Innovations in Hospital Architecture

Stephen Verderber

This indispensable reference book captures key recent developments in the rapidly evolving field of sustainable hospital architecture. Today’s architects must provide hospitals which enable high quality care for diverse patient populations in carbon neutral care settings, and this book succinctly considers what needs to be done in order to meet that challenge. The contemporary hospital is viewed in the context of global climate change, the planet’s diminishing natural resources and the spiralling cost of operating healthcare facilities. Verderber considers the future of the hospital, and supplies a compendium of 100 planning and design considerations for the building type. The book includes with twenty-eight case studies of built and unbuilt hospitals from around the world. These are grouped into five types - autonomous community based hospitals, children’s hospitals, rehabilitation and elderly care centres and hospitals, regional medical centre campuses, and visionary (unbuilt) projects. Beautifully and extensively illustrated with many photographs, diagrams and floor plans, this is essential reading for all architects, planners, engineers, product manufacturers, clients, healthcare providers and government agencies involved in sustainable healthcare environments.

Stephen Verderber is Professor at the School of Architecture, and Adjunct Professor in the Department of Public Health Sciences at Clemson University, USA, and is a practicing Registered Architect in the USA.
Innovations in Hospital Architecture

Stephen Verderber

This indispensable reference book captures key recent developments in the rapidly evolving field of sustainable hospital architecture. Today’s architects must provide hospitals which enable high quality care for diverse patient populations in carbon neutral care settings, and this book succinctly considers what needs to be done in order to meet that challenge. The contemporary hospital is viewed in the context of global climate change, the planet’s diminishing natural resources and the spiralling cost of operating healthcare facilities.

Verderber considers the future of the hospital, and supplies a compendium of 100 planning and design considerations for the building type. The book includes with twenty-eight case studies of built and unbuilt hospitals from around the world. These are grouped into five types - autonomous community based hospitals, children’s hospitals, rehabilitation and elderly care centres and hospitals, regional medical centre campuses, and visionary (unbuilt) projects. Beautifully and extensively illustrated with many photographs, diagrams and floor plans, this is essential reading for all architects, planners, engineers, product manufacturers, clients, healthcare providers and government agencies involved in sustainable healthcare environments.

Stephen Verderber is Professor at the School of Architecture, and Adjunct Professor in the Department of Public Health Sciences at Clemson University, USA, and is a practicing Registered Architect in the USA.
The very first requirement of a hospital is that it will do no human or ecological harm.
The very first requirement of a hospital is that it will do no human or ecological harm.
The evolving role of memory, place, and sustainability

A worrisome trend is undermining the continued evolution of the international movement towards carbon neutral healthcare environments. This movement is threatened by actions at times paradoxical and which run counter to the core principles of sustainable urban development and the tenets of the Smart Growth Movement.1

Often, a decision is made by elected officials and the leadership of healthcare organizations to construct a new replacement hospital on suburban and in “fringe site” contexts. Many of these replacement medical centers are being built in outlying areas at the edge of their communities. On the surface such a strategy for relocation to a new site may make sense. And in past decades no one would have raised an eyebrow. It would have appeared to make good common sense that high land costs in urban centers, the difficulty involved in the assemblage of the large developable tracts, and an enhanced ability to attract and retain top staff at the new location would be powerful justifications.2 Additional ammunition for relocation could easily be justified on the basis of on-site parking requirements, space needed for the mechanical plant, open space requirements, and having enough space to set some of it aside for future expansion.

With these justifications in hand, thousands of hospital administrators had been successful in relocating their institution to new sites, often many miles from the original legacy neighborhoods. For those institutions that opted to remain in their legacy neighborhoods the options usually consisted of:

1 expansion though land expropriation and the use of eminent domain powers with the backing of the local, state, and federal government;
2 reinvention on-site by employing a strategy of expansion combined with the construction of new satellite facilities elsewhere;
3 the purchase (or takeover) of, or the forging of partnerships with, allied care providers in order to create a coordinated network of care providers within a large metropolitan or regional market.
4 various combinations of strategies 1, 2 and 3 implemented over a multi-year period.

During the past quarter of a century, hundreds of historic hospitals have been destroyed in the name of progress (see Chapter 2). This inventory of hospitals is vast. The corresponding cultural currency, heritage, and traditions they represented to their communities is lost. Nearly every city has experienced the loss of a landmark hospital. At the present time many more are threatened with destruction.
Nearly all of those threatened hospitals and portions thereof were built in the period 1935–1970. The 1930s hospitals that remain in the U.S. were usually built in the art deco style and stand as exemplars of that period. The more recent (post-1945) hospitals were nearly always designed in the International Style. These hospitals and parts thereof are also being lost by the thousands. Most of these facilities had been added on to haphazardly over the years with the result being – from an aesthetic, functional, and operational standpoint – a case of the sum total not performing to the level of any of its constituent parts. The megahospitals of the late twentieth century represented the apotheosis of an unyielding belief in the power of medical science in the post-1945 era. By the 1960s the International Style dominated the hospital as a building type in nations around the globe. The movement to incorporate advanced building technologies resulted in a quest to develop a hospital template that would never become obsolete’ in the words of Eberhard Zadek (see Chapter 2). Healthcare facility planning, systems engineering, and interior design emerged as specialized fields apart from architecture. Health-centered political bureaucracies grew in their size and complexity. The regional teaching hospital evolved in recognition of the need to allow for internal flexibility and external extension in a highly complex, dynamic organism and in so doing became almost completely self-referential. Worse, this obsession with size, bed capacity, and technological prowess pushed aside any possibilities to create a sustainable hospital – resulting in a tightly bundled machine hospital extremely costly to run from an energy standpoint. Beginning in 1946 in the United States, with the advent of the federal urban renewal programs sponsored by the Department of Housing and Urban Development (HUD), the race was on to construct ever larger and more complex hospitals and medical research centers. This often happened at the expense of long-established ethnic neighborhoods. These neighborhoods were disfigured, and at worst completely eradicated in the name of progress, that is, more sustainable alternatives. In the meantime, evidence-based case studies are needed to demonstrate the viability of retaining the older landmark hospitals and in reassembling them for new lives. It is highly probable that the total carbon footprint of a new replacement hospital is significantly greater than that of a historic hospital reborn, when all the variables are looked at together in a single equation. Yet in the absence of any broad-based statistics on this point it remains an uphill battle to try to argue for their preservation and/or adaptive reuse versus their demolition. As is shown below, it is far harder to argue effectively for the preservation of an historic hospital in the aftermath of a major catastrophe, as is the case in the aftermath of Hurricane Katrina in New Orleans.

The battle to save Charity Hospital and a historic neighborhood

New Orleans continues to struggle to rebuild from the massive devastation caused by Hurricane Katrina in 2005. Nearly 1,800 deaths were directly attributable to the catastrophe and at $13 billion in federal mitigation costs Katrina ranks as the costliest disaster in American history. Eighty percent of the city flooded, inundating 122,000 residences, businesses, and civic institutions with toxic floodwater for up to three weeks. The city’s healthcare infrastructure was put on life support: official data indicate that there are now (2009) 25 percent fewer hospital beds in New Orleans than before Katrina hit and there are at the time of writing less than two beds per 1,000 residents as compared to over three beds before the disaster. Major healthcare institutions were damaged and many never will reopen, including three hospitals and nearly a dozen neighborhood-based primary care clinics, in addition to dozens of private physicians’ offices, dental clinics, and counseling centers. Only one general hospital is functioning at pre-Katrina capacity and 16,800 fewer healthcare sector jobs exist (down 27 percent) in the post-Katrina urban landscape. Nearly every major building on the site of the first floor of Charity Hospital, located in the Central Business District (CBD), flooded in Katrina’s aftermath and it was forced to shut down. It remains closed at the time of writing. Next door to Charity sits the Department of Veterans Affairs New Orleans Medical Center, known locally as simply the VA hospital. The main hospital opened in 1951. Its basement also flooded in Katrina’s aftermath and remains shuttered. This current iteration of Charity Hospital (1935–1938) was designed by the firm Weiss, Dreyfous and Seiferth and is the fourth Charity Hospital (whose official pre-Katrina name was the Medical Center of Louisiana at New Orleans) on the site (the first Charity Hospital opened in 1728). This firm also designed at about the same time the 35-floor skyscraper art deco State Capital in Baton Rouge (1933–1936). Charity, affectionately known as ‘Big Charity’, features a 20-level main tower with two 14-level hyptens and two 12-level side wings (Figure 5.1). The adjacent 15-storey VA Hospital opened in 1949 and its campus now includes a 12-level ramping with a two-level nursing home on its top (1987–1989), plus a medical research building (1981–1983). For generations, both Charity and VA hospitals served as training centers for physician residents and nurses from the adjacent Tulane University, and Louisiana State University (LSU) medical schools.

The owner-operator of Charity Hospital is the Louisiana State University Health Sciences Center (LSUHSC), Charity, prior to Katrina, was in a deteriorated condition due to years of deferred maintenance, lack of renovations to keep apace with medical advancements, and political bickering over its future. This had resulted in periodic accreditation compliance problems that were frequently solved in a makeshift ad hoc manner on a case-by-case basis. Prior to Katrina, the LSUHSC had been lobbying state politicians for more than a decade for construction of a completely new replacement hospital on a new site. Meanwhile, the 1938 facility was now eligible for placement on the U.S. National Register of Historic Places (henceforth referred to as the National Register). Big Charity served the poor for over 250 years and was the oldest continuously operating hospital in the U.S. until being inundated by Katrina’s floodwaters. In the days immediately following Katrina the LSUHSC announced it was permanently closing Charity Hospital and would seek federal mitigation funds from the Federal Emergency Management Agency (FEMA) to build a replacement facility in a nearby neighborhood, across the Interstate 10 from the current VA/Charity campus. The DVA similarly announced at about this time that it too was also seeking funds from the U.S. Congress to permanently close its facility. The DVA was appropriated more than $600 million to build a replacement medical center on 37 acres of a 71-acre site located in the Lower Mid-City neighborhood. The two organizations signed a formal Memorandum of Understanding (MOU) in October 2006 to jointly construct two freestanding yet interconnected hospitals that would share certain support functions, i.e. parking, dietary, central mechanical plant, and public spaces. The site is adjacent to the Central Business District and across the aforementioned interstate highway from the two shuttered hospitals. The New Orleans Redevelopment Authority (NORA) was put in charge of assembling the land, through the use of Federal Community Development Block Grant (CDBG) funds given to the city after Katrina. The DVA site alone contained 188 separate buildings. It promised to be an arduous task. Everyone in New Orleans knows Big Charity. This art deco landmark skyscraper hospital commands a lofty position in the city’s urban landscape and even more so in its collective psyche.
Nearly all of these threatened hospitals and portions thereof were built in the period 1935–1970. The 1930s hospitals that remain in the U.S. were usually built in the art deco style and stand as exemplars of that period. The more recent (post-1945) hospitals were nearly always designed in the International Style. These hospitals and parts thereof are also being lost by the thousands. Most of these facilities had been added on to haphazardly over the years with the result being – from an aesthetic, functional, and operational standpoint – a case of the sum total not performing to the level of any of its constituent parts.2

