Partnered Research Center for Quality Care

# Community Update

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## Building patient-centeredness: Hospital design as an interpretive act

Bromley, Elizabeth. *Social Science & Medicine* 75 (2012) 1057-1066

Like any other form of architecture, a hospital building is a multi-faceted sign that conveys information about the socio-cultural, economic, historical, professional, and aesthetic contexts that influenced its construction. In addition to being functional machines that deliver healthcare services, hospitals are symbols laden with information about a culture's attitudes toward health, sickness, life, and death. Because the way in which a hospital is constructed is contingent upon historical and cultural factors, the design of a hospital crystallizes ideological abstractions such as patient preferences, theories about the healing process, and business prerogatives prevailing within a given historical moment. Expectedly, hospital architectures strongly reflect ideas, assumptions, and trends concerning the nature of patient-hood, the role of healthcare professionals, and the care of the sick.

Elizabeth Bromley studied how the popular notion of patient centeredness influenced the design of a new hospital in the United States. Bromley analyzed data from public documents and thirty-five interviews with administrators, planners, and designers of the hospital, which incorporated patient-centered innovations such as an onstage/offstage layout, a concierge system, and scripted communications. The interviews revealed the ways in which the designers and administrators of the hospital interpreted and implemented the concept of patient-centeredness, which in turn raised questions about how this concept may impact medical professionals' roles, may re-conceive medical care as a consumer product intended to satisfy the patient's desires, and may insulate patients from the realities, technical and otherwise, of medical care.

Various groups, from scholars to patient organizations, have advocated the concept of patient-centeredness as a humanizing corrective to the sense of alienation that they perceive is the result of an increasingly specialized, impersonal, and technological healthcare system. Advocates of this concept want patients to have more leverage in healthcare decisions, and stress the importance of the patient's psychosocial concerns, needs, desires, and preferences in healthcare interactions.

Critics have argued that patients are not autonomous actors that bring a pre-formed set of desires and expectations to encounters with healthcare providers. These critics see patients as dynamically co-constituted within their relationships with providers such that there is no intrinsic, empowering patient viewpoint to be prioritized. Other critics have contested patient choice as an unalloyed good, and questioned whether physicians unilaterally possess power within the doctor-patient relationship. Researchers also point out that patient-centeredness is not universally defined. Thus investigating hospital design and the intentions and assumptions that underlie it presents a way to gauge how patient centeredness is both materially and ideologically constructed, and how its implementation affects patients and providers.

At least one year after the opening of the hospital, between 2009 and 2010, Bromley and her team conducted interviews with designers, planners, and administrators. The researchers asked interviewees to comment on the intentions behind the design, to describe how the hospital exceeded or failed to live up to expectations, and to indicate their priorities for hospital care. The researchers also prompted interviewees to discuss what healthcare providers and patients need from hospital facilities, and to comment on the specific features and amenities of the building. Bromley then used thematic content analysis on transcripts

of the interviews as well as media reports and published administrator interviews.

The hospital designers built the concept of patient-centeredness into the building's infrastructure through the implementation of an onstage/offstage approach to care delivery, a concierge system requiring hospital staff to fulfill customer service duties, and the scripting of staff communication with patients and family members. Interviewees explained how the hospital was built according to a Disneyland-style partitioning scheme wherein all of the materials, technology, and work processes used to deliver healthcare services were hidden from visitors and, to an extent, the patients themselves. Furthermore, the building was designed to focus occupants' attention on outside spaces, encouraging one to forget the fact of being inside a hospital. The concierge system incorporated innovations from the hospitality industry: private patient rooms with living-room furniture, room service meals, amenities such as coffee, chairs, and pillows for guests, and prompt attention to all manner of complaints by patients and family—a customer service philosophy imported from the Ritz-Carlton hotel chain. The communication script included six items, ranging from the initial greeting in which the staff member addresses the patient by surname, to courteous leave-taking, which informs the patient of when the staff member is returning and what will come next.

The interviews raised important questions and targeted areas for further empirical study. While the desire to deliver compassion—which is at a premium in patient-centered models of care—does not necessarily imply devaluation of technical expertise, it does indicate that medical professionals' understanding of their work could significantly change in hospitals like the one described above. Prioritizing communication with patients could also hamper the development of strong socio-technical networks among providers, in which knowledge and skills essential to the delivery of safe, quality care are transmitted. Furthermore, consumer-driven hospitality industry strategies may routinize and mechanize behavior, resulting in the instrumentalization of compassion. To the contrary, increased attention to provider-patient communication and compassion may prove beneficial to interpersonal care, and should be further researched. Bromley's study also questions whether the onstage/offstage model obscures the realities of care and thereby subjects patients to an imbalance of power, and whether issues of architectural form may affect hospital functionality.

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## Upcoming Partnered Research Integrity Study

On behalf of the executive committee of the NIMH Partnered Research Center for Quality of Care, we would like to encourage you to participate in the Partnered Research Integrity study. The goals of this collaborative study, jointly funded by the Office of Research Integrity of the National Institutes for Health and the National Institute of Environmental Health Sciences, are to explore (1) how academic and community research partners conceptualize and maintain research integrity and (2) how partnered processes might support or undermine research integrity in a range of research approaches that aim to be patient-centered.

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