Hospital

by
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AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

ABSTRACT

The former Princess Margaret Hospital in Toronto was a sight in need of little description: beyond the fenced property, the building, recognizably a postwar hospital, uncaringly dismantled its red brick and regularly spaced windows.

With the rare exception of few canonical cases, most modernist institutional construction, ubiquitous and undervalued, is facing a similar future. This trend however speaks more about the mindset befitting contemporary societal attitudes towards architectural modernism, than about the actual inability of the buildings to be redesigned for further use.

Through artefactual construction of discursive, literary and factual texts collected in relation to the epigone structure whose taking apart I have subsequently witnessed, I set out to trace the conditions of this typical occlusion of architectural potential, and to query the framework generating the inadvertent yet constant destruction of the architecture of a period that promised much enlightenment at its inception.

ACKNOWLEDGEMENTS

I would like to thank my supervisor, Val Rynnimeri, for his guidance, humour, wisdom, and trust, through my innumerable moments of doubt: I couldn't have done this without you.

My sincere thanks to my advisors, Anne Bordeleau, for her truly inspiring mentoring, and Robert Jan van Pelt, for his willingness to see beyond fragments, and to my external reader, David Lieberman, for his generous comments.

I am further indebted to Dereck Revington and Robert Wiljer for their dedicated involvement at the beginning of this project.

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INTRODUCTION

> He wanted to say 'of the enemy'. In ordinary life there was always some enemy to point to, but who could the enemy be here, in a hospital bed?
>
> Aleksandr Solzhenitsyn – *Cancer Ward*

One day a couple of summers ago, I happened upon the demolition of the former Princess Margaret Hospital, at Sherbourne Ave. in Toronto. From the corner of the intersection, the temporarily empty site of the once imposing adjacent Wellesley General Hospital allowed me an unmarked perspective towards the red brick building in dismantling.

An ordinary product of 20th century healthcare developments, Princess Margaret Hospital/Ontario Cancer Institute (PMH/OCI), now part of the University Health Network (UHN), is a specialized medical research and treatment facility, which has undergone a series of typical institutional transformations. Slowly emerging out of progressive national health policies, the organization was provided with its own physical body in 1958, in the form of a monolithic tower with double loaded corridors and an overall minimalist atmosphere, characteristic of the timely spirit of postwar modernism. Subsequent waves of capacity growth and technological advancement saw it undergo a number of hasty alterations. Then, the institute relocated to its current University Avenue address, in a postmodernist construction, designed to amend the perceived impersonal scale, physical inaccessibility, and provider-centred arrangements of the previous health care model. Its former hosting building was decommissioned and eventually sold out to be

dismantled.

Arguably, this outcome has been similar for the vast majority of postwar hospital construction. A combination of medical progress and late 20th century financial policies generated by the necessity of economic efficiency and/or scarcity of resources has been relentlessly rendering it functionally obsolete. Once institutionally discarded, there seems to be no alternative:

> Obsolete hospitals, no longer justifiable on either quality of care or economic basis, will be demolished by the hundreds.[1]

So far, both economic and sustainability motivators have failed to claim these structures. However, this trend speaks more about the mindset befitting contemporary societal attitudes towards modernist healthcare epigones, than about the actual inability of the buildings to be reused. Currently, their potential future seems to fall through the wide-eye nets of various involved discourses and practices.

In the following document I attempt to inhabit several of the perspectives that seemingly seal the fate of these institutional modernist structures, thus tracing the conditions of this typical occlusion of their architectural potential. Through artefactual construction of discursive, literary and factual texts focusing on the hospital whose taking apart I have subsequently witnessed, I set out query the framework generating this inadvertent yet constant destruction of the architecture of a period that promised much enlightenment at its inception.

The composing elements of this proposed artifact are both the offspring of contingency and of explicitly correlated research.[2] This choice of content is a direct consequence of my own searching for

1 Verderber, Stephen. "Architecture for Health – 2050: An International Perspective", in *The Journal of Architecture*, 8.3, (2003), 297

2 This 'grassroots' approach developed itself naturally as *the* contemporary methodology of thinking through the chosen subject matter, while some of its shortcomings eventually began to outweigh its seductive ease. The generated format retains much of its chronological development.

ways to render visible that which I was yet to recognize as existent. I thus begin with a brief description of the Health Servicing Restructuring Commission (HSRC), Ontario's distinctive political take on healthcare restructuring in the 90s. Reminiscent of the scribbled delivery list at the centre of Umberto Eco's *Pendulum*, the long record of its decommissioned hospitals prompted me to raise specific questions related to the existing built stock of those facilities. Most of them have been levelled to the ground.

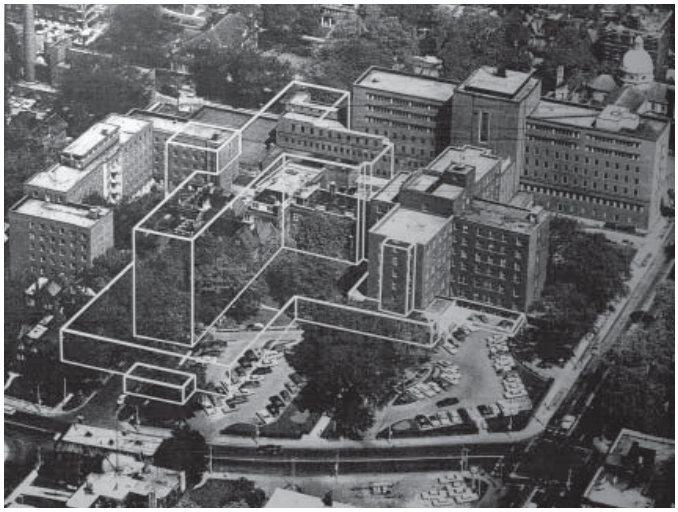
Three essays follow, describing 'proper' discursive histories which affirm and advance current dominant perspectives on the accepted value system that defines the chosen hospital, its models, and arguably contribute to enforce a certain unquestioning of its fate. The traditionally architectural domain is accessed in *Constructions*, through a summary of hospital building type history, with focus on the formal and functional specifics of Princess Margaret Hospital. Alongside an increasing variety of *forms*, this survey displays a series of clearly defined architectural *identities* often determined by factors outside the field.

Returning to the political domain, *Institution* assembles the particular biography of PMH/OCI Sherbourne chapter, reconstructed from institutional synopses and media releases. The limited format of this type of data favours a linear narrative whose conclusions repeatedly recycle a "denounce-demonize-demolish"[1] rhetoric.

Transformations mirrors the discrete world of *Constructions*, tracing the constant pursuit of a practical strain framing the adaptation possibilities for healthcare construction. At cross purpose with the discourse of architectural conservation,[2] obsolescence accounts tail most of the remodelling of the 20th

1 Adams, Annmarie. "That was Then, This is Now: Hospital Architecture in the Age(s) of *Revolution,* 1970-2001", in Henderson, John, Peregrine Horden, and Alessandro Pastore, eds. *The Impact of Hospitals, 300-2000*. Oxford: Peter Lang, 2007, 223

2 which approaches rare cases of hospital conversions only in heritage terms



century hospital programme.

Juxtaposed to these hospital histories, a series of first person narratives describe several events related to the actual demolition. They illustrate the way in which individual assessments do not escape their specific blind spots either, remaining profoundly shaped by typical albeit often invisible cultural and social limits.[1]

The several sets of photographs accompanying the texts capture the chosen site through different lenses, each characteristic of a certain attitude towards its subject matter. Artist Matthew Sweig's camera aestheticizes the crumbling structure. Desolate doors and ducts foreground most of his pictures, projecting a

1 According to French sociologist Pierre Bourdieu, perception is acquired through a more explicit learning in educational and cultural institutions, but also through a tacit acceptance of current societal norms.