The megahospitals of the late twentieth century represented the apotheosis of an unyielding belief in the power of medical science in the post-1945 era. By the 1960s the International Style dominated the hospital as a building type in nations around the globe. The movement to incorporate advanced building technologies resulted in a quest to develop a hospital template that “would never become obsolete” in the words of Eberhard Zeidler (see Chapter 2).4 Healthcare facility planning, systems engineering, and interior design emerged as specialized fields apart from architecture. Health-centered political bureaucracies grew in their size and complexity. The regional teaching hospital evolved in recognition of the need to allow for internal flexibility and external extension in a highly complex, dynamic organism and in so doing became almost completely self-referential. Worse, this obsession with size, bed capacity, and technological prowess pushed aside any possibilities to create a sustainable hospital – resulting in a tightly bundled hospital system extremely costly to run from an energy standpoint.3

Beginning in 1946 in the United States, with the advent of the federal urban renewal programs sponsored by the Department of Housing and Urban Development (HUD), the race was on to construct ever larger and more complex hospitals and medical schools. It promised to be an arduous task.

The battle to save Charity Hospital and a historic neighborhood

New Orleans continues to struggle to rebuild from the massive devastation caused by Hurricane Katrina in 2005. Nearly 1,800 deaths were directly attributable to the catastrophe and at $13 billion in federal mitigation costs Katrina ranks as the costliest disaster in American history. Eighty percent of the city flooded, inundating 122,000 residences, businesses, and civic institutions with toxic floodwater for up to three weeks.5 The city’s healthcare infrastructure was put on life support: official data indicate that there are now (2009) 25 percent fewer hospital beds in New Orleans than before Katrina hit and there are at the time of writing less than two beds per 1,000 residents as compared to over three beds before the disaster. Major healthcare institutions were damaged and many never will reopen, including three hospitals and nearly a dozen neighborhood-based primary care clinics, in addition to dozens of federal Community Development Block Grant (CDBG) funds given to the city after Katrina. The DVA site alone contained 188 separate properties. It is now only a matter of time before these behemoths of the late twentieth century will be themselves threatened with extinction in the name of progress, that is, more sustainable alternatives. In the meantime, evidence-based case studies are needed to demonstrate the viability of retaining the older landmark hospitals and in reasserting them for new lives. It is highly probable that the total carbon footprint of a new replacement hospital is significantly greater than that of a historic hospital reborn, when all the variables are looked at together in a single equation. Yet in the absence of any broad-based statistics on this point it remains an uphill battle to try to argue for their preservation and/or adaptive use versus their demolition. As is shown below, it is far harder to argue effectively for the preservation of an historic hospital in the aftermath of a major catastrophe, as is the case in the aftermath of Hurricane Katrina in New Orleans.

The owner-operator of Charity Hospital is the Louisiana State University Health Sciences Center (LSUHSC). Charity, prior to Katrina, was in a deteriorated condition due to years of deferred maintenance, lack of renovations to keep pace with medical advancements, and political bickering over its future. This had resulted in periodic accreditation compliance problems that were frequently solved in a makeshift ad hoc manner on a case-by-case basis. Prior to Katrina, the LSUHSC had been lobbying state politicians for more than a decade for construction of a completely new replacement hospital on a new site. Meanwhile, the 1938 facility was now eligible for placement on the National Register of Historic Places (henceforth referred to as the National Register). Big Charity served the poor for over 250 years and was the oldest continually operating hospital in the U.S. until being inundated by Katrina’s floodwaters.6

In the days immediately following Katrina the LSUHSC announced it was permanently closing Charity Hospital and would seek federal mitigation funds from the Federal Emergency Management Agency (FEMA) to build a replacement facility in a nearby neighborhood, across the Interstate 10 from the current VA/Charity campus. The DVA similarly announced at about this time that it too was also seeking funds from the U.S. Congress to permanently close its facility. The DVA was appropriated more than $650 million to build a replacement medical center on 37 acres of a 71-acre site targeted in the Lower Mid-City neighborhood. The two organizations signed a formal Memorandum of Understanding (MOU) in October 2006 to jointly construct two freestanding yet interconnected hospitals that would share certain support functions, i.e. parking, dietary, central mechanical plant, and public spaces. The site is adjacent to the Central Business District and across the aforementioned interstate highway from the two shuttered hospitals. The New Orleans Redevelopment Authority (NORA) was put in charge of assembling the land, through the use of Federal Community Development Block Grant (CDBG) funds given to the city after Katrina. The DVA site alone contained 188 separate properties. It promised to be an arduous task.

Everyone in New Orleans knows Big Charity. This art deco landmark skyscraper hospital commands a lofty position in the city’s urban landscape and even more so in its collective psyche.
It is a cultural touchstone, a place widely celebrated in song and verse. Many important jazz and other musicians were born there, including the immortal Louis Armstrong born in 1900 in the 1938 building’s predecessor facility. In the case of a 300-year-old city such as New Orleans, the continued vibrancy of such places is key to retaining a community’s history and its cultural identity.\(^\text{15}\) Charity was a place where generations worked, worshipped, socialized, grieved, commiserated, and celebrated life. Places such as this in the United States are rare, as they are at once ordinary, transient, and inimitable.\(^\text{16}\) This art deco skyscraper Nightingale hospital was the nation’s largest urban hospital when it was dedicated by President Franklin D. Roosevelt in 1938.\(^\text{17}\)

The joint LSUHSC/DVA proposal immediately stirred controversy and resentment in the community. The National Trust, and the Foundation for Historical Louisiana (FHL), based in Baton Rouge, the state capital, argued that while the return of healthcare and a teaching hospital was a critical issue supported by all in Louisiana, the site for the two replacement hospitals was the most costly, most-time consuming, and most destructive of all options explored by decision makers representing LSU and the DVA. The LSU/DVA strategy called for the use of eminent domain, forcing the dislocation and destruction of 263 nineteenth- and early-twentieth-century homes and businesses in an historic neighborhood to build a project costing $1.2 billion. Nearly 100 percent of the buildings in the 71-acre tract would be bulldozed, and a brewery, a school, and a 124-year-old German heritage community center, the Deutsches Haus, would also be destroyed. Furthermore, a collection of reusable buildings totaling over two million square feet in the downtown medical district would be abandoned, with no plan proposed for their reuse by the LSU/HSC or the DVA.\(^\text{18}\) The National Trust named Charity Hospital and this threatened neighborhood on its 2008 list of the most-endangered historic places in the nation, to focus national attention on the controversy.

On November 25, the U.S. Department of Veterans Affairs and Louisiana State University announced the selection of the Mid-City neighborhood as the site of their replacement hospitals and this action will destroy the historic neighborhood around Charity Hospital where residents have been rebuilding their homes in the aftermath of Hurricane Katrina. Once a prestigious center of medical training and a beacon for public health care, Charity Hospital now faces an uncertain future.

Surrounded by floodwaters when Hurricane Katrina shredded the levees around New Orleans, the art deco icon was shuttered and vacant for more than three years. Despite its legendary role in serving hundreds of thousands of uninsured patients and the critical need for medical facilities in New Orleans, this historic building continues to languish and remains vulnerable to demolition. In the wake of Hurricane Katrina, the basement of Charity Hospital suffered water damage and some of the electrical and mechanical systems were damaged or destroyed. After the water receded, the medical community, the military, and a number of volunteers pumped out the flooded basement, cleaned out the debris and restored electrical power to make the building useable again, but the doors to the hospital were permanently locked when the building was deemed unsafe and unusable by the Louisiana State University (LSU) leadership.\(^\text{19}\)

The National Trust for Historic Preservation called this decision a serious error and in a press release urged the VA and LSU to reconsider. The New York Times, in its typical, often-glib post-Katrina role as a workable for a first-class health facility, except for the third floor, under the provisions of a convoluted law called the Stafford Act. LSU wanted $480 million and the most recent federal reimbursement figure was a mere $150 million (mid-2009). It was estimated that the full cost of the new facility would reach $900 million, including land acquisition and demolition. The replacement was first planned for 424 beds, later downsized to 300 beds, and its opening date had not been set, although architects had been hired. The firm of NBBJ, its Portland and Columbus offices, was hired, in a joint venture with Eakew/Durmeiz/Ripple Architects of New Orleans.

