

***Geborgenheit in a Paradise Garden:
The architecture of the Bromley-by-Bow Centre***
A LITERATURE REVIEW AND CASE STUDY
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Bromley-by-Bow Centre, East London, Courtyard

Geborgenheit

When people come together to inquire into what gives them life, they create positive affect and a strong social bonding which ... leads to a strong sense of "Geborgenheit" (safety, security, protectedness) upon which all higher feelings--and the energy for action--nourish themselves. It is also in this collaborative act that organizational members literally create new knowledge--new conversations, vocabularies, ways of understanding things--that open up fresh and previously undiscovered alternatives for organizing.

James D. Ludema, "Deficit Discourse to Vocabularies of Hope: The Power of Appreciation", *Appreciative Inquiry: An Emerging Direction for Organization Development*, David L. Cooperrider, Peter F. Sorensen, Jr., Therese F. Yaeger, and Diana Whitney, editors. Champaign IL: Stipes Publishing L.L.C., 2001.

The Garden of Paradise

Although most of the Persian-Islamic garden elements seem to have existed prior to the Islamic empire's control of Persia, the Muslims did contribute to it, mostly in the form of garden metaphors. One such contribution is the idea of the garden as Paradise. Paradise, or the gardens of heaven, are often depicted in Quranic verses ... the gardens of Paradise have fountains of running water, two kinds of every fruit, and couches from which the believers can rest and view this all from. This sort of description of Paradise comes up several times in the Quran so it seems only logical that Muslims, seeing that these elements exist in some form in Persian gardens, would incorporate them into the new Islamic gardens that purposefully represent their version of Paradise. In addition to this concept of the garden is also meant to be an oasis. The Arab-Muslims that conquered Persia were accustomed to a harsh desert life and very little water. The garden was meant as an escape from these realities of the outside world in addition to a protection from them. This meant that Islamic gardens were often very secluded and private and were contained within high walls or an actual building (courtyards). Hasan, A. F. (1999, June). "Arabic and Islamic Architecture", Suite 101.com. Available at: http://www.suite101.com/article.cfm/arabic_islamic_architecture/21567

Background and Method

The paper first examines the limited existing literature on health, the built environment and diversity. Secondly, a single case study of the architecture (i.e., a model of unifying concepts or relational aesthetics [Bourriaud 2002]) of the Bromley-by-Bow Centre in East London is considered. By using an in-depth qualitative narrative approach in this single case study, it is possible to shuttle back and forth from the direct impact of the vision of an architect for a specific community medical facility and the wider, global picture of the state of the art of built health environments within complex multicultural settings in Britain.

The literature was searched using a method of 'system and noise', developed by Edwards, Russell and Stott (1998); Edwards, Elwyn, Hood and Rollnick (2000); Booth and Fry-Smith (2001); and Higginson, Finlay, I., Goodwin, Cook, Hood, Edwards, Douglas and Norman (2002), with additional elaboration by this researcher (Jones 2004a). It was used to select papers for inclusion in this report by balancing methodological rigor against the strength of the message itself. As reading produced a growing sense of both contexts and themes emerging from the existing literature on the built health environment and race/ethnicity/diversity, key questions developed for further investigation and analysis. It was at this point that the decision was made to conduct a case study with the person mainly responsible for conceptualising, carrying out and maintaining the vision for a particular built health environment in a multi-ethnic neighbourhood, Gordon MacLaren, the architect of the Bromley-by-Bow Centre (BbBC) in East London. This comparative method is in sympathy with the foundational meta-ethnographic approach first conceived by George Noblit and Dwight Hare (Noblit & Hare 1988). Meta-ethnography is driven by interpretation, not analysis, using such tools as key metaphors, analogy, reflexivity and ritual.

Bromley-by-Bow Centre is an innovative holistic model of primary health care within the context of community regeneration. As such it is potentially of national importance to the development of policy in health and social care (Froggett 2004; private communication). A decision was taken to conduct an investigation of this well-known and reported medical and community centre in East London through an informal and minimally structured interview (see Jones 2004b for an elaboration) and tour of the facility with the centre's architect, Gordon MacLaren. Notes were taken and reflections recorded shortly after the interview. Supplementary beliefs of the architect were taken from his unpublished paper (MacLaren 2003).

In addition, the Bromley-by-Bow Centre is currently undergoing a long-term qualitative narrative study, The Bromley-by-Bow Research Project, carried out by Froggett, Chamberlayne, Wengraf and Buckner (Froggett 2002a; Froggett 2002b; Froggett, Chamberlayne & Wengraf 2003). Through the use of biographical interviews, the research team explores the 'journeys travelled' by Centre staff, volunteers and users. They identify changes in people's life stories as a result of their involvement in the Centre. For example, they can explore movement from a position of social exclusion to inclusion as a result of changing sense of health and well-being. Informal discussions—in person and electronic—were held by this author with the project's research team, using them as key informants as well as reading their

on-going project reports. Through the author's connections with the study team, the interview with the Centre's architect was secured for this paper.