1. Princess Margaret Hospital at Sherbourne and Wellesley, cca. 1960

nostalgic atmosphere.[1] My set of demolition pictures focuses on fragments of possible architectural engagement, at discrete points, along what I considered at the time to be possible lines of sheathing breakage, in the spirit of Gordon Matta-Clark's split projects. The images depicting the subsequent construction of the condominium on the emptied site attempt to mimic the initial black and white archive shots, with their formulaic documentary framing, signalling affects associated with an omniscient camera lens looking from an angle-raised ubiquitous perspective point. This final attempt to access a more objective revised outlook nevertheless rapidly collapses in the anonymity of its details.

A further contributing element to the constructed character of this proposed artifact, the images, the personal narrative lapse into sentiment, and the essayistic glosses are paired with several quotes from Aleksandr Solzhenitsyn's 1968 novel, *Cancer Ward*.

Set in a hospital in soviet Uzbekistan in the late 1950s, the book focuses on a group of cancer patients undergoing therapy, while reproducing in their exchanges a collection of verbatim conventional sayings of their time, some honest, some turned in their head. A short story by Lev Tolstoy, *What Do Men Live By*, is read and discussed, and the expected answer is given fairly early in the book. From there, patients and readers continue to be confronted with the reality of cancer and the cancer ward.

In a textbook Bakhtinian polyphonic manner,[2] Solzhenitsyn

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1 "Celebrating and romanticizing the patina of decay could easily become a dangerous cliché: the complexity and peculiar beauty in the patterns of mould and rot; the displacement engendered by seeing commonplace objects lose all sense of meaning in the wreckage of a long-empty building, the utter stillness. Ruined and abandoned buildings are often marked by things like this and it is tempting to fantasize that the slow process of dereliction be allowed progress unhindered." Littlefield, David, and Saskia Lewis, *Architectural Voices: Listening to Old Buildings*, Chichester : Wiley, 2007, 5. A slightly different and stronger take on the subject comes from Peter and Alison Smithson

2 Žekulin, Nicholas G. "Applied Bakhtin: Aleksandr Solzhenitsyn's *Cancer Ward*." Plenary Paper, Eighth International Conference on Mikhail Bakhtin: "Dialogue and

carefully constructs his characters in slightly different relations to incongruent yet arguably similar analogical models,[1] thus justifying the peculiarities of their political views as well as their transformations,[2] according not in the least to their medical conditions, social status, and/or experience.[3] For the novel's protagonist, the text permits both a reading of transformation and a slight parody of it. Assigned to his provincial hospital bed by his prison doctor's terminal diagnostic, the uneducated albeit old-hand Oleg Kostoglotov discusses (and learns) about health, culture, politics, and human frailty. The encounter with serious illness and the gradual process of medical institutionalization, grafted onto his previous experience of political exile, governs his views and actions, while the medical treatment he receives both cures and incapacitates him. Released from the hospital in order to return to his "in perpetuity" exile, he is offered temporary accommodation by each of the two women[4] taking care of him so far. In the end, he accepts neither.

Ever since its diasporal publication, *Cancer Ward* has generated an intense interpretation debate over whether the primacy

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Culture." University of Calgary, Jun. 1997

1 For an in-depth analysis of the possible analogical models in *Cancer Ward*, see Sloane, David. "*Cancer Ward* Revisited: Analogical Models and the Theme of Reassessment." *Slavic and East European Journal* 26.4 (1982): 403-18. Sloane's suggestion is that the novel provides "analogical models based on the likeness of the doctor-patient relationship to the relationship between state authority and society."

2 Pavel Rusanov sees the society being cured by the Soviet sate, Vadim considers that a scientific approach will help the state being cured by its cancerous elements, Yefrem sees the state as the cancer draining the nation, etc. The physicians have their own varied perspectives, of which some get reassured and some contradicted.

3 Žekulin, "the desired effect is one of constantly shifting the ideological ground beneath the reader's feet. Readers … must in fact form their own opinions about each and every judgemental statement, as well as about the actions of the protagonists."

4 Both nurse Zoya (life) and doctor Vera (truth) offer to help him, after the remission of his disease, when he is released from the hospital.

of its reading is to be symbolic or realistic. On the textual level, the story is a profoundly compassionate depiction of terminal illness, offering one of the most moving fictional accounts[1] of the reality of a cancer treatment plant of its time. Yet, while this completely realistic reading[2] is possible, literary critics have had to address its allegorical interpretation,[3] for which medical phenomena carry political meaning. In fact, Solzhenitsyn's name can hardly escape political associations informing his literary texts.[4] Starting as the heroic figure of the strongest Stalinist critique in the 1960s, he was soon ignored as his nationalist and traditionally toned criticism turned to the lack of Western morality. Soviet culture historian

1 Nevertheless, the novel is in large part based on Solzhenitsyn's personal experience, as a cancer and gulag survivor.

2 Solzhenitsyn himself is said to have argued in front of the Union of Writers that its subject is simply cancer and nothing more. "Now, as to *Cancer Ward*, I am being criticized for the very title, which is said to deal not with a medical case, but with some kind of symbol. … The fact is that the subject is specifically and literally cancer, [a subject] which is avoided in literature, but which those who are stricken with it know only too well from daily experience. This includes your relatives – and perhaps soon, someone among these present will be confined to a ward for cancer patients, and then he will understand what kind of 'symbol' it is." Solzhenitsyn, A. in Labedz, Leopold ed., *Solzhenitsyn: A Documentary Record*, Bloomington: Indiana University Press, 1973, 146-7. This anecdote however implicitly relies on the audience's knowledge of Soviet censorship and was opposed by Susan Sontag, who must have been aware of the primacy of the symbolic reading, when she accused its propagation of not doing justice to the suffering caused by cancer.

3 'Cancer' standing in for the "socio-political malignancy" of Stalinist governance; as is efficiently described in Nicholson, Michael A. "Solzhenitsyn as 'Socialist Realist'." Falchikov, Michael, and Hillary Chung, eds., *In the Party Spirit: Socialist Realism and Literary Practice in the Soviet Union, East Germany, and China*, Amsterdam: Rodopi 1996, 65

4 Literary critic Harold Bloom pinpoints the coordinates of this unavoidable perspective, and wonders whether Solzhenitsyn's importance is to remain more historical than aesthetic. "Clearly, there is no *War and Peace* nor *Anna Karenina*, no *Brothers Karamazov* nor *Crime and Punishment*, among Solzhenitsyn's narratives. Are we to say that he is doomed to be remembered only in the category of the writer-as-witness, a much larger version of the sincere but limited Elie Wiesel? … Can we read *Cancer Ward* as we read *The Magic Mountain*, as another great instance of the classic European novel?" Bloom, Harold ed., *Modern Critical Views: Aleksandr Solzhenitsyn*, 2001

and art critic Boris Groys portrays him as "the most radical of the village writers,"[1] to whom history offered little choice in situating their political position vis-à-vis totalitarian dictatorship and its subsequent transformations. He thus frames Solzhenitsyn's views as indicative not of the liberation from the structures governing his life, but as the imprisoning effect and the extent of their power.

Situated outside the expanding territory of the increasingly fashionable illness narratives,[2] which ubiquitously accompany today's healthcare discourses towards more or less obvious agendas, Solzhenitsyn's tale provides this thesis with an atypical problematic kernel, looking to facilitate a zeugmatic[3] conceptual short-circuit. Its employment is both literal and performative, symptomatic of our contemporary fraught relationship with epigone modernism.[4]

By alternating these thematically related elements, I attempt

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1 Groys, Boris. *The Total Art of Stalinism: Avant-garde, Aesthetic Dictatorship, and Beyond*, Princeton: Princeton University Press 1992, 87. According to Groys, Solzhenitsyn is a post-utopian author, coming in the aftermath of the Russian art avant-garde, whose spirit he defines in terms of the demand that art move from representing to transforming the world. Solzhenitsyn is, in his view, a witness to what he perceives its local consequences have been.

