P4 Reflection

Krystian Woźniak

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Student name: Krystian Woźniak
Student number: 1526464
Studio: Explore Lab 32
Teachers: Daniel Rosbottom, Hubert van der Meel, Mark Pimlott
Delegate of the Board of Examiners: Sake Zijlstra
Date: 02.03.2022

Introduction - how and why

Before applying to the Master Architecture program at TU Delft, I had a strong interest in care architecture. Therefore, I have pursued my fascination with healthcare architecture within the frames of Explore Lab studio. From the beginning of my work, I had many issues I would like to tackle in my master thesis. It always surrounded the ideas of relationships between hospital and the city or question of humane architecture. In the initial period of my work, I was exploring the current state of the healthcare design and research, looking for the gap to fill in or the issues that would help my consideration about future urban humane hospitals.

I have undertaken a literature review in Evidence-based design and its shortcomings. Following the advice of my research plan mentors, I approach my research from a relatively new feminist perspective that calls for the inclusion of affective thought with rationalistic. Literature review revealed worth exploring social and experiential issues within healthcare design. Many studies I have consulted emphasized the need to study how built environments impact social relationships, which seems essential in a hierarchical hospital environment. Other researchers also called for the inclusion of psychological and mental wellbeing, therefore, leading to notions of subjective architectural experience. These two matters of social and experiential become primary elements of my investigation. To tackle them, I have chosen the method of case study focusing on examples that technologized society forgot, like old care practices from before the rise of modern hospitals and other architectural care practices that do not entirely function like a hospital. I assumed if a hospital is a place of care, offset from hospital examples to a more general set could presumably bring new answers. Whereas the case study formed the central part of my research paper to further the interest in qualitative research rather than rational and quantitative, I conducted the interviews with healthcare workers and patients. The purpose of the interviews was to study the inner workings of hospital facilities, especially covid and infectious diseases hospitals, and further to inform my study of social and experiential aspects.

Reflection on the approach and process.

In total, I studied 8 case studies, four examples of historical and four modern examples of care practices. Due to its extensiveness, that part only brought me many answers and proved to be enormously time-consuming. Without a doubt, the scope of that part should be smaller for the graduation work.

Similar observations apply to the interview part. As long as I have enjoyed listening to doctors, nurses, and patients in conversations that lasted from 30 minutes to 60 minutes each, the amount of work the analyze them in detail exceeded my expectations and time availability. Nevertheless, I have managed to relisten and write down the recordings during the work on my design, constantly changing and improving the latter. My primary reflection about this part is that 15 interviews of this length could quickly become another research report with its introduction and conclusion. Another thought comes with the choice of people I have spoken with and the physical context of my design assignment. Due to the specificity of my network, I was able to find and talk to almost only patients and doctors from Poland. Seriously underfunded and outdated state of polish hospitals severely influenced the answers, and without a doubt, answers of dutch staff could be pretty different. However, I could discern common notions that also intersected with solutions I have discovered in my case studies.

The interview part was also an ethical dilemma. I started with the bias that I am borrowing time from people struggling to fight the pandemic. However, that, in the end, was not a problem since a fair amount of them were willing to talk about the issues and shortcomings in their daily work and understood the importance of research and the need for change in healthcare architecture. Unfortunately, I have to admit that this comprehensive approach led to the extension of my graduation period and proves that often asked by tutors, a narrow path should be even thinner than we as researchers aspire to. Thus I several times rewrote the first paragraphs, marking and erasing fragments that were interesting for me but, in the end, irrelevant for my work. At the same time, the research process was also characterized by a constant interplay between case studies and interviews. Each new case study brought reflections and answers to the previous one resulting in an endless circle of improvement. In positive thought about my design process, I was surprised how much more I have learned from the last example and how differently I looked at the first case study after analyzing the whole set.

Simultaneously I was preparing the ground for the design part. That included research into the location of my design and answering the question of what type of facility and where would be needed. As Big urban cities of the Netherlands are now after merging and consolidation, and with market pressure to subdue provision, I have switched my focus from a general to a specialist hospital. Following advice from my design mentor, I have taken a Covid-19 pandemic as a starting point in discussing a facility that would answer pandemic preparedness. Considering the risks of the emergence of new infectious diseases in the post-antibiotic era, I had decided to pursue the topic of infectious diseases in hospitals. As this type of facility would be necessary close to more significant urban populations and transportation hubs, I had chosen the site of former Harbour Hospital (Havenziekenhuis) in Rotterdam because of its close distance to the center and proximity to the city infrastructure necessary for this type of facility. The fact that I live in Rotterdam and can visit the site multiple times contributed to that choice.