At this time, local community grass-roots groups began to turn up the heat on the LSU/DVA Memorandum of Understanding that had been signed some months earlier. That agreement was reached prior to the FEMA Section 106 Review (see below) and any public meetings. Its legality was immediately questioned by attorneys representing the to-be-dealt with residents of the targeted Lower Mid-City project site. The New Orleans-based Internet site Squandered Heritage posted many video interviews with affected residents in the neighborhood. Squandered Heritage, founded by Karen Gadbois and Karen Lentz in the aftermath of the storm, had by then garnered national attention for its tireless efforts to call public attention to the urban demolition crisis occurring in Katrina’s aftermath. Each resident interviewed told his or her personal story and how they had struggled to return to the city to live and to rebuild their life. Every building in the neighborhood was photographed and posted to the Squandered Heritage home page or on other Internet blog sites based in New Orleans. The National Trust continued to post updates on its Internet site Preservation Nation.\(^\text{20}\)

In June 2008, the FHL commissioned the Philadelphia office of the U.K. firm RMJM Hillier to assess the feasibility of preserving and redeveloping Big Charity into a state-of-the-art medical facility. Their report, released in September 2008, concluded that the facility could be rebuilt from within with a new atrium lobby in three years at a cost of $484 million. Building a new replacement would take five years and at least $620 million. No property owners would be displaced. The hospital’s building envelope, exterior walls, windows, and roof were fully repairable. The structural system was sound and this fact alone would save two years off the construction timeline. The building’s footprint, with its high-rise, fully complied with ‘modern hospital design goals of enhancing daylighting and providing views from all rooms’ (Figure 5.2). Up to 444 habitable all-private rooms would be provided (see Chapter 4). The existing floor plates were workable for a first-class health facility, except for the third floor,
It is a cultural touchstone, a place widely celebrated in song and verse. Many important jazz and other musicians were born there, including the immortal Louis Armstrong (born in 1900) and Franklin D. Roosevelt in 1938.16

The LSU/DVA strategy called for the use of eminent domain, forcing the dislocation of 263 nineteenth- and early-twentieth-century homes and adjacent buildings totaling over two million square feet in the downtown medical district would be abandoned, with no plan proposed for their reuse by the LSU/HSC, or the DVA.19 The National Trust named Charity Hospital and the threatened neighborhood on its 2008 list of the most endangered historic places in the nation, to focus national attention on the controversy:

Background

On November 25, the U.S. Department of Veterans Affairs and Louisiana State University announced the selection of the Mid-City neighborhood as the site of their replacement hospitals and this action will destroy the historic neighborhood where residents are trying to rebuild their community. The New York Times, in its typical, often-glib post-Katrina role as a serious error and in a press release urged the VA and LSU to reconsider.

Local and federal officials on Tuesday announced plans for a 71-acre medical campus in the heart of New Orleans to replace two hospitals damaged during Hurricane Katrina, a $2 billion investment that supporters say will create thousands of jobs and begin to rebuild the city's shattered health care system … One of the hospitals … would replace the city's landmark Charity Hospital, a lifeline for generations of the city's poor … the other would replace the vacant Department of Veterans Affairs hospital, also severely damaged by the flooding. The old hospitals and adjacent buildings will be abandoned under the plan, which officials described as the foundation for a new economy for New Orleans, and the largest investment in the area since Katrina. But the plan, brewing for months, has drawn strong criticism from preservationists and neighborhood activists … officials said steps would be taken to mitigate the loss, including moving some houses in the way of the proposed development. But they suggested the city's higher priority was to begin rebuilding the economy with a high-impact project. "Today we are not thinking small, we are thinking right ... we're talking about something spectacular," said Mayor C. Ray Nagin. James P. McNamara, who heads the Greater New Orleans Biosciences Economic Development District, said the campus was the most important project in the city. "For us, that is enormous," he said. That some will lose their homes as a result, he added, is "just the reality of life."17

The LSU replacement hospital proposal remained severely underfunded, however. The University was in the midst of a pitched battle over the assessed mitigation cost to be paid out by FEMA, under the provisions of a convoluted law called the Stafford Act. LSU wanted $480 million and the most recent federal reimbursement figure was a mere $150 million (mid-2009). It was estimated that the full cost of the new facility would reach $900 million, including land acquisition and demolition. The replacement was first planned for 424 beds, later downsized to 300 beds, and its opening date had not been set, although architects had been hired. The firm of NBBJ, its Portland and Columbus offices, was hired, in a joint venture with Eskew/Durnell/Ripple Architects of New Orleans.

At this time, local community grass-roots groups began to turn up the heat on the LSU/DVA Memorandum of Understanding that had been signed some months earlier. That agreement was reached prior to the FEMA Section 106 Review (see below) and any public meetings. Its legality was immediately questioned by attorneys representing the to-be-displaced residents of the targeted Lower Mid-City project site. The New Orleans-based Internet site Squandered Heritage posted many videos interviews with affected residents in the neighborhood. Squandered Heritage, founded by Karen Gabdois and Karen Lentin in the aftermath of the storm, had by then garnered national attention for its tireless efforts to call public attention to the urban demolition crisis occurring in Katrina's aftermath. Each resident interviewed told his or her personal story and how they had struggled to return to the city to live and to rebuild their life. Every building in the neighborhood was photographed and posted to the Squandered Heritage home page or on other Internet blog sites based in New Orleans. The National Trust continued to post updates on its Internet site PreservationNation.20

In June 2008, the FHL commissioned the Philadelphia office of the U.K. firm RMJM Hillier to assess the feasibility of preserving and redeveloping Big Charity into a state-of-the-art medical facility. Their report, released in September 2008, concluded that the facility could be rebuilt from within with a new atrium lobby in three years at a cost of $484 million. Building a new replacement would take five years and cost at least $620 million. No property owners would be displaced. The hospital's building envelope, exterior walls, windows, and roof were fully recoverable. The structural system was sound and this fact alone would save two years off the construction timeline. The building’s footprint, with its Haiphage, fully complied with 'modern hospital design goals of enhancing daylighting and providing views from all rooms' (Figure 5.2). Up to 446 inpatient all-private rooms would be provided (see Chapter 4). The existing floor plates were workable for a first-class health facility, except for the third floor,
The evolving role of memory, place, sustainability

which the A/E team proposed enlarging (Figure 5.3). The report recommended the new DVA hospital should be built on a smaller site that did not require the destruction of the historic homes and businesses in the nearby Lower Mid-City neighborhood (Figure 5.4). The report also cited the value of retaining an historic neighborhood that provided ample affordable housing for thousands of healthcare workers and others within close walking distance of a revived medical district. These positive outcomes were cited as being in keeping with sustainable and ecologically sound architectural and urban design principles.23

The RMJM Hillier report stated, in part:

Before Katrina, all floors of Charity Hospital were in use. Newly renovated facilities sat next to outdated, noncompliant departments. Hazardous materials such as asbestos, lead and mold, as well as outdated mechanical systems were a major concern. The fact that the facility had to remain up and running made needed renovations almost impossible … without massive temporary relocations of departments and the disruption that such an approach would cause. Now that the building has been vacated, a new opportunity presents itself … the condition assessment findings demonstrate that many issues requiring remediation affect the building as a whole … The design team concludes that the best approach is to address the entire Charity structure, with a comprehensive, innovative design that would allow a permanent re-use of the core and shell of the building, provide state-of-the-art facilities and amenities for a modern hospital and Level 1 trauma facility, and respect and enhance significant historic features. This comprehensive renovation work would use available funds promptly and effectively, and be completed within three and a half years – quicker than it would take to build a new structure, and at lower cost. This approach also takes advantage of existing associated structures on adjacent sites in order to house necessary support systems.

It continued:

Using the existing infrastructure of tunnels, utilities and bridges that connect these sites, support facilities would be upgraded to meet current code requirements … its revitalization will be an important step in the redevelopment of New Orleans, reinforcing the value of sustainability – not demolition and social displacement – as a key component … It also underscores how sound preservation principles can be creatively integrated with modern design parameters, including the most stringent healthcare requirements. The rich history of the architecture in the city is a fundamental part of the city’s success, and there can be no better example of leadership and commitment to sustainability, redevelopment and growth in areas ravaged by Katrina, than the re-use of a nationally significant and iconic historic landmark, such as Old Charity.24

The reinvented Big Charity would have a new glass-enclosed atrium front court facing Tulane Avenue, with a curb cut and drive at the main gateway (Figure 5.5). A pair of well-composed and ornamented one-level sentry structures flank the entry in the courtyard leading to the main entrance. These were originally used for outpatient services and a dispensary. They would now become a bookstore and a pharmacy (Figure 5.6). The atrium would allow for dramatic views of the front facade (Figure 5.7) and all renovation and restoration work would be in conformance with the U.S. Secretary of the Interior’s Standards for the Treatment of Historic Structures (1995). The 150-page RMJM Hillier report to the FHL contained schematic floor plans of all levels, elevations, and building sections, as well as a detailed floor-by-floor narrative.25

The Main Level plan indicates all vertical circulation systems would be reorganized to allow for distinct separation between staff and support services and direct patient care services. Visitor elevators would be reoriented towards the main entrance. All infrastructure...
which the A/E team proposed enlarging (Figure 5.3). The report recommended the new DVA hospital should be built on a smaller site that did not require the destruction of the historic homes and businesses in the nearby Lower Mid-City neighborhood (Figure 5.4). The report also cited the value of retaining an historic neighborhood that provided ample affordable housing for thousands of healthcare workers and others within close walking distance of a revived medical district. These positive outcomes were cited as being in keeping with sustainable and ecologically sound architectural and urban design principles.23

The RMJM Hillier report stated, in part:

Before Katrina, all floors of Charity Hospital were in use. Newly renovated facilities sat next to outdated, noncompliant departments. Hazardous materials such as asbestos, lead and mold, as well as outdated mechanical systems were a major concern. The fact that the facility had to remain up and running made needed renovations almost impossible … without massive temporary relocations of departments and the disruption that such an approach would cause. Now that the building has been vacated, a new opportunity presents itself … the condition assessment findings demonstrate that many issues requiring remediation affect the building as a whole … The design team concludes that the best approach is to address the entire Charity structure, with a comprehensive, innovative design that would allow a permanent re-use of the core and shell of the building, provide state-of-the-art facilities and amenities for a modern hospital and Level 1 trauma facility, and respect and enhance significant historic features. This comprehensive renovation work would use available funds promptly and effectively, and be completed within three and a half years – quicker than it would take to build a new structure, and at lower cost. This approach also takes advantage of existing associated structures on adjacent sites in order to house necessary support systems.

It continued:

Using the existing infrastructure of tunnels, utilities and bridges that connect these sites, support facilities would be upgraded to meet current code requirements … its revitalization will be an important step in the redevelopment of New Orleans, reinforcing the value of sustainability – not demolition and social displacement – as a key component … it also underscores how sound preservation principles can be creatively integrated with modern design parameters, including the most stringent healthcare requirements. The rich history of the architecture in the city is a fundamental part of the city’s success, and there can be no better example of leadership and commitment to sustainability, redevelopment and growth in areas ravaged by Katrina, than the re-use of a nationally significant and iconic historic landmark, such as Old Charity.24

The reinvented Big Charity would have a new glass-enclosed atrium front court facing Tulane Avenue, with a curb cut and drive at the main gateway (Figure 5.5). A pair of well-composed and ornamented one-level sentry structures flank the entry in the courtyard leading to the main entrance. These were originally used for outpatient services and a dispensary. They would now become a bookstore and a pharmacy (Figure 5.6). The atrium would allow for dramatic views of the front facade (Figure 5.7) and all renovation and restoration work would be in conformance with the U.S. Secretary of the Interior’s Standards for the Treatment of Historic Structures (1995). The 150-page RMJM Hillier report to the FHL contained schematic floor plans of all levels, elevations, and building sections, as well as a detailed floor-by-floor narrative.25

The Main Level plan indicates all vertical circulation systems would be reorganized to allow for distinct separation between staff and support services and direct patient care services. Visitor elevators would be reoriented towards the main entrance. All infrastructure
support would be housed on the first level and above in order for the hospital to remain functional in a catastrophic event. The Basement Level would provide the option for below grade parking. The Main Level would house the Level 1 Trauma Center and related support functions.