2 Psychiatrist Arthur Kleinman has coined the phrase, a synonym for 'autobiographical text,' in order to describe the ways in which illness takes on personal and cultural meanings. His focus is on how *narrative* helps to bring order and give coherence to the experience of illness. Lisa Diedrich broadens his definition to include various literary formats from memoirs to essays on literature, to fictional works depicting health related issues, in *Treatments: Language, Politics, and the Culture of Illness*. Minneapolis: University of Minnesota Press, 2007

3 Zeugma as a figure of speech has become homonymous for a link that doesn't really exist, in essence a subtraction in which the same action is applied to incompatible domains. Zeugmatic constructions, according to American literary theorist Joan Copjec, will often sensitize the addressee to any deviation from the rule-governed assumptions that there should be no conceptual difference between the two domains presented. It is this sensitization that I am interested in achieving.

4 Recent approaches seem to orbit around an interesting proposition: Is Modernity our Antiquity?

to counter our current 'storytelling management' hegemony, in which narrative forms are constantly high-jacked and aggressively redeployed by various groups in order to support their particular interests.[1]

Nevertheless, the question this thesis implicitly asks can be phrased as follows. Is the singularity of our current participatory advocacy adequate in dealing with the vast amounts of ubiquitous modernist landscape?

1 Salmon, Christian. *Storytelling: Bewitching the Modern Mind*. London, New York: Verso 2010, especially "Narrative as Instrument of Control": "The rise of storytelling … may even have trivialized the very concept of narrative. The instrumental use of narrative for the purposes of management and control has, for instance, resulted in denunciations of the fictional contract because it transforms readers into guinea pigs." 7

COMMISSION

> [He] walked down the well-known pathways, meeting no one but an old street sweeper. He turned around and looked at the cancer wing. The building was a towering mass of bright brick, brick upon brick, and none the worse for seventy years of age.
>
> Aleksandr Solzhenitsyn – *Cancer Ward*

Ontario's Health Services Restructuring Commission (HSRC) was appointed by the Harris government in April 1996, with a four year mandate, to make decisions on restructuring the province's hospitals and to recommend changes to all other aspects of its health services system.

The health-policy environment in Ontario in the mid 90s was dominated by growing concern that Medicare, one of the most cherished of Canadian social programs, was in some kind of trouble: health care kept on demanding annual increases in funding (well above the general rate of inflation or the growth of government tax revenues) and financial resources were beginning to run low.[1] Ontario was in fact the last province to approach hospital rationalization in the 1990s, and chose to use a different mechanism from the one implemented by the other provinces, which generally consisted in 'devolution' into Regional Health Authorities (RHAs).[2] The decentralization

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1 Beside the specific numbers the provincial government had to deal with, the disrupting behaviour of the health care financing was generally following international trends, from its British model to its American more technology oriented counterpart.

2 Sinclair, Duncan G., Peggy Leatt, and Mark Rochon. *Riding the Third Rail: the Story*

of authority and the move toward regionalization was driven by a general desire to upgrade the bankrupt modernist model of care and replace its 'silos' with high-quality care at a more reasonable scale and cost.

Following directions sketched by the National Forum on Health (1994-97), HSRC acted as an independent agency of doctors, health care educators, hospital administrators, former hospital board members and other experts, operating under the Public Hospitals Act and the Ministry of Health Act. Its creation and attributes were shaped by a combination of medical and financial factors, in which the pressing need to upgrade the inertia-dominated health care system was used, among others, to occlude as much as possible political accountability.

From within the medical practice, the persistent call of health reformers advocating a broader view of the 'determinants of health' gained momentum as the 'alienating experience' of modern medicine was increasingly resonating with a larger interested and entitled population. Moving away from the 'modernist model', the needs of the sick were found to extend far beyond the acute and expensive 'illness'-care available within hospitals. The promotion of advancements in technology and practice patterns focused on allowing more and more medical services to move beyond the hospital walls. In-patient procedures became 'in-and-out' surgery, ambulatory services supported by community-care programs increased in numbers, and the emphasis shifted away from curative care to health promotion and disease prevention. The funding and organization of services needed to change accordingly. The main intention was to rebalance spending by shifting money away from the hospitals to other sectors of the health care system.

On top of the financial needs of the medical restructuring, the adverse financial events of the 1980s and 90s heightened the

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of Ontario's Health Services Restructuring Commission, 1996-2000. Montreal, Qc.: Institute for Research on Public Policy, 2005

crisis, affecting the overall performance of the entire care system. With the health budget reaching 32% of the provincial budget, and the acute care consuming little under half of that, hospitals became the main target of the restructuring program. Because, in addition to its medical agenda, it appeared in a climate of economic crisis, HSRC differed from its successor provincial commissions and councils in having an unprecedented and seemingly unconstrained authority to restructure public hospitals.

During its mandate, the commission changed the health landscape in 22 of Ontario's urban and regional communities, by ordering amalgamations and 'take-overs', and creating larger hospital organizations capable of greater quality and economies of scale.[1] Provided that additional alternative-care placements were to be made available, Ontario's public hospitals were considered, in aggregate, larger than necessary to meet the need for hospital-based acute care. Funding of hospitals was cut by 18%, while the health budget remained constant for 1996-1999.

Preliminary discussions regarding the Metropolitan Toronto Area started in March 1997. The commission based its research on previous Metropolitan Toronto District Health Council (MTDHC) work, acknowledging once again the fact that healthcare in Metro Toronto was afflicted by the 'usual' problems of duplication of services, surplus capacity, and aging physical plants. On April 27, 1998, HSRC released its final directions for rehabilitation, long-term care, and sub-acute services in Toronto. The conclusion of the report recommended major administrative mergers and financial restructuring of Toronto's provisions. While the commission decisions were generated by economic efficiency principles, the physical conditions of the facilities also played a key role.

Tired old buildings were closed, and systems of governance were

1 ibid., 103

> established to reflect the broader community. In the final analysis, the system was depoliticized, and volunteer HSRC commissioners drawn from the health sector made decisions based on fact, not newspaper headlines or emotional or parochial interests.[1]

Overall, $1.9 billion was delegated by the Province of Ontario into the modernization of 64 hospital sites since the establishment of the HSRC. Considering all these factors, it is easy to understand that the commission's work stood not without controversy[2] or contingencies.[3] The HSRC completed its mandate and closed down on March 28, 2000.

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1 MacLellan, Bruce. "Experiencing Politics: A Primer." Leatt, Peggy and Joseph Mapo, eds., *Government Relations in the Health Care Industry*. Westport, CT: Greenwood Publishing, 2003

2 "Executives at Women's College Hospital in downtown Toronto were among the best at managing the news media to turn up heat on government. Whenever a report appeared to suggest closing the old facility, the hospital used the media to engage public support with a backdrop of anxious mothers and babies." MacLellan 2003

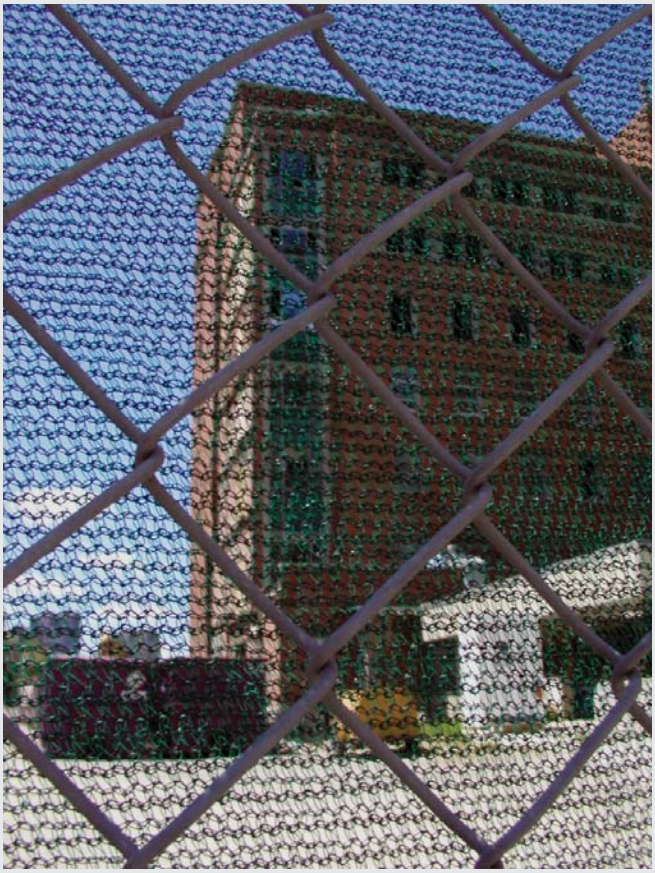
3 Riverdale Hospital, a bolder example of modernist architecture in Canada was eventually 'rehabilitated' and is now part of the new Bridgeport Health Centre.