Review of the literature

The impact of the environment on health is complex and difficult to disentangle; health within an environmental context must be considered as a multifaceted and holistic phenomenon (Hunt, Falce, Crombie, Morton & Walton 2000, cited in Morris 2003: 2). Nonetheless, current means for evaluating quality in healthcare design 'are predicated on a narrowly conceived (and culturally specific) body of "expert" knowledge' (Gesler, Bell, Curtis, Hubbard & Francis 2004: 120). The built healthcare environment, 'rather than a neutral backdrop to social relations ... can uphold dominant cultural discourse, social divisions and inequalities' (Gillespie 2002: 211). In addition, culture can be understood as a therapeutic barrier or as a therapeutic resource. 'Therapeutic environments must be considered as *physical* environments (both natural and built), *social* environments and *symbolic* environments' (Gesler et al 2004: 119). In architecture, deliberation on questions concerning 'design and character' often do not allow ample consideration of symbolic and social space, while questions of social space are only obliquely addressed through questions on community and social impacts (which mainly focus on landscaping and local context) (Gesler et al 2004: 125).

Accommodation of cultural heritage in healthcare settings requires sensitivity to both spatial organisation and the physical environment in order to support culturally based activities and rituals (Day & Cohen 2000: 361); (see Jones 2004c, for examples of minority ethnic end-of-life practices and expectations in the healthcare environment). Encouragingly, architects and sociologists have increasingly come to consider the impact of architecture and spatiality on human social life and well being. According to Gillespie (2002), 'architecture, as the ordering of space, is *itself* constitutive of society'. Not a neutral backdrop to healthcare delivery, health architecture embodies and perpetuates social divisions. The spaces designed for healthcare sit squarely between the world of science and the world of culture and reflect the inequalities between doctors, health workers and patients' (2002: 212). Spatial arrangements too often reinforce the relative powerlessness of patients contextualised around issues of functionality, regimentation, discipline—or the long common ward (2002: 213).

In contrast, culturally competent healthcare systems

are defined by a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable effective work in cross-cultural situations. Culture refers to integrated patterns of human behaviour that include language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. Competence implies having the capacity to function effectively as an individual and an organization within the contexts of the culture beliefs, behaviours, and needs presented by consumers and their communities (Anderson, Scrimshaw, Fullilove, Fielding & Normand 2003: 68-69).

Anderson et al state that a culturally competent healthcare setting should include amongst a mix of requirements, 'culturally specific healthcare settings' (2003: 69). In fact, culture and ethnicity create a unique pattern of beliefs and perceptions around what "health" and "illness" actually mean. Organisational supports for cultural competence include maintaining current demographic, cultural, and epidemiologic profiles of the community and implementing services that respond to the cultural and linguistic characteristics of the service area as well as developing participatory, collaborative partnerships with communities and the use of a variety of formal and informal mechanisms to facilitate community and patient or consumer involvement in designing and implementing activities (2003: 71).

Gesler, Bell, Curtis, Hubbard and Francis (2004) summarize the history of NHS design as follows:

Research on innovative design was encouraged most notably in the early days of the NHS (Studies in the Function and Design of Hospitals [1955]. Clinical, social and architectural ideas came together at this time to create the vertical ward tower set on top of a horizontal block with service and support functions, influenced by office buildings and hospitals built in Europe and the US. These designs symbolized modernity, efficiency and an optimistic attitude toward technology and progress. The NHS research agenda, however, had its failings, with subjective values ignored in favour of clinical functionality. Most recently, the adoption of designs that borrow from non-clinical settings, including commercial spaces, indicate an incoherent research agenda or programme of studies. In fact, it seems likely that the Private Finance Initiative (PFI) process will discourage innovation and the new hospitals may not respond to the larger agenda of the community and the environment (Gesler et al 2004: 121).

The promotion of a culture of healthcare consumption in the UK has thus become evident both in the media and in the visible landscape with a trend toward publicly prominent places in terms of the sites and visibility of healthcare services—a shift in thinking from service user to the world of the consumer (Kearns & Barnett 1997: 172). 'Healthcare providers are responding to these consumerist pressures by introducing to clinics and hospitals consumption spaces similar to those of private, commercial outlets including shops and hotels' (Gesler et al 2004: 118). In fact, healthcare has become co-modified more recently through bold architecture and signs, mimicking the practices of commercial enterprises (Kearns & Barnett 1997: 173). For their part, patients drive the consumerist agenda with demands for healthcare environments reminiscent of 'airport departure lounges, ski villages and Ikea' (Gesler et al 2004: 123). The King's Fund book, *Improving Hospital Design* (Wickings 1994), argues that patients should be able to control their environment (Dormer 1994) through concepts such as 'patient-centred care', which includes the concept of 'architectures of personal care' (Gesler et al 2004: 123).