The Second Level would house the center for interventional procedures, surgical pre- and post-op, and diagnostic imaging, including radiation therapy. The Third Level would house an 8-bed labor and delivery (LDR) unit, and a 22-bed postpartum unit and related support. The Fourth Level would be strictly devoted to mechanical support, functioning as an interstitial floor. Levels 5 to 12 would be reconfigured to single bed inpatient patient care units (PCU) and associated support functions. The Fifth Level would house a 24-bed women’s services unit, endoscopy, and a 24-bed clinical research center IP unit. Levels 6 to 8 would house PCUs – each floor with two 24-bed units – 16-bed ICUs, and related support. Levels 9 and 10 would house additional PCUs, dialysis and rehabilitation services, and the CIU. Level 11 would house an on-call suite, pulmonary services, patient escort unit, environmental services, staff lounge, biomedical engineering, and the central pharmacy. Level 12 would house two 30-bed behavioral health units and related support. Level 13 would house an 18-bed acute behavioral health unit. Levels 14 to 20 would house the administration and support, including an auditorium on the top floor.

The patient rooms within the various PCUs would all be same-handed, identical rooms in terms of their layout. As discussed in Chapter 4, this strategy was preferable and in keeping with current national best practices in nursing care compared to mirror-image A/B A/B inpatient rooms (with back-to-back patient headwalls). The patient room would be fully standardized in all respects. The architects acknowledged, however, that this method at this time was yet to be definitively proven as ‘safer’ for the patient. However, the RMJM Hiller team asserted that as more hospitals were built in this manner in the next few years, nursing-based medical errors in the PCU setting were likely to decrease significantly (Figure 5.8). Moreover, the slight shift, or angling, in plan, of the all-private inpatient rooms would yield a sawtooth pattern along the corridors, yielding additional privacy for patients and family (Figure 5.9).
support would be housed on the first level and above in order for the hospital to remain functional in a catastrophic event. The Basement Level would provide the option for below grade parking. The Main Level would house the Level 1 Trauma Center and related support functions.

The Second Level would house the center for interventional procedures, surgical pre- and post-op, and diagnostic imaging, including radiation therapy. The Third Level would house an 8-bed labor and delivery (LDR) unit, and a 22-bed postpartum unit and related support. The Fourth Level would be strictly devoted to mechanical support, functioning as an interstitial floor. Levels 5 to 12 would be reconfigured to single bed inpatient patient care units (PCU) and associated support functions. The Fifth Level would house a 24-bed women’s services unit, endoscopy, and a 24-bed clinical research center IP unit. Levels 6 to 8 would house PCUs – each floor with two 24-bed units – 16-bed ICUs, and related support. Levels 9 and 10 would house additional PCUs, dialysis and rehabilitation services, and the CTU. Level 11 would house an on-call suite, pulmonary services, patient escort unit, environmental services, staff lounge, biomedical engineering, and the central pharmacy. Level 12 would house two 30-bed behavioral health units and related support. Level 13 would house an 18-bed acute behavioral health unit. Levels 14 to 20 would house the administration and support, including an auditorium on the top floor.

The patient rooms within the various PCUs would all be same-handed, identical rooms in terms of their layout. As discussed in Chapter 4, this strategy was preferable and in keeping with current national best practices in nursing care compared to mirror-image A/B A/B inpatient rooms (with back-to-back patient headwalls). The patient room would be fully standardized in all respects. The architects acknowledged, however, that this method at this time was yet to be definitively proven as ‘safer’ for the patient. However, the RMJM Hiller team asserted that as more hospitals were built in this manner in the next few years, nursing-based medical errors in the PCU setting were likely to decrease significantly (Figure 5.8). Moreover, the slight shift, or angling, in plan, of the all-private inpatient rooms would yield a sawtooth pattern along the corridors, yielding additional privacy for patients and family (Figure 5.9).
The Section 106 Review

The mission of FEMA is to function as a first responder agency to provide emergency disaster relief for victims of national disasters and related emergencies. FEMA is quick to point out that it is not in the hospital construction business. In the context of historic preservation, however, FEMA is empowered by the U.S. Congress to assure that any disaster mitigation funds it dispenses to organizations and municipalities locally do not occur in a manner that violates federal policies and mandates. In Katrina’s aftermath, FEMA opened a large New Orleans field office. FEMA is mandated by the U.S. Congress to comply with the provisions of the Section 106 Review process. This legislation is administered by the Advisory Council on Historic Preservation, an independent federal agency that promotes preservation nationally by providing a forum for influencing federal actions, programs, and policies that impact historic properties. As part of the National Historic Preservation Act (NHPA) of 1966, Section 106 of NHPA is a critical component. It is because it requires

The consideration of historic preservation in the multitude of federal actions that occur nationwide… the Section 106 Review encourages, but does not mandate, preservation… [it] ensures that preservation factors are factored into federal agency planning and decision making. Because of Section 106, federal agencies must assume responsibility for the consequences of their actions on historic properties and be publicly accountable for their decisions. At the state level of government, the State of Louisiana operates the State Historic Preservation Office (SHPO). This agency is under the auspices of the governor and is housed within and staffed by the Lieutenant Governor’s office. In each of the fifty states, the SHPO coordinates the state’s historic preservation program and consults with federal and local agencies during the Section 106 Review process. It issues independent reports and recommendations that are a key component in the Section 106 Review. The Louisiana Office of Community Development (OCD) is an organization within the State of Louisiana Division of Administration. The primary goal of the OCD is to improve the quality of life of the state’s residents through its three programs: the Community Development Section, the Disaster Recovery Unit, and the Local Government Assistance Program. Grants are administrated to local organizations by these entities.

The Section 106 Review centered on more than 150 National Register-listed historic homes situated within the 71-acre neighborhood slated for destruction. The neighborhood includes, specifically, the historic Dixie Brewery (1922–1926) on Tulane Avenue, and the modernist landmark former Pan American Life Building (1961–1963) on Canal Street. The aforementioned Memorandum of Understanding (MOU) signed a year earlier between the DVA, the city, and LSU committed the city and state to spend up to $79 million to acquire and completely ‘cleanslate’ the site of all structures. A series of ‘information gathering’ meetings were held with affected residents. This ‘consultative phase’, as FEMA calls it, appeared, at least on the surface to casual observers, to be above board and properly conducted, but opponents suspected that something was amiss from the outset. Opponents contended that while it appeared on the surface and from a public relations standpoint that FEMA and the SHPO had properly conducted the Section 106 Review, actually these two entities were put under intense political pressure to support 100 percent the MOU signed by LSU, the VA, and the City of New Orleans. Second, opponents contended that the impacted neighborhood’s residents had been dismissed in the Section 106 Review. Grass-roots preservationists and the National Trust argued that it would be entirely feasible to relocate intact dwellings to vacant tracts in adjoining residential areas presently offering a multitude of available existing vacant lots at a relatively low cost or, better yet, to simply close the alternate site that was offered and remained available nearby – a site that did not require the demolition of a single historic building or forcibly relocate a single citizen.

The Section 106 Review concluded that the LSU and the VA had properly gone through the motions and were therefore on solid legal ground to pursue their vision. Opponents, however, contested this conclusion. Also, this ruling now qualified LSU to receive the disaster mitigation funds they were counting on to build their hospital. In a letter to the State of Louisiana Legislative Appropriations Committee on Health and Human Services, dated 4 December 2008, Sandra Stokes, of the Foundation for Historical Louisiana, wrote:

I would like to thank you for your graciousness in the aftermath of the Charity Hospital incident on Tuesday 2 December 2008 when the Foundation for Historical Louisiana (FHL) and the principal architect from RMJM Hillier, along with a physician, were excluded from attending the inspection of the Charity Hospital building in New Orleans by the House Committee on Appropriations, Subcommittee on Health and Human Services. We were obviously surprised and disappointed that we were unable to observe or participate in the committee’s tour of the building. We have accumulated a great deal of information about the building, its condition and its future viability as a re-built medical center. We thank you for your interest and concern regarding this important issue and we await the opportunity to present the findings of the Charity Hospital feasibility study in a public hearing before your committee.

We do wish to state what we observed regarding the events which transpired at Charity Hospital. The FHL and the architects responsible for the independent study for re-use and adaptation of Charity Hospital were invited by state representatives to explain parts of the study on site. We were stopped at the door by Charles Zewe, spokesperson for LSU, saying ‘I strongly object to you being here.’ When asked exactly who was blocking our entry, Mr. Zewe replied ‘I’m stopping you, on behalf of LSU.’ He also said the tour was only for representatives, even though we observed other non-representatives had been allowed entry. We observed that Mr. Jim McNamara, who is not a state representative and is an active advocate for building a new LSU hospital, was allowed through the doors after this encounter. When we asked Mr. Zewe about this discrepancy, Mr. Zewe said Mr. McNamara was an invited guest of LSU. It was very clear to us that LSU was actively acting as a gatekeeper on who would be permitted into the building.

It is our understanding that the issue regarding state funding of LSU’s plan to abandon the Charity building as a medical center and build a brand new hospital is very much an open question at this point in time. We are aware (however) of LSU’s public position that the issue is ‘closed’ and that LSU is planning on proceeding with construction. If this is true why would the committee have gone to Charity Hospital to seek information on 2 December?

It is our understanding that, despite these statements, the financial issues underlying this project are still very much unresolved. We are especially concerned that the actual cost of this LSU proposed project greatly exceeds what has been publicly stated ($1.2 billion). Further, LSU’s refusal to seriously consider the less costly and more expedient alternative of restoring the existing Charity Hospital building has serious consequences both financially and with regard to timely restoration of accessible health care in New Orleans. We look forward to a full and open discussion on this important issue. We are also available to revisit the Charity Hospital site with the committee should that be helpful in this process.

