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A HARDWORKING BILLBOARD FOR BRAND UTS
CIVIC ARCHITECTURE FOR PEOPLE AND PLACE
LADY CILENTO CHILDREN'S HOSPITAL BRISBANE

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Bendigo Hospital

01

02

03

DESIGN ARCHITECT
Bates Smart

HEALTH PLANNING ARCHITECT
Silver Thomas Hanley

LOCATION
Bendigo, Victoria

CLIENT
Lend Lease

PROCUREMENT METHOD
Novated contract

SIZE (FLOOR AREA)
99,000 m²

NO. ROOMS/BEDS
2515 rooms

COST
$630 million

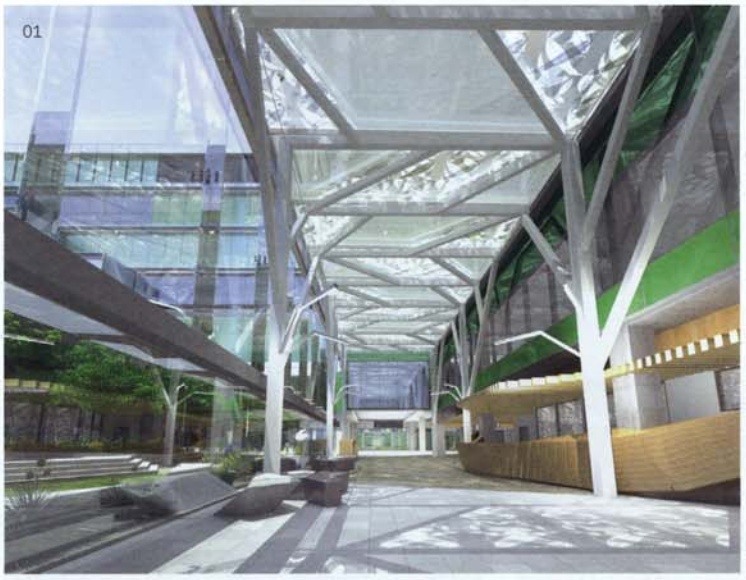
TIMEFRAME
Due for completion December 2016

01
Primarily clad in precast concrete panels, the building's facade will also consist of high-performance glazing and powdercoated aluminium panels.

02
The ground-level floor plan shows an internal street separating the regional integrated cancer centre from medical imaging and the emergency department.

03
The lobby's ceiling will be made of woven timber, its small apertures allowing natural light to create a dappled pattern on the light-coloured plaster walls and concrete paving.

Royal Adelaide Hospital


01


02


03


04

KEY DESIGN CONSULTANTS
Silver Thomas Hanley DesignInc (STHDI in joint venture)
Bestec
LCI
Wallbridge & Gilbert and KBR (WGKBR in joint venture)
Tract
HP

LOCATION
North Terrace, Adelaide

CLIENT
Government of South Australia

PROCUREMENT METHOD
Public–private partnership, design and construct contract

SIZE (FLOOR AREA)
175,000 m²

NO. ROOMS/BEDS
800 beds (including 100 day beds)

COST
$1.85 billion

TIMEFRAME
Due for completion 2016

01
The cloister at the hospital's main entry is a welcoming space and allows natural light to permeate internal spaces.

02
Within the state-of-the-art facility, light floods through glass facades, internal courtyards and gardens while natural materials, like stone and timber, create a familiar and welcoming environment.

03
The concourse, which includes retail and restaurant facilities, overlooks the pedestrian piazza and will be accessible to staff, patients and visitors.

04
With an emphasis on patient privacy and comfort, all inpatient rooms, like this Intensive Care Unit room, consist of single beds.

The Gold Coast University Hospital by GCUH Architecture (PDT+STH+HASSELL) Photography: Christopher Frederick Jones

ideally include not only the design outcome, but also the brief intent and subsequent factors such as user groups, operational considerations and contractor issues, which modify the brief.

Although these examples from Queensland suggest a broader and deeper scope of analysis, they remain short-term, project-focused studies. Ron Billard, principal of Billard Leece Partnership (BLP), agrees on the need to generate data that is specific to each completed project; however, he also advocates for a POE process that compares outcomes across a range of similar projects. Having recently completed four subacute healthcare facilities across Australia, BLP has made the unusual decision to undertake all four POEs at the same time, making a comparative analysis possible.

Ian Forbes, an experienced health facility planner and adjunct professor at University of Technology, Sydney, argues that although NSW Health also uses its POE results to influence changes in the AusHFG, there is a reluctance to release that knowledge to the design firms that are engaged in public health facility design. He also questions the value of the AusHFG as a design tool, suggesting that he had "serious concerns about their rigid imposition, which would limit the possibility for change and innovation in functional and physical solutions."

According to Forbes, what is missing in all the rigorous evaluation methodologies developed for POE is the need for continuing and open discussion. He suggests that "dialogue among participants involved in the review is perhaps the most important aspect of the evaluation. Seeking to find simplistic methodologies that will answer all aspects of health facility design is just not possible."

To create a truly performative architecture, one that is based on a deeper understanding of the complex relationship between people and their environment, we need more reliable information, the kind that can only emerge from long-term, coordinated post-occupancy analysis of completed buildings. However, sociologist John Law reminds us that the world is not to be understood by adopting a methodological version of auditing, because, in doing so, we fail to "make and know realities that are vague and indefinite because much of the world is enacted in that way."[2]

Perhaps part of the problem also lies in the terminology that we choose – the word "evaluation" suggesting a judgement of the past, when our primary interest is actually in shaping the future. In its place, the term "post-occupancy analysis" suggests a holistic, process-oriented approach where not only facilities but also the forces that shape them (political, economic, social, etc.) are taken into account, more accurately reflecting the life cycle of an evolving architecture-in-use.

As a profession we stand to gain from a rigorous, coordinated approach to post-occupancy research, where results are made widely available, not as a set of prescriptive rules but as a suite of evolving principles, worthy of continuing development. When we treat knowledge as an iterative, continuous process – and not a product that we aspire to complete – predictable patterns begin to emerge, but we also generate a whole new suite of questions that provoke a speculative response. Perhaps in this way we may reconcile the contemporary need for predictability in our performative environments, without diminishing what is essentially a non-repeatable, creative act of design.

1. A 2013 survey of 420 design practices around the world by *Evidence Based Design Journal* found that just 5 percent of firms undertake any form of POE as part of their normal practice. Where practices were primarily involved in the design of healthcare facilities, the percentage that undertook POE rose to 34 percent. ebdjournal.com/blog/general-design/the-knowledge-problem

2. John Law, *After Method: Mess in Social Science Research* (New York: Routledge, 2004).

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