Indeed, recent changes in British health reforms, including the shift to a market economy of healthcare and its ensuing consumerism, emphasise the 'good life for all, through the individual pursuits of objects to satisfy individual wants' (Kearns & Barnett 1997: 174). In a survey, patients reviewed likes and dislikes in clinical

settings by mentioning terms such as “ambience”, “comfort”, “décor”, and “spaciousness” (1997: 178), terms not unlike ones that might be used in a review of the newly-opened branch of a Selfridges in Birmingham. The metaphor of a shopping mall of healthcare, in many ways, (re)mystifies the process of care, cure and healing (1997: 179), obscuring the clinical gaze and reinventing Foucault’s *Panopticon* as the familiar shopping arcade/stripmall/high street with its omnipresent CCTV surveillance. The move from patient-centred care to consumer-led care has recently been challenged by a ‘third way’ approach with the theory of ‘relationship-centred care’, emanating from the US and proposed for British health services by Nolan, Davies, Brown, Keady and Nolan (2004). The authors take a critical look at some of the assumptions underpinning person-centredness, and suggest that a relationship-centred approach to care might be more appropriate (2004: 45).

NHS Estates are recognised as aiming to improve decision-making in the NHS by identifying best practice and evidence with which to argue for an environment that reflects good design (Riley 2003: 3). Indeed, NHS Estates have acknowledged that there are ways in which the design and provision of health-care premises may be made more responsive to and supportive of, cultural and religious diversity. NHS Estates’ *Environment and the Patient Database* (2003) is compiled of a scoping review of studies covering a wide variety of topics including views from rooms, sunshine, décor, contact with nature, music, sound and noise, multiple occupancy versus private rooms, room size, ward design, floor surfaces, seating, way-finding, touch, odours, ventilation and so forth. None of the studies unearthed in the database (output restricted to 50 records), however, directly considered how the design and provision of health-care premises may be made more responsive to and supportive of, cultural and religious diversity specifically.

The consideration of ‘art’ as an important therapeutic device has also been investigated (‘Art for health’, NHS Health Development Agency 2000). In 1999, the Health Development Agency (HDA), then the Health Education Authority, conducted research with the aim to build a community arts-in-health database. This resulted in the publication of “Art for Health: A Review of Good Practice in Community-Based Arts Projects and Interventions which Impact on Health and Well-being” (Health Development Agency 1999) and an online database which contained key elements gleaned from the research. The Health Development Agency then granted the National Network for the Arts in Health (NNAH) funding to maintain this important piece of work with the remit to expand it further to include arts projects in both community and healthcare settings. The National Network for the Arts in Health and the Centre for Arts and Humanities in Health and Medicine (CAHHM) looked at the questionnaire originally used by the Health Development Agency. NNAH and CAHHM then drafted a new questionnaire, taking into account comments received by the HAD in 1999, as well as how NNAH and CAHHM might use the questionnaire as an opportunity to share information between the two organisations; rather than two questionnaires, NNAH and CAHHM together developed one (UK National Network for the Arts in Health (<http://www.nnah.org.uk/>)). Of more than 70 projects currently listed, however, only one (MASH [Media Asian Sexual Health Project]) directly aims its efforts at a minority ethnic community.

In practice, budgetary restraints too often prevail in designing healthcare facilities; the inclusion of artwork is usually left in limbo. The lack of understanding of the function

of art in the healthspace often leads to the purchasing of low-priced commercial prints or posters or works that function as negative distractions (Oppermann 1996: 4). 'Planners should consider the inclusion of artworks within the design from the very beginning. An arts plan that is drawn in collaboration with the community and users will create positive ambience through the development of social support, sense of control, extend the environment and create compatibility...' (1996: 9).

In a literature review entitled, "Health, Well-Being and Open Space" (Morris 2003), the author summarised considerations of open spaces and the natural environment as both having a negative and positive effect on human health. Trees and greenspaces can aid economic regeneration, filter air pollution, stabilise ground surfaces, intercept rainfall, create visual and sound barriers, provide temporary cover for derelict sites, shading and water protection, and decreased local air temperatures. In addition, the review cites urban greenspaces as major contributors to the quality of the environment and human health and well-being in inner city and suburban areas. She cautions that terms such as 'quality of life' are not well defined, however, and there is little information which outlines the ways in which health professionals understand them. On the other hand, outdoor recreation provides an opportunity to increase quality of life and heighten social interaction. Physical activity in the natural environment not only aids an increased life-span, greater well-being, fewer symptoms of depression, lower rates of smoking and substance misuse, but also an increased ability to function better at work and home. The study concludes by recommending long-term strategies to integrate land-use planning with economic regeneration and short-term strategies to establish a clearer link between accessible urban greenspace and healthy living (Morris 2003: 23-24).