Of most urgent concern is that the U.S. Department of Veteran Affairs has announced selection of a site co-located to the proposed new LSU hospital site in New Orleans. We believe the selection of this site by the VA was heavily influenced by LSU’s public statement of their intention to build the new LSU hospital. If the VA builds on the site selected, and the state does not proceed with LSU’s new hospital, the VA will be left isolated from the Medical District. From a public health perspective since the location of these two hospitals will require the demolition of hundreds of historic buildings, including private homes and businesses, covering 71 acres in Lower Mid-City the State has agreed to carry out the expropriations of these homes and businesses on behalf of the City of New Orleans. Based on the representation...
The Section 106 Review

The mission of FEMA is to function as a first responder agency to provide emergency disaster relief for victims of national disasters and related emergencies. FEMA is quick to point out that it is not in the hospital construction business. In the context of historic preservation, however, FEMA is empowered by the U.S. Congress to comply with the provisions of the Section 106 Review process. This legislation is administered by the Advisory Council on Historic Preservation, an independent federal agency that promotes preservation nationally by providing a forum for influencing federal policies, programs, and actions that impact historic properties. As part of the National Historic Preservation Act (NHPA) of 1966, Section 106 of NHPA is a critical component.28 This is because it requires: (1) ensures that preservation factors are factored into federal actions that occur nationwide ... the Section 106 Review encourages, but does not mandate, preservation ... [it] exists separately from ... The Section 106 Review process centered on more than 150 National Register-listed historic homes situated within the 71-acre neighborhood slated for destruction. The neighborhood includes, specifically, the historic Dixie Brewery (1922–1926) on Tulane Avenue, and the historic Pan American Life Building (1961–1963) on Canal Street. The aforementioned Memorandum of Understanding (MOU) signed a year earlier between the DVA, the city, and LSU committed the city and state to spend up to $79 million to acquire all ... [it] is our understanding that the issue regarding state funding ... The issue has been quite controversial since the location of these two hospitals will require the demolition of hundreds of historic buildings, including private homes and businesses, covering 71 acres in Lower Mid-City. The State has agreed to carry out the expropriations of these homes and businesses on behalf of the City of New Orleans. Based on the representation ...
that the new LSU hospital is a ‘done deal’ demolitions of homes will begin soon in the densest part of this historic neighborhood. The citizens who are facing the loss of their homes and businesses are the same people who were encouraged to come back and rebuild after Katrina. They struggled to reestablish their community, only to now face losing their homes again – this time to bulldozers. Many of these taxpayer citizens have stated their intention to leave the state altogether if these expropriations go forward. If, in fact, the best solution is to restore and reuse Charity Hospital as the site for the LSU hospital, the location of the VA hospital needs to be reconsidered and reconfigured. There is urgency to this matter, as the VA has announced its intention to proceed. The VA has assured all parties in the Federal Section 106 Historic Preservation Review process that they are committed to building in New Orleans. There are other alternatives that could be a win-win for everyone.

The vacant Charity Hospital building presents an opportunity the State has never had before: the complete transformation of a historically significant icon into a world-class medical facility. The building is currently unoccupied. This is a new, extremely rare opportunity that allows the entire building to be gutted. The one million square foot, structurally sound shell could be fitted out into a modern, sustainable medical marvel. Such a restoration would send an important message about the progressive stance of the State of Louisiana in the preservationist, the Mid-City Neighborhood Organization, campaign to discredit the countervailing arguments of the local grass-roots preservationists, the Mid-City Neighborhood Organization, the City of New Orleans, the Louisiana State University, and other opponents of the proposed complex. ‘It’s going to be tough to get this project built, it’s always been tough,’ LSU spokesman Charles Zeew said, ‘And we are fiercely sick and tired of people trying to define us as secretive, mean-spirited and focused only on the aggrandizement of the institution … We’re simply not going to stand for it anymore.’

The newspaper account continued:

Meanwhile, as this controversy grew in intensity, the VA, authorized to build a 200-bed facility, was, behind the scenes, quietly being courted by another healthcare provider organization in the metro area (Ochsner Medical Foundation Hospital) and beyond (the community of Gulfport, Mississippi). Ochsner offered the VA a parcel of land directly across the street from its main campus on Jefferson Highway just across the Orleans Parish (County) line in Jefferson Parish. Jefferson Parish has a long history although the vast majority of its growth occurred in the post-World War II period and it is now a suburban community. Its population totals more than 600,000 at present. As politicians in the region became aware of the fracas, the citizens also sought to woo the VA to their turf. The U.S. congressional delegation from the Mississippi Gulf Coast region made a pitch for the new VA medical center to be built in their district. This would place it as far as 75 miles from downtown New Orleans. This strategy would be counterintuitive to the avowed goal of then-President George W. Bush to do whatever it takes to rebuild New Orleans, as he proclaimed two weeks after Katrina in front of a held-erect speech St. Louis Cathedral, while the entirety of the city remained desolate and without electrical power.

On 29 January 2008 a pro-new hospital letter was published in the local daily newspaper, The Times-Picayune, authored by John Lombardi, the president of the LSU System. His editorial reiterated the same argument that had been made for months – in fact from the days immediately following Katrina in the fall of 2005. It was a propaganda war at this point that was being waged by LSU. The newspaper (and the public) lapped it up like a cat goes for fresh spilt milk.

Louisiana State University proceeded to launch a public relations campaign to discredit the countervailing arguments of the local grassroots preservationists, the Mid-City Neighborhood Organization, the City of New Orleans, the Louisiana State University, and other opponents of the proposed complex. ‘It’s going to be tough to get this project built, it’s always been tough,’ LSU spokesman Charles Zeew said, ‘And we are fiercely sick and tired of people trying to define us as secretive, mean-spirited and focused only on the aggrandizement of the institution … We’re simply not going to stand for it anymore.’

The leadership of LSU engaged in questionable decision-making. ‘Their attitude has been, “If we get any opposition, we’ll just attack the opposition,”’ Zeew said. LSU (and the VA) are proposing a $1.2 billion academic medical complex that would be built on a 71-acre footprint bounded by Claiborne Avenue, Tulane Avenue, Rochelle Street and Canal Street. Local preservation groups are pushing the VA to build in the lower nine blocks of the larger footprint, with LSU rebuilding a new hospital from within the shell of Charity Hospital … the plan calls for LSU also to assume control of the old VA campus, which sits across Gravier Street from Charity.’

The case of Big Charity demonstrates that urban redevelopment and building analyses, federal environmental reviews, transcripts of review sessions convened under federal historic preservation law and letters from both sides making their cases to state and federal lawmakers … [state officials] also refute the idea that Charity could be gutted and rebuilt in less time and for less money than a new hospital, insisting that architects and builders who say so are understating the cost of rehabilitating a 70-year-old building. Zeew said the idea of a refurbished Charity is “laughable nonsense.” When preservationists invited LSU and VA officials to speak alongside them at a series of neighborhood meetings to discuss the project, LSU and the VA declined … These [preservationist] groups have gone from historical to hysterical … It’s time to move on with this.” Zeew said.

The paper also noted: “Urban myth had it that the facility that the faculty had fallen into obsolescence, especially in the view of local citizens who had private medical

Historic hospitals and the need for confluence

The case of Big Charity demonstrates that urban redevelopment and building analyses, federal environmental reviews, transcripts of review sessions convened under federal historic preservation law and letters from both sides making their cases to state and federal lawmakers … [state officials] also refute the idea that Charity could be gutted and rebuilt in less time and for less money than a new hospital, insisting that architects and builders who say so are understating the cost of rehabilitating a 70-year-old building. Zeew said the idea of a refurbished Charity is “laughable nonsense.” When preservationists invited LSU and VA officials to speak alongside them at a series of neighborhood meetings to discuss the project, LSU and the VA declined … These [preservationist] groups have gone from historical to hysterical … It’s time to move on with this.” Zeew said.

Sadly, and paradoxically, in the aftermath of Katrina, New Orleans experienced the destruction of its twentieth-century architectural landmarks at an accelerated and alarming rate, at a time when every extra effort should have been made to preserve landmark buildings from the city’s long legacy of world-renowned architecture. Many important buildings worthy of placement on the National Register have already fallen to the wrecking ball, post-Katrina, including the modest masterpiece St. Frances Cabrini Church, designed by the firm of Curtis & Davis (1960–1963). If a city’s urban landscape is the manifestation of its citizens’ shared sense of pride and identity, its historic buildings nestling within, then the conservation of this heritage should be first and foremost on the civic agenda.

At the time of writing the outcome of this controversy was yet to be determined although there were some signs that a growing number of local and state officials were beginning to listen to the arguments made by the by-then 30 or more various preservation, and healthcare advocacy, organizations in the battle to save Charity Hospital. Above all, ironically, more than 50 percent of the funding needed for the LSU/HSC replacement hospital proposal remained unspent.22

At the time of writing the outcome of this controversy was yet to be determined although there were some signs that a growing number of local and state officials were beginning to listen to the arguments made by the by-then 30 or more various preservation, and healthcare advocacy, organizations in the battle to save Charity Hospital. Above all, ironically, more than 50 percent of the funding needed for the LSU/HSC replacement hospital proposal remained unspent.22

Historic hospitals and the need for confluence

The case of Big Charity demonstrates that urban redevelopment and building analyses, federal environmental reviews, transcripts of review sessions convened under federal historic preservation law and letters from both sides making their cases to state and federal lawmakers … [state officials] also refute the idea that Charity could be gutted and rebuilt in less time and for less money than a new hospital, insisting that architects and builders who say so are understating the cost of rehabilitating a 70-year-old building. Zeew said the idea of a refurbished Charity is “laughable nonsense.” When preservationists invited LSU and VA officials to speak alongside them at a series of neighborhood meetings to discuss the project, LSU and the VA declined … These [preservationist] groups have gone from historical to hysterical … It’s time to move on with this.” Zeew said.

The leadership of LSU engaged in questionable decision-making. ‘Their attitude has been, “If we get any opposition, we’ll just attack the opposition,”’ Zeew said. LSU (and the VA) are proposing a $1.2 billion academic medical complex that would be built on a 71-acre footprint bounded by Claiborne Avenue, Tulane Avenue, Rochelle Street and Canal Street. Local preservation groups are pushing the VA to build in the lower nine blocks of the larger footprint, with LSU rebuilding a new hospital from within the shell of Charity Hospital … the plan calls for LSU also to assume control of the old VA campus, which sits across Gravier Street from Charity.’