In that part, I have spent a fair amount of time considering the neoliberal character of healthcare in the Netherlands and the impact of the market on architecture itself. That led me to an additional question about the balance between market and science-based requirements of the hospitals and the desire for humane environments. This ended with the conversation I had with the new Isala Hospital project manager in Meppel, which brought some answers about decision-making in the healthcare architecture process.

My design part started with studying the site's context, its shortcomings, advantages, history, materiality. Along the way, I was consulting and discussing my design brief, which was built upon existing briefs and was translated into the needs of the Greater Rotterdam Area in the form of a specialist 200-bed hospital. While constructing the brief, I drew the abstract charts and diagrams of its functional structure to understand the requirements of hospital machines better. I followed with ongoing studies in massing. However, too much time was spent in a mass study that lacked essential solutions in the plan and section. In that period, necessary was a reminder for my tutors to focus on my desire for the humane hospital as my work started reminding the process I was trying to avoid from the beginning. Only after the diagrammatic sketching process was I able to move one to the scale of the architectural plan.

Along with my work, I was constantly reminded by tutors about the importance of sections, and I followed my design in working with multiple sections simultaneously. Another issue I encountered was the inability to focus on one part and consistent story as I was constantly distracted by various issues I found necessary for my work. I greatly appreciated the advice that helped structure my narrative and thought process in those times. Finally, I cannot solve everything, and some parts can be assumed.

Relation between design and research

My research produced a fair amount of answers on how hospitals and be humanized. Most of the studied by me examples were urban institutions, and that context was helpful in the design part of an urban hospital. Moreover, interviewed staff and patients luckily for me had experiences with rather inner big city hospitals rather than institutions on their outskirts; however, both groups' representation was present. The aim and main research questions were designed to help and navigate the design part; thus, research and design in the main work were inherently connected from the beginning. Struggling but interesting was the clash during designing between trying to implement all humane qualities while keeping in mind market mechanism driving the healthcare with technological and functional requirements of hospital machine. Thus the name of my work – hospital and the machine. What I have found noteworthy was the interplay between design and research. I used to come back to my case studies and interviews using the lens of design problems I have encountered along the way, finding it highly fruitful and coming up with solutions or theoretical considerations. The constant dialogue between those two parts and keeping my research work open during the design process was inherently more helpful than when I tried to close the first part and work only with results produced in the one-time frame. I treated coming back to my research by simultaneously zooming out in the design process leading to rethinking it but without entirely and spontaneously changing its core.

My graduation topic relates to the classical understanding of architecture design as designing a building with its all issues of construction, climate, logistics, or function. However, my work's core lies within the relationship between users in the built environment and the relationship between the user and the built environment. The social issue is underlying notions in my thought process. That connects to my case studies where the success of a few of them lay not in architecture or social issues alone but a balanced relationship between them. Maggie's center would be a unique but empty shell if the charity did not use us with a particular policy.

Furthermore, I could use the knowledge and techniques I acquired during my first year of master's. I pursued historical research methods, and I learned from history thesis and ethnographic methods from Global Housing studio, like looking for patterns of use or sharing in historical case studies. Multiple times, I needed to remind myself that I was preparing to be an independent designer and that my tutor would give me every answer. In the end, the master's program aims to produce a master's in the field of architecture.

Healthcare architecture design is the narrow field of architecture discipline. As we sometimes see good results in their work, the most successful healthcare designs come from designers without prior experience in the area. That is proof that we still need new answers and perspectives to change the current state of hospital environments. I pursued my graduation in a zone that is still underresearched. However, the subjective approach produces subjective results, even if some of them happen to be universal. Thus I believe my work contributes to the field as an incentive to pursue more matters I enlisted in my conclusions. I will not say that what I have discovered is new and revolutionary. Instead, it somewhat confirms good practices we already know but tend to forget. I hope to bring this knowledge further in my career to start professionally in healthcare design.