The mix of greenspace, health and minority ethnic participation is exemplified in the efforts of the Black Environmental Network (BEN). The goal of BEN is to encourage ethnic minorities in Britain participate in environmental projects. The use of the term "black" is used symbolically in the title of the organisation to represent the common experiences of all ethnic minority communities in the UK. The organisations brief is one of multi-ethnicity and the contribution to society that understanding between faiths and cultures can bring. The organisations remit is focused on ethnic participation within the built and natural environment sectors, but their methodology is applicable in bringing forward ethnic participation from any sector—a 'spearhead for social inclusion' (Black Environment Network [BEN] presentation to the National Assembly of Wales, April 2002).

According to BEN Director, Judy Ling Wong, 'for many ethnic groups, the entry in to environmental participation has been an experience which has allowed themselves to re-define themselves. They can choose to take up the powers of expression and assertion that come with entering onto a wider stage. ...The full activation of the process of discovery by the mainstream population and the ethnic communities leads towards integration' (Wong 1998: 2). Wong concludes, 'we must be focused and create specific projects within particular circumstances. We must then continually build on this work and link up the impact of these avenues for social change' (1998: 3).

The interface of a minority ethnic culture with another culture, in this case, the socio-medical culture and its built environment, can be 'distressing, isolating, and disorientating experience' in such a way that it can be 'entirely disabling, leaving a mark that plays a role in the lack of confidence to participate in the mainstream' (Black Environment Network 1998: 1). 'Multi-culturalism is about diversity and its unity in diversity, just as biodiversity has come to be recognised as crucial within the interacting ecosystem' (1998: 2). BEN has been actively involved in promoting 'cultural gardens'—a practical project which creates a multi-cultural resource. The culture garden is an exercise in recognition, a realisation that much of the 'nature' around us originally comes from places all over the world. The experience of BEN is that such projects combine elements which include the environment, play, social aspects, health and the arts (1998: 5). Crucial to the BEN approach is the creation of settings that are inclusive, including information in other languages, or pictures and posters on walls illustrating ethnic minority presence or participation, recognition of various cultural festivals and holidays, etc.

Conclusions to the literature review

'The discourse of medicine proceeds not only through the speech and actions of staff and patients but also through the technical and material aspects' of its built environment. For example, 'the architecture of the hospital embodies and imposes an order through the enabling of the clinical gaze and the facilitations and restrictions it imposes on social relationships' (Radley & Taylor 2003: 77). Patients and their families come to the healthcare environment with cultural assumptions about both care and the setting and their perceptions of those experiences are shaped by these expectations (2003: 78).

Places do not exist in a disconnected manner. They are full of stories and meanings. A hospital means different things to different people. It can mean the place where s/he was cured from an illness, or where a child was born, or where a father died or a friend died. It also has different meanings to the doctor, the cleaner, to the nurse and to the administrator. It is this richness that a placemaking process makes visible so the place embraces all its meanings (Oppermann 1996: 4).

In his address presented by Architects for Health during Architecture Week 2003, Lawrence Nield of Bligh Voller Nield raised the issue, amongst other points, that 'hospitals are sick' and that the reinvention of the hospital is overdue. He stressed that it is time to deal with "events" rather than "fixtures" (Nield 2003: 2). The NHS's LIFT programme promises to improve healthcare facilities nationwide, targeting priority schemes set to revolutionise local healthcare facilities. Craig Linnell of Buschow Henley, project architect on the Fulham project, sees LIFT (Local Improvement Finance Trust; its aim is to develop and encourage a new market for investment in primary care and community based facilities and services) as a great opportunity for the practice's "people-centred" design approach. Linnell explains how architecture will be central to plans to enhance local surgeries, making buildings much more visible in the community. By applying cost-saving measures of an overall structural grid and design of clinical areas, money can be made available for 'better quality finishes, internal gardens and extra public space' (Hattersley 2003: 1). By

concentrating on what Linnell calls the “in between”, spaces can become calming and uplifting—the feel good factor so necessary in making people all faiths, cultures and backgrounds well.