The newspaper account continued:

Behind the back-and-forth are reams of competing architectural and building analyses, federal environmental reviews, transcripts of review sessions convened under federal historic preservation law and letters from both sides making their cases to state and federal lawmakers … [state officials] also refute the idea that Charity could be gutted and rebuilt in less time and for less money than a new hospital, insisting that architects and builders who say so are understating the cost of rehabilitating a 70-year-old building. Zeew said the idea of a refurbished Charity is “laughable nonsense.” When preservationists invited LSU and VA officials to speak alongside them at a series of neighborhood meetings to discuss the project, LSU and the VA declined … These [preservationist] groups have gone from historical to hysterical … It’s time to move on with this.” Zeew said.

The case of Big Charity demonstrates that urban redevelopment and building analyses, federal environmental reviews, transcripts of review sessions convened under federal historic preservation law and letters from both sides making their cases to state and federal lawmakers … [state officials] also refute the idea that Charity could be gutted and rebuilt in less time and for less money than a new hospital, insisting that architects and builders who say so are understating the cost of rehabilitating a 70-year-old building. Zeew said the idea of a refurbished Charity is “laughable nonsense.” When preservationists invited LSU and VA officials to speak alongside them at a series of neighborhood meetings to discuss the project, LSU and the VA declined … These [preservationist] groups have gone from historical to hysterical … It’s time to move on with this.” Zeew said.
that the new LSU hospital is a ‘done deal’ demolitions of homes will begin soon in the densest part of this historic neighborhood. The citizens who are facing the loss of their homes and businesses are the same people who were encouraged to come back and rebuild after Katrina. They struggled to reestablish their community, only to now face losing their homes again – this time to bulldozers. Many of these taxpaying citizens have stated their intention to leave the state altogether if these expropriations go forward. If, in fact, the best solution is to restore and reuse Charity Hospital as the site for the LSU hospital, the location of the VA hospital needs to be reconsidered and refigured. There is urgency to this matter, as the VA has announced their intention to proceed. The VA has assumed all parties in the Federal Section 106 Historic Preservation Review process that they are committed to building in New Orleans. There are other alternatives that could be a win-win for all.

The vacant Charity Hospital building presents an opportunity for the State has never had before: the complete transformation of a historically significant icon into a world-class medical facility. The building is currently unoccupied. This is a new, extremely rare opportunity that allows the entire building to be gutted. The one million square foot, structurally sound shell could be fitted out into a modern, sustainable medical facility. The building is currently unoccupied. This is a new, potentially exciting opportunity for the VA to build on a much less expensive, time-consuming and destructive option. Meanwhile, as this controversy grew in intensity, the VA, authorized to build a 200-bed facility, was, behind the scenes, quietly being courted by another healthcare provider organization in the metro area (Ochsner Medical Foundation Hospital) and beyond (the community of Gulfport, Mississippi). Ochsner offered the VA a parcel of land directly across the street from its main campus on Jefferson Highway just across the Orleans Parish (County) line in Jefferson Parish. Jefferson Parish has had a long history although the vast majority of its growth occurred in the post-WWII period and it is now a suburban community. Its population totals more than 600,000 at present. As politicians in the region became aware of the fracas they also sought to woo the VA to their turf. The U.S. congressional delegation from the Mississippi Gulf Coast region made a pitch for the new VA medical center to be built in their district. This would place it as far as 75 miles from downtown New Orleans. This strategy would be counterintuitive to the avowed goal of then-President George W. Bush to do ‘whatever it takes’ to rebuild New Orleans, as he put it in his September 2005 address to the nation. Meanwhile, Katrina was evidence that the VA needed to build in New Orleans. The VA has assured all parties in the Federal process that they are committed to building in New Orleans. There are other alternatives that could be a win-win for all.

If, in fact, the best solution is to restore and reuse Charity Hospital as the site for the LSU hospital, the location of the VA hospital needs to be reconsidered and refigured. There is urgency to this matter, as the VA has announced their intention to proceed. The VA has assumed all parties in the Federal Section 106 Historic Preservation Review process that they are committed to building in New Orleans. There are other alternatives that could be a win-win for all.

The vacant Charity Hospital building presents an opportunity for the State has never had before: the complete transformation of a historically significant icon into a world-class medical facility. The building is currently unoccupied. This is a new, extremely rare opportunity that allows the entire building to be gutted. The one million square foot, structurally sound shell could be fitted out into a modern, sustainable medical facility. The building is currently unoccupied. This is a new, potentially exciting opportunity for the VA to build on a much less expensive, time-consuming and destructive option. Meanwhile, as this controversy grew in intensity, the VA, authorized to build a 200-bed facility, was, behind the scenes, quietly being courted by another healthcare provider organization in the metro area (Ochsner Medical Foundation Hospital) and beyond (the community of Gulfport, Mississippi). Ochsner offered the VA a parcel of land directly across the street from its main campus on Jefferson Highway just across the Orleans Parish (County) line in Jefferson Parish. Jefferson Parish has had a long history although the vast majority of its growth occurred in the post-WWII period and it is now a suburban community. Its population totals more than 600,000 at present. As politicians in the region became aware of the fracas they also sought to woo the VA to their turf. The U.S. congressional delegation from the Mississippi Gulf Coast region made a pitch for the new VA medical center to be built in their district. This would place it as far as 75 miles from downtown New Orleans. This strategy would be counterintuitive to the avowed goal of then-President George W. Bush to do ‘whatever it takes’ to rebuild New Orleans, as he put it in his September 2005 address to the nation. Meanwhile, Katrina was evidence that the VA needed to build in New Orleans. The VA has assured all parties in the Federal process that they are committed to building in New Orleans. There are other alternatives that could be a win-win for all.

Historic hospitals and the need for confluence

The case of Big Charity demonstrates that urban redevelopment and on-the-ground realities sometimes do not share the same universe. Let us first examine the role of urban redevelopment from the standpoint of cultural cleansing and how this may relate to carbon neutrality. Voltaire once said that it was dangerous to be right in matters on which the established authorities are wrong. Unbridled power is an intoxicant. The leadership of LSU engaged in questionable decision-making and it is arguable that the seeds of their motivation to abandon Charity had been planted by the public consciousness years before Katrina. Charity had for years prior to Katrina been underfunded and had, by default, become a model of hospital obsolescence. The institution muddled along with as little public operational funding as it could make and it is arguable that the seeds of their motivation to abandon Charity had been planted by the public consciousness years before Katrina. Charity had for years prior to Katrina been underfunded and had, by default, become a model of hospital obsolescence.

The newspaper account continued:

Behind the back-and-forth are reams of competing architectural and building analyses, federal environmental reviews, transcripts of review sessions convened under federal historic preservation law and letters from both sides making their cases to state and federal lawmakers […] (state officials) also refuse the idea that Charity could be gutted and rebuilt in less time and for less money than a new hospital, insisting that architects and builders who say so are underestimating the ease of rehabilitating a 70-year-old building. Zewe said the idea of a refurbished Charity is “farfetched nonsense.” When preservationists invited LSU and VA officials to speak alongside them at a series of neighborhood meetings to discuss the project, LSU and the VA declined. … These [preservationists] groups have gone from historical to hysterical … It’s time to move on with this.” Zewe said.

The case of Big Charity demonstrates that urban redevelopment and on-the-ground realities sometimes do not share the same universe. Let us first examine the role of urban redevelopment from the standpoint of cultural cleansing and how this may relate to carbon neutrality. Voltaire once said that it was dangerous to be right in matters on which the established authorities are wrong. Unbridled power is an intoxicant. The leadership of LSU engaged in questionable decision-making and it is arguable that the seeds of their motivation to abandon Charity had been planted by the public consciousness years before Katrina. Charity had for years prior to Katrina been underfunded and had, by default, become a model of hospital obsolescence. The institution muddled along with as little public operational funding as it could make and it is arguable that the seeds of their motivation to abandon Charity had been planted by the public consciousness years before Katrina. Charity had for years prior to Katrina been underfunded and had, by default, become a model of hospital obsolescence.
insurance. At least ten years prior to Katrina (1999) the administration publicly stated its interest to build a replacement facility.4 However, no money was forthcoming from the state legislature. In addition, the public had come to regard Charity as at best a second-tier hospital, because it cared for mostly poor African-Americans. Unfortunately, issues of race and class inequities constituted the heart of this myth, two factors historically at the root of everything in New Orleans throughout its 300-year history. The effects of this policy were clearly visible even to the casual observer. The interior was dated. It was drab in appearance. Charity Hospital looked tired, as if it was hanging on by a thread. Because of this, the middle and upper classes in the metro area developed a very negative overall image of the hospital.