The scope and scale of the first exercise seemed both daunting and safe. We were all used to map locations, efficient red crosses to condense complex and unsuspecting hidden roots into a rather indifferent bloom; the locations, in my case, of the decommissioned wards. I only disagreed when it came to scavenging the city, this significant place or the other, feeding the traditions with one more clone-ish spot, or the same most of the time, secured in the folds of a foreign history, unbeknownst.

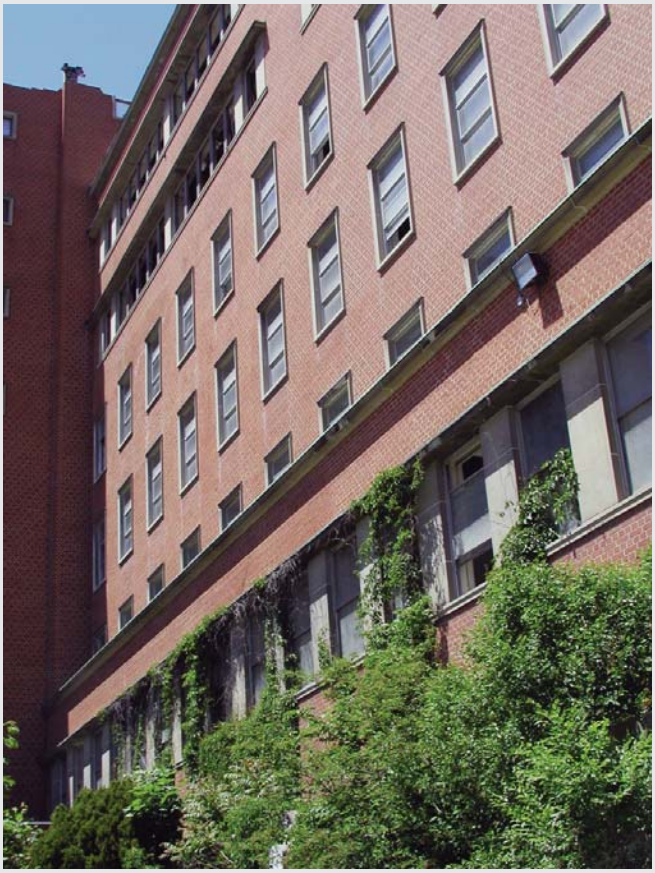
Then one afternoon, I happened upon it, the dull site of the former Ontario Cancer Institute, at Sherbourne Street in Toronto. The finding wasn't entirely accidental. Marked on my plan was the adjacent lot, on the north-east corner of the intersection, of the once imposing Wellesley General Hospital; now emptied of construction, allowing a fleshed perspective towards the red brick building in dismantling.

A large bulldozer was pulling the steel to be recycled through the resisting façade.

One of the workers, yellow marks on the back of his required uniform, turned and repeated: 'access to the demolition site?' as if nobody had such an idea before. An instant later his forehead relaxed and his teeth creased the smile: 'you need permission from the owners.'



2. Princess Margaret Hospital demolition site, summer 2004, by author

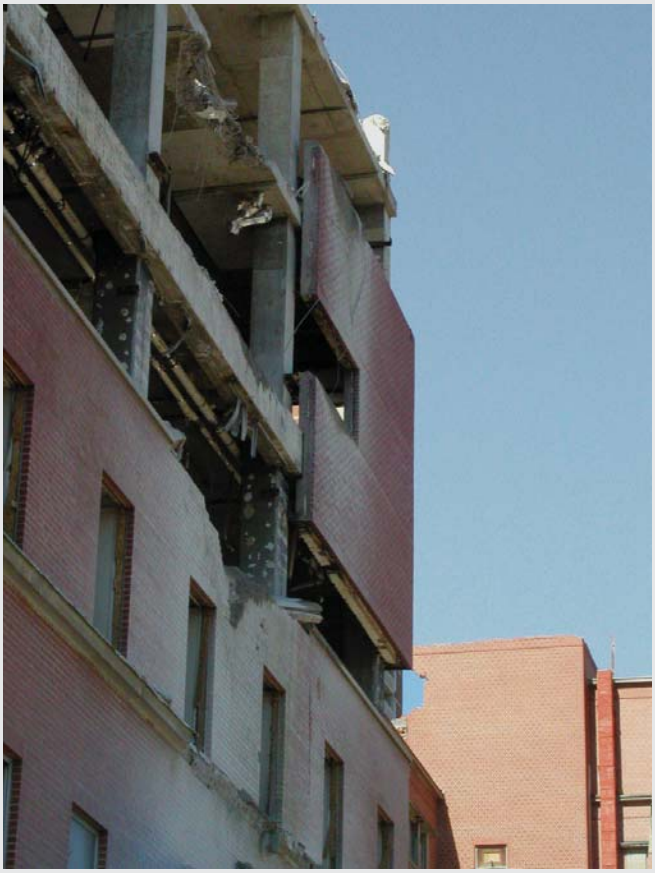


3. Princess Margaret Hospital demolition site, summer 2004, by author

4. Princess Margaret Hospital demolition site, summer 2004, by author

So I moved to the sunny side, camera untying to shoot, with the July heat pushing my shoulders into the indecent layers of crumbling high walls. My first thought: the structure, the bricks, the shafts, the canopy, the long arm of the noisy machinery all could be rearranged – thought before.

Yet, my stumbling freedom insisted on its interval as it flowed out of my discreetly cornered lens' frame, and I paced through its chaotic preoccupation, taken by the possibilities for this place. Unfinished and unbound, the thoughts went pilling up like truckloads at a landfill, and for a while I couldn't evade them and I wished I could speak about them in a loud voice.



5. Princess Margaret Hospital demolition site, summer 2004, by author

CONSTRUCTIONS

> The beds stood in serried ranks, with their heads to the wall.
>
> Aleksandr Solzhenitsyn – *Cancer Ward*

Existing hospital architecture literature traces the beginnings of organized care back to the healing practices of the ancient Egyptians, Greeks, Middle Eastern and Eastern cultures, developed between 1000 B.C. and 100 A.D. From the Greek Asclepieia to the Roman Valetudinarium, the first hospitals were similar in form and function to the places of isolation where ideals made a more prominent appearance: the temple or the military camp.[1] They were often square or rectangular structures open towards nature or onto themselves, usually through a courtyard. While the Greek model promoted 'healing through dreaming,'[2] the Vitruvian notion of 'good design' stood its ground as a rational well-ventilated barracks-like building, whose entrance and exit were severely restricted.[3] Often antagonized, their constitutive principles will inform most of the later models.