KEY FINDINGS IN THE LITERATURE

- ⊕ Architecture is recognised as having impact on social life and well being.
- ⊕ Architecture is often a means by which the dominant cultural discourse is upheld, reaffirming divisions and inequalities.
- ⊕ Healthcare spaces often reflect the inequalities and reinforce powerlessness.
- ⊕ The interface of a minority culture with the built health environment can be distressing, isolating and disorientating.
- ⊕ Patients and families come to the healthcare environment with cultural assumptions about care and its setting.
- ⊕ Therapeutic environments must be considered as physical, social and symbolic environments.
- ⊕ Culturally competence healthcare environments enable effective work in cross-cultural situations and should, include, where appropriate, culturally specific healthcare settings.
- ⊕ Formal and informal mechanisms should be in place to insure and facilitate full community participation in designing and implementing healthcare environments.
- ⊕ PFI processes discourage innovation and risk ignoring the larger agenda of the community and the environment.
- ⊕ A shift from service-user centred health care to the world of the consumer has taken place.
- ⊕ Relationship-centred care is proposed as a ‘third way’.
- ⊕ The metaphor of a shopping mall of healthcare obscures the clinical gaze and re-mystifies the processes of care, cure and healing.
- ⊕ There is a general lack of understanding of the function of art in healthcare settings.
- ⊕ Open spaces and the natural environment have both positive and negative effects on human health.
- ⊕ Efforts are needed to establish clear links between accessible urban greenspace and healthy living.
- ⊕ Ethnic participation with the built and natural environment sectors leads to social inclusion.
- ⊕ “It is time to deal with events, rather than fixtures”.
- ⊕ A people-centred approach to healthcare design is called for.
- ⊕ The LIFT initiative offers promise of better quality finishes, internal gardens and extra public space add to the calming and uplifting elements of healthcare design.

Bromley-by-Bow Centre: A Case Study



PHOTOS courtesy Wyatt MacLaren architects

The Bromley-by-Bow Centre (BbBC) was established nearly 20 years ago in a small run-down church in East London by Andrew Mawson OBE, a Christian minister with a vision for the community—“all eating from the same table”. There is a collegiate sense to the buildings situated on the three acre site, even cloister-like. From the beginnings the building projects were considered ‘flowers of the institution itself’ in the founder’s vision. Thus, the early dream of an enclosed and enveloped physical respite from the outside world with participants sharing at common table planted the seed for the metaphor a walled garden. The Centre is now a secular, multi-faith, multicultural organisation that has grown exponentially over the ensuing years.

The Bromley-by-Bow Centre is exceptional in that it nests General Practice and health promotion activities within a large and diverse community centre which, in turn, is driven by a major larger inner-city regeneration scheme. The uniqueness is in its integration of GPs and other health professionals within community projects. The primary care team draws upon the skills and strengths of artists, youth workers and others to deliver an integrated approach to healthcare. The concept of care as a relationship rather than an activity is central (Froggett 2002: 145) to the BbBC philosophy.

The Bromley-by-Bow Centre approach to community regeneration works as a catalyst for change in one of the most socially excluded communities in the UK. The Healthy Living Centre has developed a exceptional model of community health in which local people have become partners in both the ownership and delivery of services alongside professional



partners. The Centre was named in the Government white paper, “Our Healthier Nation” as an innovation example. The concept is built upon what the Bromley-by-Bow Centre describes as its five pillars: health, education, enterprise, arts and the environment. It’s national reputation is enhanced by frequent tours of the site by dignitaries (counsellors, Cherie Blair QC and the Prince of Wales, for examples) as well as representatives from a range of organisations from throughout the UK (*On the day that I visited, a team from Hartleypool was exploring the ways in which the gardens at BbBC could be replicated at their own project*). In fact, the Department of Health has highlighted it as a prototype for others to study; it is the seminal model for the government’s LIFT programme.

The Centre offers over 100 activities each week bring together over 114 staff consisting of GPs, community nurses, health networkers, artists, gardeners, community care workers and a youth team to explore and create new ways of thinking about health in a holistic way. The number of volunteers at the Centre seldom drops below 50. There is a strong belief that health improvement is a direct result from the development of the whole self within a stimulating, high quality environment and that all of the Centre’s activities contribute to this core aim. In this way, the “environment”, including the built environment, has a key role to play in improving and maintaining healthy participant lives.

The Centre is utilised by approximately 1500 different individuals who participate in programmes regularly. Twenty-three percent of local households have one or more members attending activities regularly, as service-users or volunteers. Forty-eight percent of the Centre’s staff live in Bromley-by-Bow. Bromley-by-Bow was heavily bombed during the 2nd World War, creating open spaces and broad horizons which still remain. According to



BbBC’s architect, Gordon MacLaren, ‘The area is almost “suburban” in feel. This sort of “fractured environment” is now, according to MacLaren, an international phenomenon.

This socially excluded community, one of the most deprived areas of Britain, experiences high levels of unemployment, under investment, low incomes, poor health and bad housing. Sixty-one percent of households are from ethnic minorities; 43% of people aged 16-74 have no qualifications; unemployment is at almost three times the national level; almost 70% of tenure is council/housing association, compared with less than 20% for England; and the area contends with almost five

times the level of overcrowding than the national level (2001 census social indicators). The ethnic composition of the Centre's users, volunteers and staff members closely matches that of the local population. Over 50 languages and dialects are spoken within ten minutes' walk of the Centre. Bromley-by-Bow itself is a reservoir of social housing with a population of white, Bangladeshi and Somolian residents. The Bangladeshi residents' origins are rural and they are Sylhetti-speaking. Fifty-six languages are spoken in the BbBC community.