To critics, Katrina was seen as a godsend for the LSU administration. It was their once-in-a-lifetime chance to get out of Big Charity. More importantly, the possibility that FEMA might actually foot the bill for a new hospital was simply too irresistible to pass on. The LSU public relations spin put on the flood damage was instantaneous and consistent from the first week after the catastrophe (exactly the same strategy as that taken by the Archdiocese of New Orleans in the case of Cabrini Church). Their PR machine proclaimed the hospital was destroyed and unsalvageable. With this justification LSU felt justified in its decision to padlock the hospital and declare it a total loss. There would be one small complication to their logic: the FEMA/Stafford Act’s 51 percent rule.42

The FEMA 51 percent rule reads that any structure that is damaged in a federal declared disaster zone is eligible for total replacement costs if it is declared to be 51 percent or more destroyed. Of course, public relations people declared the hospital totaled, so they, from that point on, had banked on the full replacement cost. The new flood damage was the perfect excuse to do so. Thousands of old buildings were eradicated from the urban landscape in the months and years after the disaster, and this number included many nationally significant buildings. It was not unlike the aftermath of a war.43 In addition to the art deco period landmarks, it seemed now that post-World War II modernism was also under attack. The city’s modernist landmarks became easy prey.44 Modernist landmarks destroyed as a result of this demonstration of post-Katrina irrational exuberance included the aforementioned St. Francis Cabrini Church, the Longshoremen’s Building on South Claiborne Avenue, the State Supreme Court Building and adjacent State of Louisiana Office Building (both 1955–1957), a number of minimalist public elementary schools, and public libraries.45

Esther Charlesworth argues that architects miserably failed to provide effective reconstruction strategies for cities polarized by ethnic and economic conflict after World War II.46 She proposes architects should work as part of interdisciplinary teams (as in the battle to save Charity Hospital). She also argues that any planning process should be incremental and not governed by abstract, top-down bureaucratic machines, such as LSU, or the VA. Those who are fighting at the grass-roots level to save this neighborhood and this landmark hospital were being drowned out by a large chorus of ill-informed naysayers and anti-preservationists uninterested in hearing anything about compromise, uninterested in hearing anything about any both-and possibilities. As for Charlesworth’s second point, the hyperaccelerated race to abandon one (hospital), destroy another part of the city (the nearby neighborhood), the reckless FEMA-driven Section 106 Review, the LSU (and to a lesser extent VA) PR machine, and local and state elected officials’ desperation to build the new Charity ‘yesterday’ in an urban renewal through removal made meaningful discourse next to impossible.47

Now enter the role of carbon neutrality in this controversy. All of these lost buildings would be extremely expensive to build today from scratch.48 It would have been a far more sustainable strategy to simply renovate them and bring them back to life. It is interesting that in the chaotic, haphazard atmosphere of clean-up after Katrina virtually no flood or wind-damaged debris was recycled. Moreover, Charity Hospital and the targeted neighborhood deserved to be sustained and enhanced, not obliterated. It was a viable building in a viable community and this community had demonstrated it was resuscitating itself back to life, building-by-building, street-by-street. It did not help that the public’s ‘built environment literacy’ level was very low in general prior to Katrina and especially on the matter of saving Big Charity. But curiously, few in the general public attacked Charity as being ‘ugly’. Most of the public’s ire was directed towards its poor condition prior to Katrina. However, to critics, this was the strategic intention after Katrina.

Next, let us examine the role of evidence-based research and design for health in relation to the saga of Charity Hospital, and particularly from the standpoint of the goal of carbon neutral healthcare architecture in the twenty-first century. In the 1960s and 1970s the interstitials and airconditioning components of the high-tech megahospital convinced themselves their innovative building chasiss would remain functionally viable 100 years or more into the future. No evidence-based research was conducted at that time to support such claims. At the least, their vision of an ‘obsolete hospital was a radical reaction to the accelerating rate of facility obsolescence occurring in hospitals at the time. Their construction proved to be the costliest experiment in the entire history of hospital architecture. Their then-radical arguments were directly and intentionally framed against the generation of ‘obsolete’ high-rise Nightingale hospitals such as Charity. It was only later that we would cost so much to sustain these facilities because they consumed 30 to 40 percent more in annual energy consumption costs compared to their predecessors. To critics at the time, they were viewed as glutinous behemoths for their energy consumption (after the 1973 Arab Oil Embargo), and for their wayfinding challenges, overwhelming scale, and threatening appearance. Natural daylight and ventilation was limited due to the unprecedented widths of the floor templates. By contrast, as proven in the case of Charity Hospital, some surviving high-rise Nightingale hospitals remain beloved. Charity had attained urban mythical status. It was an icon. It is highly doubtful if this will ever be the case for the late-twentieth-century high-tech megahospital. Compared to the narrow footprint of the earlier skyscraper hospitals, the exaggerated massiveness of the building floor templates in intestinal and similar megahospitals is dysfunctional from a carbon neutrality standpoint. With so many departments now far away from a window and a view to the outside, or any chance for fresh air or natural light, even staff morale began to be adversely affected.49 More recently, attention has been redirected in the U.K. as to how these places can be operated with fewer toxic discharges, and modified based on safer construction practices. At the community scale parallel efforts are underway to reduce the number and length of automobile journeys to and from British hospitals and to locate health facilities in more walkable communities.50

It is too late to bring back the inventory of pre-World War II historic hospitals lost in countless cities (see Chapter 2).51 Historic hospitals such as Charity were demolished long ago in other parts of the U.S. to clear land for their replacements – all in the name of progress. As discussed above, myth perpetuation on the part of elected officials remains a political and cultural impediment to the challenges of an already mammoth rebuilding progress in post-Katrina New Orleans. These same myths also affected the inability to redeploy many neighborhood primary care clinics.52

A city’s urban landscape is the manifestation of its citizens’ shared sense of purpose, place, and identity.53 Charity Hospital – symbolizing the aforementioned myth of the city as part of a carbon neutral future – merits a second look. This and other surviving historic hospitals can have new lives (see Chapter 2).53 Historic hospitals such as Charity were demolished long ago in other parts of the U.S. to clear land for their replacements – all in the name of progress. As discussed above, myth perpetuation on the part of elected officials remains a political and cultural impediment to the challenges of an already mammoth rebuilding progress in post-Katrina New Orleans. These same myths also affected the inability to redeploy many neighborhood primary care clinics.53

A city’s urban landscape is the manifestation of its citizens’ shared sense of purpose, place, and identity.53 Charity Hospital – symbolizing the aforementioned myth of the city as part of a carbon neutral future – merits a second look. This and other surviving historic hospitals can have new lives (see Chapter 2).53 Historic hospitals such as Charity were demolished long ago in other parts of the U.S. to clear land for their replacements – all in the name of progress. As discussed above, myth perpetuation on the part of elected officials remains a political and cultural impediment to the challenges of an already mammoth rebuilding progress in post-Katrina New Orleans. These same myths also affected the inability to redeploy many neighborhood primary care clinics.53
Hayden argues that places such as Charity Hospital have proven to be at once ordinary, transcendent, and imitable. To critics, the dismissal of Charity post-Katrina was tantamount to an act of cultural cleansing and urban myth perpetuation. It was a strategy justified through a combination of expediency and opportunism. It symbolized the dismissal of the power of place, the premeditated dismantling of civic memory, and that of an African-American community so fundamentally woven into the tapestry of the city's long cultural history. Where LSU saw this as a win-win, others did not. It was a lose-lose proposition for those about to be forcibly displaced from their neighborhood, a lose-lose for the immediate neighborhood in the CBD where Charity now sits, and a lose-lose for a civic building that is among the most significant in the entire city. As mentioned, to critics public officials' apartheid towards Charity Hospital was deeply rooted in long-standing race- and class-based divisions. Most of the to-be-displaced residents of the targeted construction zone were African-American, as were nearly all of the patients (and many staff) who received care at Charity.

The strategy developed by LSU to abandon Charity has been used with regularity in post-Katrina New Orleans. It seemed that anyone who had wanted to tear down a building that they didn't like for whatever reason before Katrina now was able to use Katrina as the perfect excuse to do so. Thousands of old buildings were eradicated from the urban landscape in the months and years after the disaster, and this number included many nationally significant buildings. It was not unlike the aftermath of a war. In addition to the art deco period landmarks, it seemed now that post-World War II modernism was also under attack. The city's modernist landmarks became easy prey. Modernist landmarks destroyed as a result of this demonstration of post-Katrina irrational exuberance included the aforementioned St. Francis Cabrini Church, the Longshoremen's Building on South Claiborne Avenue, the State Supreme Court Building and adjacent State of Louisiana Office Building (both 1955–1957), a number of minimalist public elementary schools, and public libraries.

Aesthetic characteristics that architects mismeasured failed to provide effective reconstruction strategies for cities polarized by ethnic and economic conflict after World War II. It proposes architects should work as part of interdisciplinary teams (as in the battle to save Charity Hospital). She also argues that any planning process should be incremental and not governed by abstract, top-down bureaucratic machines, such as LSU, or the VA. Those who are fighting at the grass-roots level to save this neighborhood and this landmark hospital were being drowned out by a large chorus of ill-informed naysayers and anti-preservationists uninterested in hearing anything about compromise, uninterested in hearing anything about any both-and possibilities. As for Charleworth's second point, the hyperaccelerated race to abandon one (hospital), destroy another part of the city (the nearby neighborhood), the reckless FEMA-driven Section 106 Review, the LSU (and to a lesser extent VA) PR machine, and local and state elected officials' desperation to build the new Charity 'yesterday' in an urban renewal through removal made meaningful discourse next to impossible. Now enter the role of carbon neutrality in this controversy. All of these lost buildings would be extremely expensive to build today from scratch. It would have been a far more sustainable strategy to simply renovate them and bring them back to life. It is interesting that in the chaotic, hap hazard atmosphere of clean-up after Katrina virtually no flood or wind-damaged debris was recycled. Moreover, Charity Hospital and the targeted neighborhood deserved to be sustained and enhanced, not obliterated. It was a viable building in a viable community and this community had demonstrated it was resuscitating itself back to life, building-by-building, street-by-street. It did not help that the public's ‘built environment literacy’ level was very low in general prior to Katrina and especially on the matter of saving Big Charity. But curiously, few in the general public attacked Charity as being ‘ugly’. Most of the public’s ire was directed towards its poor condition prior to Katrina. However, to critics, this was the strategic intention after Katrina.

Next, let us examine the role of evidence-based research and design for health in relation to the saga of Charity Hospital, and particularly from the standpoint of the goal of carbon neutral healthcare architecture in the twenty-first century. In the 1960s and 1970s the interstitialists and ascendant components of the high-tech megahospital convinced themselves their innovative building chasms would remain functionally viable 100 years or more into the future. No evidence-based research was conducted at that time to prove otherwise. As mentioned, their vision of the future hyper-obsolescence hospital was a radical reaction to the accelerating rate of facility obsolescence occurring in hospitals at the time. Their construction proved to be the costliest experiment in the entire history of hospital architecture. Their then-radical arguments on the part of the goal of carbon neutral healthcare architecture in the twenty-first century, and this number included many nationally significant buildings. It was not unlike the aftermath of a war. In addition to the art deco period landmarks, it seemed now that post-World War II modernism was also under attack. The city's modernist landmarks became easy prey. Modernist landmarks destroyed as a result of this demonstration of post-Katrina irrational exuberance included the aforementioned St. Francis Cabrini Church, the Longshoremen's Building on South Claiborne Avenue, the State Supreme Court Building and adjacent State of Louisiana Office Building (both 1955–1957), a number of minimalist public elementary schools, and public libraries.