The European Middle Ages were mainly dominated by the

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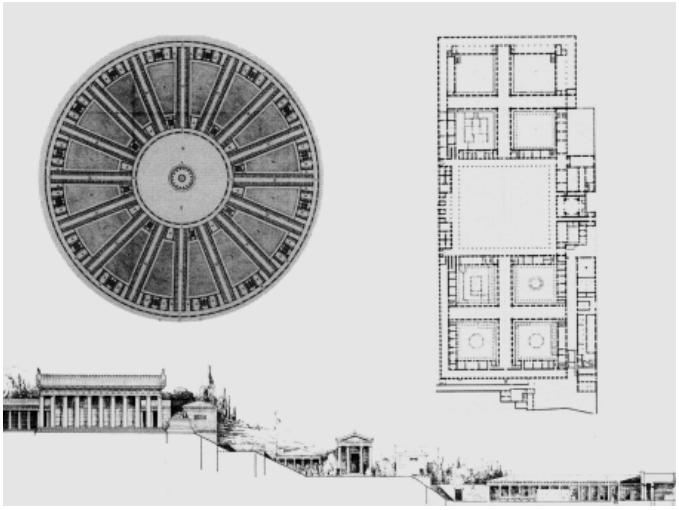
1 Risse, Guenter B. "Pre-Christian Healing Places" in *Mending Bodies, Saving Souls: A History of Hospitals*. New York: Oxford University Press, 1999, 15-67

2 Thompson, John, and Grace Goldin. *The Hospital: A Social and Architectural History*. New York: Yale University Press, 1975, 3

3 Vitruvius, Pollio. *On architecture*. Trans. F. Granger. London: W. Heinemann. Loeb Classical Library 1931, I.4

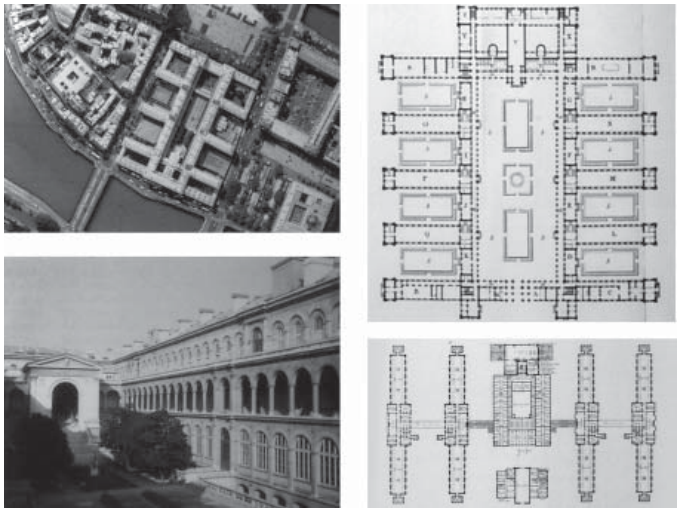


courtyard type variations, and the caring for the sick and the disfranchised slowly advanced under the patronage of the Catholic Church, whose clergy provided for generous, cold, and frequently infected monastic hospitals, built of the edges of villages and cities, throughout the 5th to the 13th centuries. While in the Greek model the rich were treated to higher standards than the lower economic classes inside the same precincts, the charitable factor of Christian care inclined the balance in favour of the poor and the undesirables.

During the Renaissance, the governance of hospitals shifted from ecclesiastical to stately, urbanely, or privately, while their architecture followed the rediscovered symmetrical formal syntax, often focusing on repetitive order for the plans and palace-like facades. One of the most famous examples, the Ospedale Maggiore, was founded in Milan in 1456. Designed by Antonio Averulino, also known as Filarete,[1] it

1 In his comprehensive architectural treatise, Filarete discards earlier arrangements

6. design for hospital on the Ile des Cygnes, Bernard Poyet and C.P. Coqueau, 1785; Ospedale Maggiore Filarete, 1456; Greek Ascleipion, Acropolis



featured a classical composition with a large central courtyard, delineated on each side by four smaller ones, reflecting the separation of men and women. A testimony of contemporaneous ideas of mid 15th century public space, the dignified character of the building established a significant framework for the type's civic representation.

From the Renaissance to the French Enlightenment, the hospital slowly emerged as a stand alone building type through the clarification, enlargement, and decoration of the gridded courtyard structure, with centrally situated chapels giving way to operating rooms. At the end of the

as inadequate, including famous examples such as Bruneleschi's Ospedale degli Innocenti in Florence, and carefully argues for a number of practical considerations of design. Ospedale Maggiore was still in use during World War II. Filarete, Antonio A. *Treatise on Architecture.* Trans. by John R. Spencer. New Haven, Conn.: Yale University Press, 1965, 82

7. E. Gilbert and A.-S Diet, Hotel Dieu, Paris, 1864-77. Arial view of hospital built on the Ile de la Cite; entrance front; M.-P. Gauthier, Lariboisiere Hospital, Paris, 1846-54; Marylebone Hospital, London, 1878

18th century, social reform philosophy permeated architectural thought,[1] resulting in an enrichment of its ideals and attitudes. Questions pertaining to the realm of institutional change took foreground. Along with other programs considered of public concern, such as the prison, the market, and the cemetery, the hospital undertook a major transformation, its design trying to distance itself from traditional ideas of embellishments and monumentality. 'Beauty' in proportions and ornamental geometry became gradually subordinated to the idea of *spatial order*. Rational considerations pushed to their utopian ends saw the development of the radial plan hospital, preceding the Benthamian panoptic syntax of the prison by around half a century. Surveillance was beneficial, while confinement was conceived as protecting from the city, viewed as

1 Vidler, Anthony. *The Writing of the Walls: Architecture Theory in the Late Enlightenment*. New York: Princeton Architectural Press, 1987, 51-72

8. hotel Dieu, Montreal, Florence Nightingale pavilion, redux cca 1881

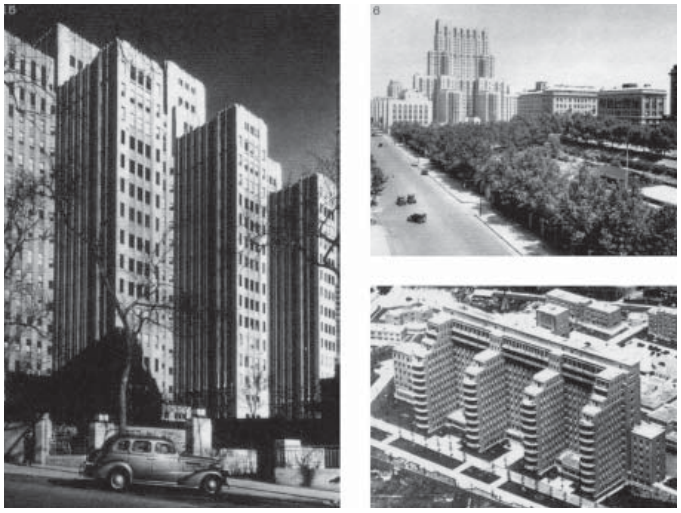
the place that produced or increased illness. Spatial organization thus became a significant tool of necessary reform.[1]

The counter-movement to this proto-universal canon of hospital architecture as locked-up 'safe ground' with precise and emphasized boundaries generated *the pavilion model*. Situating itself in the classical Ascleipion tradition, it usually consisted of a collection of individual structures grouped in a loose compound. Wards were originally just small structures where the sick and their families could sleep, and there were separate buildings for each function, from bathing to healing and praying. Following its Greek roots, the model emphasized the healing potential of looking into the city, and feeling visually and aurally connected to it, while resting in a larger version of the family home.

A new reform began with Florence Nightingale, considered by many, the initiator of hygienic hospital design. Combining elements from these two trends, her principles for hospital organization seem even today extremely clear and sound. They were based on one hand on the need to bathe the interior spaces of the patient wards in abundant natural daylight and ventilation, and on another, on the desire to ensure efficient supervision as well as well-being for the nursing staff. St. Thomas Hospital in London (1871) used her theories of interior planning, from the specifics of bright white wall colours to the linear configuration of the supply-spine block.

The 18th century also saw the emergence of oncology as an independent discipline with its first specialized hospitals. Among the earliest facilities, a ward of 12 beds was built in 1740, on the grounds of Rheims Cathedral. The motivation for the separated facility was in this case the fear that cancer was contagious, a belief seldom encountered throughout the Middle Ages, but prevailing in pre-revolutionary France. This determined the

1 For a thorough analysis of the various proposals that were made, see Middleton, Robin. "Sickness, Madness and Crime as the Grounds of Form," *AA Files* 24 and 25 (1992)

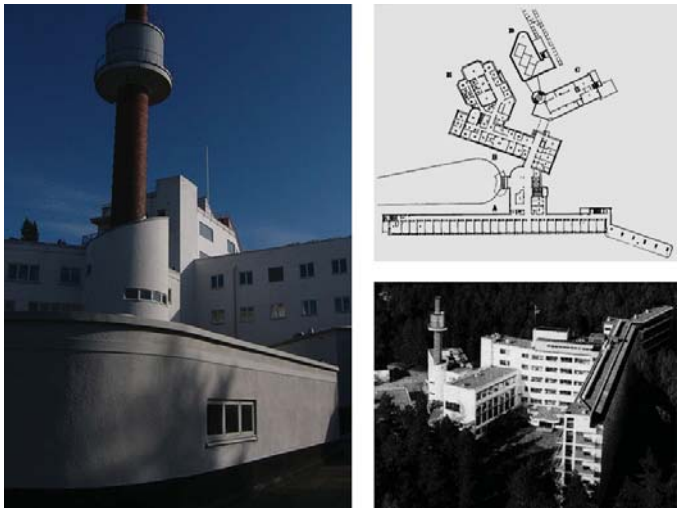


residents of Rheims to move its location outside the city limits a couple of decades later. In England, a similar hospital was opened in June 1792, providing both relief for the ill and a space for the investigation of the disease. Because of its focus on dedicated research, the Middlesex Hospital Cancer Charity is considered by many as the first cancer hospital.[1]

Changing medical theories of disease transmission, fronted by the discovery of bacteria and the shift from the miasmic to germ theory (around mid 19th century), coupled with mounting financial considerations, soon undercut the rationale for the single or double loaded pavilions. Nightingale's pavilion model became increasingly compromised by further technological advancements, such as the invention of the x-ray machine in 1885, pushing

1 In 1853, the number of beds was 26.

9. J. Gamble Rogers, Columbia-Presbyterian Medical Centre, New York, 1926-30; Coolidge, Shepley, Bulfinch and Abbot, New York Hospital-Cornel Medical Centre, New York, 1933; J. Walter, Hopital Beaujon, Clichy, Paris, 1933-35

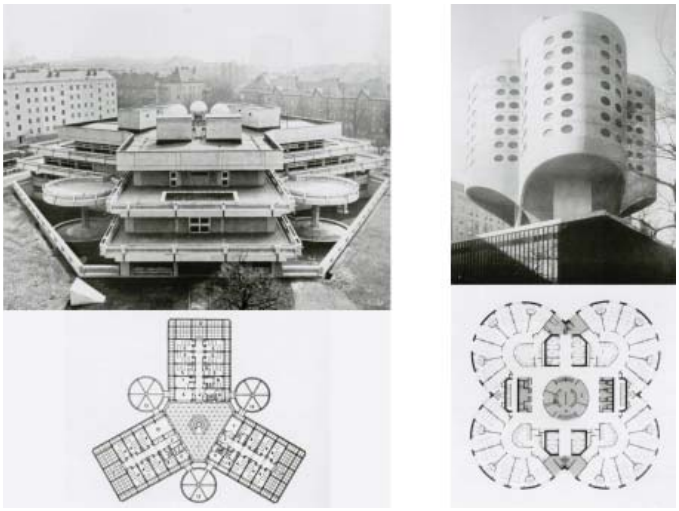


hospital design away from orderly spatial organization and into embracing and accommodating the new technology. As medical equipment was an expensive acquisition for any hospital, most practices resolved to concentrate around central urban areas and make use in common of technological facilities. With the rising urban land values, the low-lying pavilion hospital was gradually replaced by the more compact *urban hospital block*.

Socially, despite the medical advances of the late 19th century, hospital beds remained empty for a while, due to the stigma generated by their almshouse days. By early 20th century, most hospital leadership was aggressively advertising to their communities the idea that better care was received in the provided health care facilities.[1] At the same time however, as the hospitals became the house of medical science, most of their services

1 Betsky, Aaron. "Framing the Hospital: the Failure of Architecture in the Realm of Medicine." *The Architecture of Hospitals*, Wagenaar, Cor ed. 2006, 73

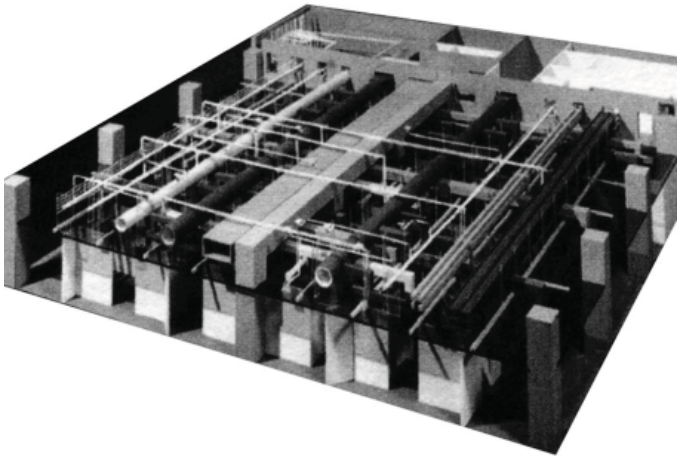
10. Alvar Aalto, Sanatoria, Paimio, Findland, 1929-1933



were gradually rendered out of reach for the poorest classes it traditionally contained. Designed as buildings symbolically representing their progressive medical values, hospitals all over the North American territory aimed at displaying their bold public personae. From James Gamble Rogers's Columbia-Presbyterian Medical Center in New York (1926-1930) to Coolidge, Shepley, Bulfinch and Abbot's New York Hospital-Cornell Medical Center, the sober early modernist monumentality was to be found in Europe also, in the form of J. Water's Hôpital Beaujon in Clichy, just outside Paris (1935-1953). All, including the nature-oriented Alvar Aalto's Paimio Sanatorium (1023-1933), featured exuberant architectural élan, which expressed the social status of their patrons.

Meanwhile, the study of neoplastic diseases continued through the 19th century mainly in specialized spaces. Initially called *laboratories*, they gradually became *institutes* by mid 20th

11. Gustav Peichl, Meidling Rehabitation Centre, Vienna 1965; Bertrand Goldberg. Prentiss Hospital for Women and Psychic Institute, Chicago, 1975



century, and *centres* by 1975, reflecting changes in size and importance. Funds, previously provided by private donations, gradually shifted patronage. The New York State Pathological Laboratory opened in 1898, was an early example of governmental research.

The second wave of modernism took hold of European and North American culture in the aftermath of the Second World War. The cold elegance of the International Style was employed to represent the apotheosis of an unyielding belief in the power of medical science.

> It was now possible to reduce the hospital to its structural essence and allow it to become a sheer container of the volumetric machines for being healed.[1]

1 Verderber, Stephen and David J. Fine, *Healthcare Architecture in an Era of Radical Transformation*. New Haven, CT: Yale University Press, 2000, 203

12. Zeidler Partners, McMaster interstitial system, Hamilton Ontario 1972

The complexity of the specialized zones continued to increase exponentially, prompting unique functional planning for diagnosis, treatment, surgery, administration and other support functions. Larger and ever more intricate hospitals were built, sometimes at the expense of disfiguring long-established neighbourhoods. Most were time and again deemed by critics as being obsolete from their opening days.

However, with this shift, the hospital became, almost inadvertently, part of the new social revolution, returning to the spreading masses. Retaining their position at the top of the medical and technological pyramid, they also regained their role as social institutions, reflecting in their architecture new aspirations of democracy and social justice, alongside scientific progress. Still, due to novel economic concerns, which targeted investment in rising capacity demands instead of 'architectural experiments', a strange dichotomy started developing between an increasingly austere exterior and the emerging concern for the design of the wards inside. Canada's first Cancer Institute took advantage of the long narrow site adjacent to Wellesley Hospital and provided a clean monolithic double loaded corridor tower, overlooking an imposing generous entrance.

Alongside, a new generation of specialized buildings for research and treatment of cancer began construction, following recent National Health Acts and their spawning organizations. Architecturally, they featured typical institutional architecture, expressed in clean volumes frequently dominating the surroundings.

Technology finally took the main stage in the 1970s and architects developed strategies to accommodate its growing appetite for space. In a most oft replicated example, Zeidler first employed the interstitial system at The McMaster Health Sciences Centre (MHSC) in Hamilton, designed in 1972. This meant that every other floor was to contain the machinery that ensured the smooth running of the hospital, everything from HVAC units to medical equipment.

The most important change in the past three decades was the shift from late modern to post-modern models of hospital design. If the international style was monolithic, earnest, and progressive, the new

architecture was going to be playful, ironic, and historicist. This new reform included a regained sensitivity to local context, an increased use of colour and ornamentation, and overt references to other building types. In Canada, the atrium was now almost the norm, described as a symbol of universality, making full use of its potential to provide urban, public indoor space. In addition to the MacKenzie Health Sciences Centre, the two most significant examples are Toronto's Atrium (New Patient Tower) at the Hospital for Sick Children (1993) and the Ontario Cancer Institute Princess Margaret Hospital (1995), also designed by Zeidler Partnership Architects. Nevertheless, the healing machine claimed its domination behind their central atriums. Postmodernism also meant an acknowledgement of automobile-based suburban living, Disneyesque facades and the inclusion of shopping facilities in hospitals.[1] Labelled

1 Sloane, David Charles; Sloane, Beverly Conant. *Medicine Moves to the Mall.* Baltimore: Johns Hopkins University Press, 2003

13. Joao Filgueiras Lima, Sarah Kibitschek Locomotor Hospital, Salvador, Brazil, 1991; Toyo Ito & Associates, Cognacq-Jay Hospital, Paris, 2007

"retail therapy", this blurring of lines between facilities designed for health care and for profit became as evident as the presence of renters such as Second Cup just inside the entrances of many Canadian hospitals. 'Patient centred care' in conjunction with 'evidence based design' changed again the hospital. Their findings also prompted the emergence of new kinds of health care spaces such as hospices, walk in clinics, and fertility centres, as well as an overall growing emphasis on home care.

Among the emblematic solutions generated by the conceptual shift of the eighties, the cancer caring centre emerged as the bold promoter of a new kind of design for healing. The first Maggie's Centre, a much publicized such construction, was built in the vicinity of the oncology department of the Edinburgh Western General Hospital in 1997, the culmination of landscape architect Maggie Keswick Jencks's vision of beautiful, supportive sanctuaries for the people facing the dreaded disease.

14. Richard Murphy, Maggie's Cancer Caring Centre, Edinburgh 1997

She strongly believed that architecture can have an important role in the process of healing and she imagined this alternative to the cold institutional environment in which she received her own diagnostic and treatment. Springing out of an old stable with a pitched roof and generous windows, the bright little building evokes ideas of intimacy and domesticity, set in by engaging architectural features.

"In a way, it was an ideological idea we were putting forward," said architectural historian and husband Charles Jencks. "It was the post-modern notion of body, mind, and spirit all being connected."[1] Evaluative studies have already shown positive results. "From a statistical point of view, [the centres] actually extend the life of the patients."[2]

In parallel, the new sustainability paradigm induces hospitals to adapt their physical bodies to lower ecological footprints, while the cycle of scientific advancement in technologies and interventions, as well as increasingly sophisticated information systems and expanded knowledge of the processes underlying health and disease will continue their unabated progress, continuing to render existing facilities inadequate for optimum medical care.

1 Jencks, Charles. "Maggie Centres and the Architectural Placebo." *The Architecture of Hospitals*, Wagenaar, Cor ed., Rotterdam: NAi Publishers, 2006, 445

2 Jencks 2006, 458

This was the second year she had been working on blood transfusions and she could not remember a single patient who had not been suspicious. They all behaved as though theirs was the purest aristocratic blood and they were afraid of it being tainted. Invariably, they looked sideways at the blood and claimed the colour wasn't right, or the group wasn't right, or that it was too hot or too cold, or that it was congealed.

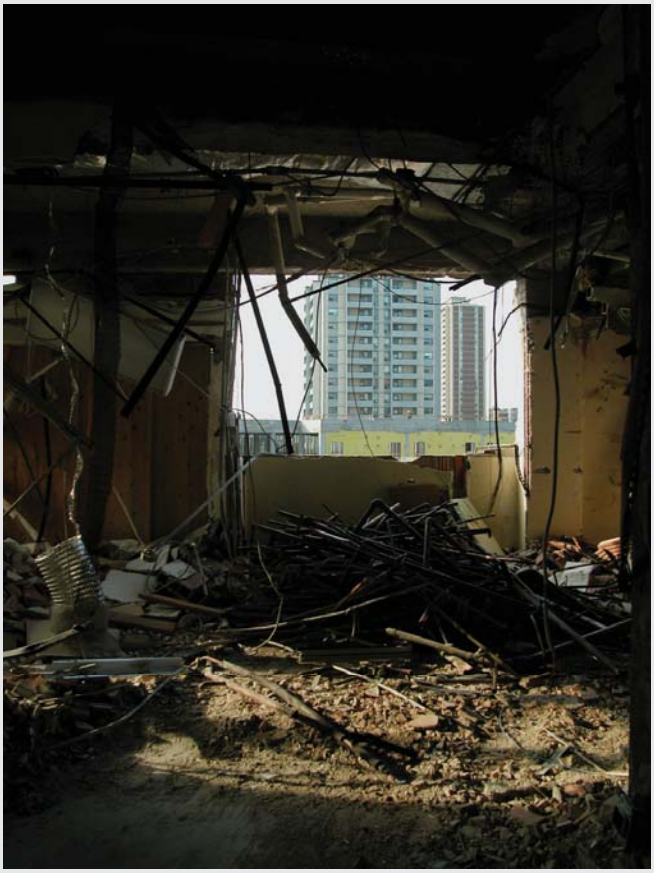
Kostoglotov had already seen people with bloody swellings in the clinic. His own sluggish, diseased blood, ruined by the X-rays, was still more precious to him than any fresh addition.

Then she turned on the screw. The bubbles started. Looking up the ceiling, he began slowly to think aloud: 'If my life is totally lost, if I can feel in my bones the memory that I am a prisoner in perpetuity, a perpetual "con", if Fate holds out no better prospect, if the only expectation I have is being consciously and artificially killed – then why bother to save such a life?'

The gay transparent bubbles kept gurgling. The level of blood in the bottle was falling. A quarter of it was already transfused. It was a woman's blood.

Aleksandr Solzhenitsyn – Cancer Ward

At Xexe Gallery, Mathew Sweig's 'Terminus' exhibition contained paintings of Princess Margaret Hospital in its last days. You could see in this heroically scaled drawings no trace of the messy St. James town, projecting off the ground, dense and unhygienized. Against the bright memory of the gallery show, I dared to insist, what is to be done with this building, which was neither here nor there, ubiquitous cancer post-war hospital?!



15. Princess Margaret Hospital demolition site, summer 2004, courtesy Matthew Sweig

16. Princess Margaret Hospital demolition site, summer 2004, courtesy Matthew Sweig

17. Princess Margaret Hospital demolition site, summer 2004, courtesy Matthew Sweig

Matthew was renting one of those sparsely decorated artist studios down Richmond Street. Upon the scheduled visit, he asked me whether I prefer tea or coffee. Heating through, he loosed the warm liquid between two adhered mugs and with blushing warmth, the alien drink started to tame my shyness and to enhance acuity, the race of heart, and a vague anticipation of gestures.

I repeated the questions he answered in the newspaper article: why was he interested in the site, why paint after photographs. His uncle was working for the demolition company and he was able to thread the closed down structure at ease, so I asked to see the interior shots. 'These aren't the originals, I have already altered them' followed his invitation to move beside him in front of the computer pregnant with duplicate files to be transferred on.

18. Princess Margaret Hospital demolition site, summer 2004, courtesy Matthew Sweig

19. Princess Margaret Hospital demolition site, summer 2004, courtesy Matthew Sweig

20. Princess Margaret Hospital demolition site, summer 2004, courtesy Matthew Sweig

Before I left, I told him that I was still looking for the plans of the building. We were to see each other again had I found them.

