals are recasting the relationship between medical experts and patients. The idea that patients can in fact play a role in their own recovery highlights this, and suggests that individual models of health-care pioneered in the commercial sector are challenging

models where medical practitioners are regarded as all-knowing experts and patients are merely bodies to be appraised, sorted and treated. Whether new hospitals respond appropriately and meet the needs of medical experts and patients alike remains to be seen, but what is clear is that new materials, practices and ideas are coalescing in the PFI programme in the UK, demanding scrutiny in the context of broader changes in the relations between society and space in the West.

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Appendix: PFI schemes approved since May 1997 (England only)

Capital Value £m

Completed PFI schemes

Dartford & Gravesham NHS Trust	94	
North Cumbria Acute Hospitals NHS Trust	67	
Buckinghamshire Hospitals NHS Trust	45	
Queen Elizabeth Hospital NHS Trust		96
Calderdale & Huddersfield NHS Trust	65	
County Durham & Darlington Acute Hospitals NHS Trust – North	61	
South Manchester University Hospitals NHS Trust	67	
Cambridgeshire Norfolk & Norwich NHS Trust	158	
Worcestershire Hereford Hospitals NHS Trust	64	
Worcestershire Acute Hospitals NHS Trust	87	
Barnet & Chase Farm Hospitals NHS Trust	54	
County Durham & Darlington Acute Hospitals NHS Trust – South	48	
Swindon & Marlborough NHS Trust	100	
Leeds Community & Mental Health Services Teaching NHS Trust	47	
King's Healthcare NHS Trust		76
Bromley Healthcare NHS Trust	118	
Hull & East Yorkshire Hospitals NHS Trust	22	
Berkshire Healthcare NHS Trust	30	
West Middlesex University Hospitals NHS Trust	60	
South Tees Acute Hospitals NHS Trust	122	
St George's Hospital NHS Trust	46	

PFI schemes with construction started

University College London Hospitals NHS Trust	422
Dudley Group of Hospitals NHS Trust	137
University Hospitals Coventry and Warwickshire NHS Trust	379
Gloucestershire Royal NHS Trust	32
Southern Derbyshire Acute Hospitals NHS Trust	312
East Lancashire Hospitals NHS Trust – Blackburn	110

PFI Schemes in negotiation but not yet reached financial close

2nd Wave Schemes Prioritised

Barts & The London NHS Trust (remaining Wave 1A)	1,052
Central Manchester Healthcare/	
Manchester Childrens Hospitals NHS Trusts	420
Newcastle Upon Tyne Hospitals NHS Trust	220

3rd Wave Schemes Prioritised

Leeds Teaching Hospitals NHS Trust	174
Oxford Radcliffe Hospitals NHS Trust	134
Barking, Havering & Redbridge Hospitals NHS Trust	182
Portsmouth Hospitals NHS Trust	192

4th, 5th and 6th wave schemes which have placed OJEC adverts

University Hospital Birmingham/South Birmingham MH NHS Trust	379	
Avon & Western Wiltshire Mental Health NHS Trust	83	
North Staffordshire Hospital NHS Trusts	269	
University Hospitals of Leicester NHS Trust	403	
Lewisham Hospital NHS Trust	47	
Hull & East Yorkshire Hospitals NHS Trust	56	
Mid Yorkshire Hospitals – Wakefield		211
St Helens & Knowsley Hospitals NHS Trust	229	
North West London Hospitals NHS Trust	69	
North Middlesex Hospitals NHS Trust	74	
Brighton Health Care NHS Trust	44	
Mid Essex Hospitals NHS Trust	110	
Oxford Radcliffe Hospitals NHS Trust	94	
Salford Royal Hospitals NHS Trust	196	
Bradford Hospitals NHS Trust	191	
Tameside & Glossop Acute Services NHS Trust	84	
Sherwood Forest Hospitals NHS Trust	125	
Peterborough Hospitals NHS Trust	293	
<u>4th, 5th and 6th wave schemes which have not placed OJEC adverts</u>		
St Mary's NHS Trust – Paddington Basin	800	
Walsall Hospitals NHS Trust	117	
Whipps Cross Hospitals NHS Trust	313	
United Bristol Healthcare NHS Trust		104
Barnet & Chase Farm Hospitals NHS Trust	41	
Essex Rivers Healthcare NHS Trust	127	
Maidstone & Tunbridge Wells/Invicta Community Care NHS Trusts	290	
Plymouth Hospitals NHS Trust	274	
Royal Wolverhampton Hospitals NHS Trust		312
Southampton University Hospitals NHS Trust	60	
South Devon Healthcare NHS Trust	120	
East Kent Hospitals NHS Trust	200	
Total PFI	11,008	

(Source: Department of Health, 2003,
<http://www.doh.gov.uk/pfi/schemes3.htm>)