Claire Charleworth is a contemporary architect who advocates intelligent, mixed-income housing and community housing projects in an effort to prove effective reconstruction strategies for cities polarized by ethnic and economic conflict after World War II. She proposes architects should work as part of interdisciplinary teams (as in the battle to save Charity Hospital). She also argues that any planning process should be incremental and not governed by abstract, top-down bureaucratic machines, such as LSU, or the VA. Those who are fighting at the grass-roots level to save this neighborhood and this landmark hospital were being drowned out by a large chorus of ill-informed naysayers and anti-preservationists uninterested in hearing anything about compromise, uninterested in hearing anything about any both-and possibilities. As for Charleworth's second point, the hyperaccelerated race to abandon one (hospital), destroy another part of the city (the nearby neighborhood), the reckless FEMA-driven Section 106 Review, the LSU (and to a lesser extent VA) PR machine, and local and state elected officials' desperation to build the new Charity 'yesterday' in an urban renewal through removal made meaningful discourse next to impossible.

Now enter the role of carbon neutrality in this controversy. All of these lost buildings would be extremely expensive to build today from scratch. It would have been a far more sustainable strategy to simply renovate them and bring them back to life. It is interesting that in the chaotic, haphazard atmosphere of clean-up after Katrina virtually no flood or wind-damaged debris was recycled. Moreover, Charity Hospital and the targeted neighborhood deserved to be sustained and enhanced, not obliterated. It was a viable building in a viable community and this community had demonstrated it was resuscitating itself back to life, building-by-building, street-by-street. It did not help that the public's 'built environment literacy' level was very low in general prior to Katrina and especially on the matter of saving Big Charity. But curiously, few in the general public attacked Charity as being 'ugly'. Most of the public's ire was directed towards its poor condition prior to Katrina. However, to critics, this was the strategic intention after Katrina.

Next, let us examine the role of evidence-based research and design for health in relation to the saga of Charity Hospital, and particularly from the standpoint of the goal of carbon neutral healthcare architecture in the twenty-first century. In the 1960s and 1970s the interstitialists and ascendant components of the high-tech megahospital convinced themselves their innovative building chasms would remain functionally viable 100 years or more into the future. No evidence-based research was conducted at that time to prove otherwise. As mentioned, their vision of the future hyper-obsolescence hospital was a radical reaction to the accelerating rate of facility obsolescence occurring in hospitals at the time. Their construction proved to be the costliest experiment in the entire history of hospital architecture. Their then-radical arguments on the part of the goal of carbon neutral healthcare architecture in the twenty-first century.

A city's urban landscape is the manifestation of its citizens' shared sense of purpose, place, and identity. Charity Hospital – symbolizing the intersection of medical care, neighborhood, and urban myth – merits a second look. This and other surviving historic hospitals can have new lives (see Chapter 2). This is within this framework that historic preservation and sustainable healthcare design must be viewed as seamless, as one rather than two disparate or parallel endeavors. Without this, synchronicity will be unattainable. An older hospital located in an established neighborhood near to public transportation can lessen that institution's carbon footprint, compared to it being located somewhere/nowhere out on the suburban fringe far from consumption costs compared to their predecessors. To critics at the time, they were viewed as glutinous behemoths for their energy consumption (after the 1973 Arab-Oil Embargo), and for their wayfinding challenges, overwhelming scale, and threatening appearance. Natural daylight and ventilation was limited due to the unprereadized widths of the floor templates. By contrast, as proven in the case of Charity Hospital, some surviving high-rise Nightingale hospitals remain beloved. Charity had attained urban mythical status. It was an icon. It is highly doubtful if this will ever be the case for the late-twentieth-century high-tech megahospital. Compared to the narrow footprint of the earlier skyscraper hospitals, the exaggerated massiveness of the building floor templates in interpolial and similar megahospitals is dysfunctional from a carbon neutrality standpoint. With so many departments now so far away from a window and a view to the outside, or any chance for fresh air or natural light, even staff morale began to be adversely affected. More recently, attention has been redirected in the U.K. as to how these places can be operated with fewer toxic discharges, and modified based on safer construction practices. At the community scale parallel efforts are underway to reduce the number and length of automobile journeys to and from British hospitals and to locate health facilities in more walkable communities.

It is too late to bring back the inventory of pre-World War II historic hospitals lost in countless cities (see Chapter 2).11 Historic hospitals such as Charity were demolished long ago in other parts of the U.S. to clear land for their replacements – all in the name of progress. As discussed above, myth perpetuation on the part of elected officials remains a political and cultural impediment to the challenges of an already mammoth rebuilding progress in post-Katrina New Orleans. These same myths also affected the inability to reassess many neighborhood primary care clinics.

A city's urban landscape is the manifestation of its citizens' shared sense of purpose, place, and identity. Charity Hospital – symbolizing the intersection of medical care, neighborhood, and urban myth – merits a second look. This and other surviving historic hospitals can have new lives (see Chapter 2). This is within this framework that historic preservation and sustainable healthcare design must be viewed as seamless, as one rather than two disparate or parallel endeavors. Without this, synchronicity will be unattainable. An older hospital located in an established neighborhood near to public transportation can lessen that institution's carbon footprint, compared to it being located somewhere/nowhere out on the suburban fringe far from
public transportation. In the face of global climate change, when so many new buildings are built on what was previously farmland, historic hospitals were worth reconsidering because they symbolize a place's collective memory and its cultural heritage. Many staff and patients rode the bus to and from Charity. It was a three-minute walk from the Tulane Medical School to Charity. In other words, a hospital's carbon footprint is more than its own campus and buildings. Its footprint extends broadly throughout its local community. Doug Farr, in his book Sustainable Urbanism: Sustainable Design with Nature (2000) singled out two significant drawbacks to the current LEED system in the U.S. The first is the relatively low total number of buildings that have received LEED certification in comparison to those that have applied or are somewhere in the review process. This creates a bottleneck because LEED and the USGBC wish to broaden the definition of ‘evidence’ gathered and presented so big and complex.

The second drawback was, in his words, “LEED’s building-centric focus and the low value it places on a project’s location and context, particularly concerning auto dependency.” The prerequisites and criteria weightings in the LEED system remained heavily weighted toward the building itself – and not much to its ripple effects in the community – and this had remained unchanged from the start of the program in 2000. There were no specific criteria for this aspect of a project and no more than 6 percent of all credits addressed these issues, greatly limiting the consideration of urban context or their immediate surroundings. Efforts are underway to launch a LEED program for urban neighborhood redevelopment in collaboration with the Congress for New Urbanism. This broadened view of sustainable urbanism and historic preservation would greatly aid the grassroots local effort to save Charity Hospital and the 71-acre neighborhood slated for demolition.

Beyond the LEED program, specialists in preservation, conservation, and sustainable architecture and urbanism need to work together to broaden the definition of ‘evidence’ gathered and presented in support of carbon neutrality. Preservationists typically due diligence, cultural inventory, recognition, archival research, and fieldwork in their research and the Section 106 Review protocols include seven litmus test questions to assess if a given building or place is culturally and architecturally significant. Specialists in healthcare, for their part, typically use interviews, satisfaction surveys, patient medical records, staff records, behavioral observation, and workflow analyses in their research.56

The hospital needs of medically underserved populations remain acute in post-Katrina New Orleans. Nationally, as stated earlier in this book, nearly 48 million Americans lack medical insurance. However, the southern region of the U.S. has the highest percentage of uninsured – 19 percent (compared to 15 percent nationwide). With a statewide population of 4.2 million, the percentage of medically uninsured and underinsured persons in Louisiana reached 750,000 in 2007 and this exceeded the national average.55 It is well known that medically underserved populations have less access to care options in their communities and as a consequence, diagnosis and treatment often occur too late. When this happens, the emergency departments of acute care hospitals, i.e. places such as Charity Hospital, become overwhelmed with patients with no way to pay for their care. This is a crisis in both the public and private sectors.55

Let this be a cautionary tale to others trying to save an historic hospital or any other type of historic healthcare facility. Even in normal times it is an uphill battle. Those responsible for this innovative alternative to the abandonment of Charity are to be commended for their strategy of hiring (at their own personal private expense) an experienced team to provide a feasible counterpoint – specialists with a strong record in historic preservation and current best practices in new hospital construction. Regardless, the jury remains out on whether the politicians, hospital officials, and community representatives will reach a consensus in Louisiana (as well as anywhere where such controversies exist) on the growing problem of how to address the critical interaction between sustainable urban design, architecture, and historic preservation in the arena of environments for healthcare. However, and sadly, in New Orleans it appeared that the local business community had cast its lot in full support of building the two new hospitals on the 71-acre site of an historic neighborhood.56

Meanwhile, a local coalition of citizen-led community groups filed a lawsuit in Federal Court to block the permanent closure of Charity Hospital.56 The architectural profession is just now beginning to sponsor workshops to aid architects seeking to recycle their clients’ older healthcare facilities in the U.S.56 These themes are reprised in the chapters that follow.

From the epochal events of 11 September 2001, to the inability of a mother in Ethiopia to obtain life-saving immunizations for her infant, a confluence of geopolitical and population growth challenges is resulting in highly pressing global health conditions. The world’s 6.1 billion population increases by nearly 9,000 persons each hour. Several worldwide population institutes estimate that, by 2050, between 9 and 10 billion people will be living on the planet.51 Populations in need of global architectural intervention include communities ravaged by HIV/AIDS, malaria, tuberculosis, plague such as the virulent Ebola virus in Africa, and new strains of yellow fever. Add to this the profound pain caused by new settlements built in places where they should not be, such as in low-lying coastal zones, earthquake-prone regions, and in the midst of notorious hurricane ‘alleys’. Ecologically sustainable buildings and typologies for health are needed in support of diverse occupants, their aspirations, and functional requirements. In a world of high construction costs and diminishing natural resources, we are being forced to relearn useful lessons from practices known for hundreds of years.

The field of architecture for health is at a turning point. In the coming years uncomfortable trade-offs will be made, although critical discourse on the challenges that lie ahead remains fragmented. The hospital, both as an idea and a building type, warrants reconsideration. It is teetering between an unsustainable status quo and an uncertain future. As a force that strives to promote human and ecological health, either/or trade-offs will no longer suffice. An environmentally compassionate future is the future of the hospital. The two principal discourses on the challenges that lie ahead must be relearned.嵋 formulate useful lessons from practices known for hundreds of years.

The final chapter in my 2000 book consisted of six ‘megatrends’ likely to guide developments in the coming decade. These were: