



We Don't Want the Taj Mahal

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EDITORIAL

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If my architect colleagues at the architectural practice, *antarctica*, had a dollar for every time that a client said, "We don't want the Taj Mahal", they would probably be millionaires. Embedded in this sentiment of clients, however, are important desires which this edition of the Australasian Medical Journal addresses. Just as the Taj Mahal is a monument to love, I believe that clients want, and designers need to deliver, buildings of high quality which reflect the love that people in the health professions and people in the architectural profession have for their work.

But ... how do we achieve such quality? Most people want a 'beautiful' building. Beauty may only be skin deep, but the desire for a building which is beautiful in its context is strong and understandable. Some people want a building which is 'beautiful' on the inside – one which functions well, especially one that protects its users against harm, and encourages their wellbeing. Despite this, my experience is replete with designs which contain preventable problems – the procedure room across the waiting room from the steriliser; the ambulance bay accessible by tilting the trolley almost vertical.

Apart from the hospital sector, the evidence for what makes a building in the health sector great is scant. Particularly outside hospitals, we need to build the evidence-base, and in the meantime pool with wisdom of experts. Great design begins with a knowledgeable client, who understands their 'business' and can meaningfully engage the people they care for (both

patients and staff) in the design process. My experience is that most clients have (often nascent) hypotheses about design and its outcomes. They have a strong sense of the outcomes they are seeking, and ideas about the mechanisms that will achieve them. It is disappointing, however, that the few people think of their design activity as 'research' and create a framework around it that helps to determine if it is successful.

Few people, for example, capture baseline data that would allow them to see whether their outcome was actually achieved, or use other mechanisms like narrative analysis or grounded research. If a new or refurbished site was 'green' how would we know, apart from instinct? If it was better for staff, how would we know? We might undertake an appraisal of staff retention rates or near misses for patients, to explore whether a new design is better. The papers in this journal contain examples of circumstances where people have gone further than a 'gut feel'.

Of course, some things are difficult to assess. The economic benefit of design is an example of this. The degree to which a design captures the 'mood' or 'character' of its context is another. That things are difficult to assess doesn't mean that they aren't important, nor that we shouldn't 'dip our toes in the water' looking at ways to do so. I believe that clients desire a building which is known (if only to those 'in the know') to be 'great'. Yet, I am perplexed and concerned by the small number of people in Australia who can name a site which they would emulate in primary care. Perhaps we don't have the 'Taj' in primary care, or perhaps its/their whereabouts is a closely guarded secret.

I believe that great design un-bundles the dichotomy of 'patient-centred' and 'staff-centred'. Research, such as that published in this edition of AMJ, suggests that what is good for patients is often good for staff. We need to see the wellbeing of patients and staff as in a symbiosis when we design, rather than an example of Cartesian dualism – the wellbeing of patients and staff being utterly distinct



and independent of each other. Great design is co-production. At *antarctica*, we believe that it is built on trust, transparency, good will and generosity. Like the 'meeting of experts' model pursued in healthcare relationships, all parties are respected for the knowledge (formal or folk) that they bring to the table. The animated engagement of the parties brings the 'aha' moments of design which move a design from being good to being 'great'.

High quality design might seem more expensive at the beginning. This fear is often what underpins statements about 'not wanting the Taj Mahal'. Good designers are aware of this. Yet, even small improvements (or small problems) created at the design phase echo through the life of a building. The costs of construction are many times the costs of design. The costs of operating a building are many times the cost of construction. Thus, as my grandmother might have said, 'a stitch in time saves nine'.

What can be expensive in design is the cost of effective briefing, the costs of re-work when the issues are not understood, and the recurring costs of inefficiency and ineffectiveness if the design is not optimal. We all want master craftsmen, like those who built the Taj. They may be a little more expensive in the short-term, another reason to look rigorously at the benefits in the long run.

In health design, like other fields, this expertise requires knowledge. Even more, it requires wisdom – a deeply thought-through understanding of health, a degree of resolve to understand what amongst the research can be translated into a design, and the humility to know that all people have their own wisdom to contribute. As many in the health field know, wisdom and experience are not the same.

Designers need to address the 'dogma of type'. In the field about which I am passionate, primary care, there is sometimes an unthinking reliance on type. What is designed can be a large 'house' or a small 'hospital'. Yet, I would argue that an excellent primary care service is neither a large house, nor a small hospital. The art of engaging the community in discussion might be more important than a past catalogue of institutional or residential buildings, especially when a formulaic approach limits the opportunities of fresh insights and innovation.

The papers in this journal reflect what can be achieved and improved with attention to the issues and available evidence. Given the realities of health services research, I imagine many authors would be sanguine about the likelihood that their insights would be adopted. Yet, this

should not be what happens. Biased as I am, having begun to work on both sides of the 'fence' – still as a consultant in the health field, yet also with an architectural practice – I believe that we must do better in choosing designers for the health field.

Pragmatically, we need to develop a more sophisticated 'market' in health design – one which seeks out people with a passion for the field, recognises them for their commitment and encourages their sharing of their achievements. The Australian Labor Party, when it came to government about three years ago, embarked on an ambitious, somewhat controversial, investment in 'super clinics'. Arguably, this was one means of addressing the capital under-investment that resulted from years of stinting on the price of fees for general practice in the schedule that governs a supposedly universal, publicly-funded health insurance system in Australia. Will they, or, more importantly, the Australian people, get high quality design for the investment? Without a rigorous independent evaluation of the designs we won't know. Additionally, we are unlikely have access to the lessons learned by these sites. The incoming Australian Government should commit itself to such an evaluation, and to the transparent reporting of its results.

Regardless, I'd implore you, the reader, to ponder a moment next time you are involved in a discussion of design, and ask, 'Do I want the Taj Mahal?' You probably do. Discerning choices and a commitment to add to the weight of evidence will get you close.

PEER REVIEW

Commissioned. Not externally peer reviewed.

CONFLICTS OF INTEREST

The author is an employee of *antarctica architecture and design*.