The structures attempt to reflect the philosophy of the Centre; people are placed before structures and administrative barriers are kept to a minimum. Buildings use high-quality materials throughout, contributing to building up the self-esteem of the community and the Centre's users. Very few doors are locked, engendering an informal relaxed and open atmosphere.

GP's responses to patients' problems are enhanced and enriched by the availability of tools and programmes that go beyond a conventional medical response. The health model is clearly a social health one, rather than a medical model. Health indicators have begun to move in the right direction with more and more people registering at the Healthy Living Centre and registering for health checks, difficult tasks in deprived communities.



Bromley-by-Bow Centre has been observed by visitors as a thriving and attractive environment, light, bright, spacious, energetic and considered by many as beautiful. It acknowledges the sensual as well as the spiritual nature of human needs (Froggett 2002: 146). People are busy coming and going and are noticeably different in age, interests and backgrounds.

While BbBC 'incorporates some projects that are group-specific or ethnically based, it has allowed a high degree of openness, tolerance and carefully gauged confrontation—even with views to which it is averse. For example, it has dealt with overt racism among users of the Centre in a softer manner that would be admissible in local authority organisations, and claims to have negotiated this most difficult of territories by focusing on the preservation of face-to-face relationships of care' (Froggett 2002: 147).

The reception area in the Healthy Living Centre doubles as a joint reception for the whole Centre and other services at the Centre can be accessed via this one reception. GP Julia Davis, Healthy Living Centre Director explains: 'Primary care was only part of a person's health and the reception was designed to reflect this as well as the high Bangladeshi population in the area. To do this, health information took many different guises and the Centre tires to remove the language barriers that would exist if just the usual set of leaflets were left out'.

The Community Action Network (CAN) recently established by BbBC's founder, Andrew Marston, builds upon the success of BbBC. The national Healthy Living Centre programme LIFT—a 31 billion Government programme to replicate the thinking that underpins the BbBC—is now in place. The site includes the recently-opened 70 seat restaurant, "Pie in the Sky", staffed by Centre workers and volunteers and designed in an 'open kitchen' format. (Information on the Centre compiled from: BbBC website; renewal.net Case Study; London Assembly; and Davis 2004)

BbBC: The researcher as observer

The spaces seemed somehow familiar to me upon arrival. The winding footpaths and walls gave me a sense of adventure and discovery; on the other hand they did not make it so easy for me to quickly find my way around. Still,, MacLaren attempts to 'try to provide a sense of orientation for the visitor by arranging functions in ways that are easily identified with particular entrances, exits and vistas. Never relying on signage as means of directional communication' (MacLaren 2003: 3).

The buildings are a conglomeration of old buildings, refurbished buildings and new ones. They are held together visually by the use of a muted palette of beige, brick and warm wood tones, and the landscape of winding paths, sheltered garden nooks and open spaces. There are many windows and doors; there seemed to be doors leading outside everywhere. There was no sense of being closed in (or shut out) but rather, always a sense of the beckoning of the outdoors. The outdoor spaces themselves are a combination of several approaches, some dictated by use, others by 'folly'. Three porta-buildings used for day care in the Centre of an open space (and clearly viewed from much of the indoor space) seemed eyesores and distractions to the spirit of the rest of the landscape. These three "temporary" buildings seemed to have become integrated in the visual memory of the architect and those who used the buildings frequently, but to the newcomer, they were 'sore



The planting and gardening seemed to be not only the focal point of the Centre visually, but also supported the architect's main metaphor of a Paradise Garden.

The cultural mix of people using the Centre was apparent. In fact, it is observed that the centre brings together communities that do not comfortably share the same cultural space outside of the Centre (Froggett 2002: 146). The Café seemed to be the main focus of the site and was busy, bustling and well-used. The restaurant staff, working away in an open-plan kitchen, was comprised of a mix of cultural backgrounds, as were the diners.

The old Church space has been converted into a day nursery, using furniture, dividers, etc. that can be broken down for large events in the space. The Church seemed to be deconstructed visually, much in the same way that old Church buildings have been converted for use as restaurants or clubs elsewhere. The feel of it, however, was definitely NOT the commercial kinds of conversions or builds that make hospitals look like trendy restaurants or cafés, or health centres like shopping malls. There was more than just a sense of ‘social architecture’ here too; perhaps the insistence on the open spaces, the meandering paths and constructions, the metaphor of the Paradise Garden—all are strong pulls away from the more typical visions of architects who are building hospitals and health centres more strongly reflecting the zeitgeist of the market economy and the ‘patient’ as medical tourist.

Gordon MacLaren, architect of the BbBC

For the twenty years since its founding, architect Gordon MacLaren of Wyatt MacLaren LLP, London, has been shepherding the physical ‘space as place’ of BbBC through his vision and commitment. Gordon gave me a “running commentary” as we toured the Centre on the day that I visited. I asked him to talk about the Centre in relation to the design of the built healthcare environment and its use by people from minority ethnic groups.

MacLaren began our conversation by talking about ‘aesthetics’ as a term in design and public buildings and spaces that is not part of the vocabulary of new labour-speak or new ‘regeneration’ speak. Concepts of regeneration, in Gordon’s view, coalesce around the market economy as the driving force behind social architecture. Regeneration in these terms means generating money/capital and ultimately raising taxes through creating new tax bases.



MacLaren spoke frequently of a sense of ‘place’ being a comfortable place for the user where they are not threatened by the expectations of others. Although this sort of ‘pressure’ does exist to a certain extent in the Medical Centre at BbBC, it is minimized. Unfortunately, there is still a clear divide between patients and staff brought about by utilitarian necessities.

'Architecture is a product (or maybe more accurately a service) in modern consumer society'. ...Architecture has to appeal to a communal and not just an individual taste. ...It can have difficulty with the ideas of permanencies and durability which arise out of religious and ethical and social convictions (MacLaren 2003: 4). Architecture is both a structure and a social good. ...Architecture is more like music than most other art forms because it is so closely associated with memory and expectation, repetition and emotion' 2003: 7). Architecture seems to benefit from an audience (2003: 8).

He repeatedly brought up the metaphor of a Paradise Garden as the conceptual basis of the enclosed garden-like components of the Centre. Gordon stated that this outside space at BbBC is designed for 'more outlandish' behaviour—a place where 'you can go mad, and nobody bothers you!' this is his self-described "Paradise Garden" and clearly both the cornerstone and the gemstone of his design efforts at BbBC.

Although BbBC grew organically outward from the seed of the original church, the architecture and design tries to detoxify religious symbols. For example, a ceramic plaque of a Madonna and child on one exterior wall becomes a mother and child—a universal symbol for the childcare and support services available through the Centre. Speaking of religious or faith-based diversity, MacLaren believes that human beings have more similarities than differences, or the concept of the shared habitat. For example, he points out that there may be more differences between men and women than, say, Christians and Muslims. At 12 noon and 9 am the bell chimes in the tower of the Healthy Living Centre—a Christian symbol but also a timekeeping function. Gordon states that it doesn't seem to bother people from other faiths who use the Centre. Another example: there are stained glass panels in places around the Centre. The in-house artist who creates them appears to play with the concept of 'saint' in these works, deconstructing their original meaning. MacLaren believes that basic cultural references are universal: eating, sharing food, looking at nature. Many cultural symbols or practices can be viewed as abnormalities by another culture. For example, the Christian cross itself is often perceived by Muslims as Man murdering God. 'The values applied by individuals from different cultural backgrounds to the same cultural artefacts can be disconcerting and often risk upsetting the creation of "common ground"' (MacLaren 2003: 9).

'Make the pleasures of cultural reference and signification secondary. Be prepared for unexpected and often hostile reactions to cultural artefacts that represent state or religious authority. If such artefacts are incorporated with a degree of cultural relativity they are usually accepted on the basis of their representation of historical continuity and are not seen as dictatorial or coercive' (MacLaren 2003: 3).

Almost the entire public space is built on the ground level, a non-hierarchical space, rather than just a disabled-friendly space. Cultural spaces are often defined in terms of round versus rectangular; for example, someone coming from Africa is used to buildings being based on round huts and so forth. The buildings at BbBC seem to reflect both rectilinear and round shapes in their design.



MacLaren returned to consideration of space and place. To him, space represents the movement of human beings, what is growing or green, and the sky. He believes that buildings (architecture) should be (are) a frame for these visual references. He also thinks that basic information helps us to better deal with stress. On the other hand, there is very little signage at the Centre. He believes in creating rooms and areas with views of gardens and that nature and access to nature weigh in very strongly. Windows and doors represent flow and access.



Asked about his thoughts on hospital design, the architect responded, 'People need spaces where they can be both private and convivial. Larger spaces create larger 'events' for privacy. There needs to be a way of retreating from open spaces to private places'. Elsewhere (MacLaren 2003) MacLaren has described this phenomenon: 'Humans are more convivial in their relations with others if they are able to find a degree of privacy or 'personal space' close to other places or spaces where they can interact'. 'Civilisation cannot easily be unrelated to the institution of the family' (2003: 5).

MacClaren concludes: 'No modern architect managed to escape the style of his personal zeitgeist' (MacLaren 2003: 8). BbBC is 'neither self-consciously modern or antique, rather it is middle-of-the-road in terms of its realisation in recognisably "natural" materials but radical in terms of a spatial configuration that create carefully considered thresholds between connecting spaces and destinations and between public exteriors and private interiors' (2003: 10). BbBC has the character of a place, rather than the character of a single space, a protected secure place, a "Paradise Garden".

Conclusions—grounding the single case in theory and the literature

The Bromley-by-Bow Centre and, more specifically, the vision of its architect, reaffirm many of the more promising and forward-looking findings (p. 8) in the literature review. As the key example of innovative programme design in the creation of Healthy Living Centres in Britain as well as the core model of the LIFT programme, BbBC has certainly not gone unnoticed. In this review case study, however, an attempt has been made to move beneath bricks and mortar—even sidestep the direct model of community social interaction—and unearth some of the guiding theoretical principles that underpin its built environment as architecture or art.

The principles of Relational aesthetics (Bourriaud 2002) offer a theoretical grounding to the case at hand; indeed, the philosophy of architect Gordon MacClaren has resonance with Nicolas Bourriaud's model of Relational aesthetics. For example, architecture as relational art and, therefore, artistic activity, 'strives to achieve modest connections, open up (one or two) obstructed passages, and connect levels of reality kept apart from one another' (8). Key to Relational aesthetics is the guiding principle that '*relational* art (an art taking as its theoretical horizon the realm of human interactions and its social context, rather than the assertion of an independent and *private* symbolic space) points to a radical upheaval of the aesthetic, cultural and political goals introduced by modern art' (14).

Central to relational art are inter-subjectivity, being-together, the encounter and the collective elaboration of meaning (15). The small spaces of daily gestures determine the superstructure of "big" exchanges and are defined by it (17). Art, in Relational aesthetics, is a state of encounter. The essence of humankind as purely trans-individual, made up of bonds that link individuals together in social forms which are invariably historical (18). Relational aesthetics does not represent a theory of art, but is based in models of sociability; meetings, encounters, events, collaborations, games, festivals and places of conviviality all make up what is relational and, therefore, art (28). Art in post modern times is concerned with occupying time, rather than occupying space (32). Art is made of the same material as social exchanges (41), consisting of an interactivity with the viewer, and as a tool serving to link individuals and human groups through a preference for contact and tactility (43).

A statement of Bourriaud's with which MacClaren might agree: 'It seems more pressing to invent possible relations with our neighbours in the present than to bet on happier tomorrows' (45). Relational aesthetics see the everyday, or the quotidian, as a much more fertile terrain (47). 'The most pressing thing is no longer the emancipation of individuals, but the freeing-up of inter-human communications' (60). 'We find in pride of place a project to rehabilitate the idea of Beauty' (62). Our intentions need to consist of conveying the human sciences and the social sciences from 'scientific paradigms to ethnical-aesthetic paradigms' (Guattari cited in Bourriaud 2002: 96).

With these principles in mind, (which seem in sympathy with the architect of Bromley-by-Bow Centre, judging by our conversations and his writing), we can now revisit the reviewed literature in a foundational way. Key to the findings is the fact that architecture is recognised as having impact on social life and well being. An architecture that uses this as the starting point rather than the end result is evident in

the BbBC. The fact that therapeutic environments must be considered as physical, social and symbolic spaces places plays out consistently and continually in the planning and organising of space at the Centre. Insuring and facilitating full community participation in designing and implementing healthcare environments are guiding principles at work at BbBC. The idea of 'relationship-centred care' as the 'third way' is evident in the organisation of activities at the Centre. A Relational aesthetic model comes in to play here with attention to public/private space, the celebratory nature of encounters and the spaces in which these take place as well as the Centre's insistence on giving 'space' for working out differences and conflicts.

The general lack of understanding of the function of 'art' in healthcare settings is underscored by how differently concepts of art, decoration, etc. are handled at the Centre. Art is a working, living, breathing component of the care process at BbBC. Art is generated through relationships and art is truly the 'product' of relationships at the Centre. Open spaces and the natural environment are never far from activities at Bromley-by-Bow Centre. The central organising function of these spaces contribute to a sense of environment as experience of pleasure, the built environment as both framework and frame for activity that takes place in and around the natural environment. In the creation of a 'Paradise Garden' and open spaces easily accessed by the public, the design contributes accessible urban greenspace to healthy living in the community.

The call to architects by Nield that, "It is time to deal with events, rather than fixtures" (Nield 2003: 2) resonates with both a theoretical grounding in Relational aesthetics and the vision of MacLaren, the BbBC and its built environment. MacLaren's people-centred approach to healthcare design takes the concept to demonstrable realities through an aesthetic of 'relational architecture' carried out to its fullest extent. The BbBC is truly 'a vision that is quite simply human' (Bourriaud 2002: 57).



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