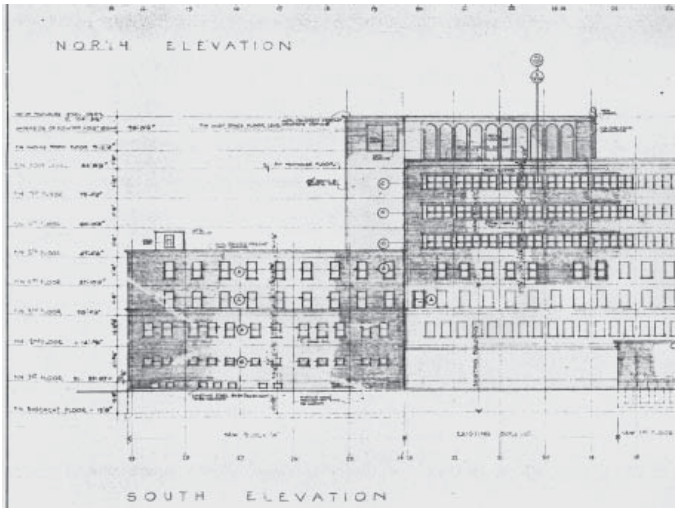
21. Princess Margaret Hospital demolition site, summer 2004, courtesy Matthew Sweig

INSTITUTION

> What she suffers from is an underdevelopment of science. When science advances, all chicken-houses will be clean and decent.
>
> Aleksandr Solzhenitsyn – *Cancer Ward*

In May 1958, after 6 years of planning and construction, the building on 500 Sherbourne Street was completed and ready for patients. While a series of research spaces were in operation since 1957, the official opening of the Ontario Cancer Institute/Princess Margaret Hospital happened on September 25, 1958. This was the culmination of a process that started 26 years earlier, in April 1943, when the government announced and incorporated the Ontario Cancer and Research Foundation (OCTRF) to formulate and implement cancer care policy. Its mandate covered most aspects of cancer control, such as research, coordination of diagnostic and treatment centres in general hospitals, public and professional education, the transportation of patients, recording of cases, and evidently, the establishment of a cancer hospital/institute. It was however only in February 1951, that Premier Leslie Frost announced the provision of funds for the construction of a central cancer treatment and research centre and incorporated the Ontario Cancer Institute by an act of legislature.[1] In 1952, the Ontario Cancer Institute Act designated the OCI Board to be responsible

1 This was a bold step, since no dedicated cancer hospital existed elsewhere in the country. The OCI remained unique until the Cross Hospital was established in Edmonton in 1968. McCulloch, E.A. *Ontario Cancer Institute: Successes and Reverses at Sherbourne Street*. Montreal, Qc.: McGill: Queen's University Press, 2003



for the construction of the building at 500 Sherbourne, on the grounds of the Wellesley Division of the Toronto General Hospital. Scholarly research at the time was advising:

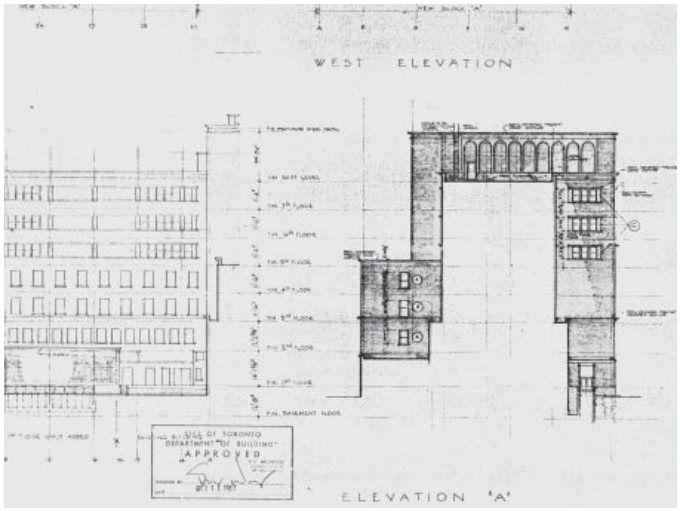
> The architect should demonstrate to the owner that it will pay to make careful long range plans even when immediate needs are urgent and future expansion possibilities may seem remote.[1]

The initial project, as well as the long series of additions and alterations to the building, were designed and supervised by Allward & Guinlock Architects. The completed building was a long narrow structure, fronting on Sherbourne Street and occupying almost half of the block between Sherbourne and Jarvis Streets, eight stories high over most of its extent, with the possibility to expand toward Homewood Lane.

South of the site, the Wellesley Hospital building was physically

1 Wheeler, E.T. *Hospital Modernization and Expansion*. New York; Montreal, Qc.: McGraw-Hill, 1971, 9

22. PMH North Elevation alteration drawing, 1967, Allward & Gouinlock Architects



joined at almost every floor with the new construction. The physical link between the OCI/PMH and the Wellesley was a clinical necessity. The new cancer institute was never intended to have many of the services essential for a general hospital. A major example was the policy to exclude all but the most minor surgery. This prompted most of the plans of the new hospital to be rather flexible in terms of room use. As for the cooperation between the two healthcare units, it remained somehow cold. The PMH/OCI developed from the beginning as a very independent-thinking institute, not interested to come under the authority of any other hospital. Through the years, Wellesley and OCI/PMH had different cultures, which never seemed to blend. The Ontario Cancer Institute kept an image of a highly specialized research complex, while Wellesley was a general hospital with physicians dealing with regular patients.

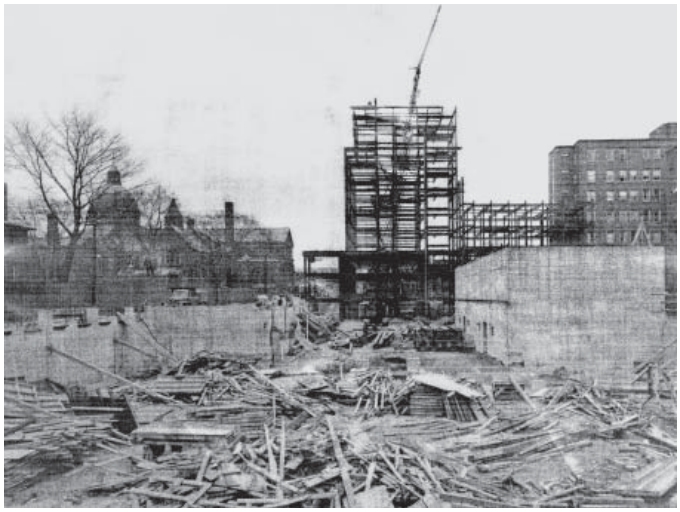
Starting in 1962, major expansions were completed in 1969, 1977, and 1982, focusing on updating the actual healthcare facilities and adding more patient units. Despite this, spatial constraints remained

23. PMH West Elevation alteration drawing, 1967, Allward & Gouinlock Architects

constant, and, with the increase of patient cases, the situation only worsened by the mid-1980s. In 1972 the boards of the OCTRF and the OCI jointly conducted a capacity role study. While "fundamental research was a world-class provincial asset", clinical services were problematic in quality, because of the steady and predictable increase in the number of cancer patients coming for treatment. In order to meet the problem completely on site, the PMH/OCI would have had to double in size. Instead, the board opted for limiting the number of new patients per year. Still, some expansion was needed in order to update radiotherapy for the designated fifty five hundred new patients. The study recommended the construction of 90,000 square feet of additional space, most of it for outpatient clinics and research space.

> When the provincial government considered the role study and the OCI master program, their own fiscal problems led them to decide against the expansion on Sherbourne Street. In a few years the results of this negative decision were to be very hurtful for cancer patients and

24. Princess Margaret Hospital construction site, spring 1957, courtesy PMH Archives



the professionals that cared for them.[1]

The adjectives used to describe Princess Margaret Hospital in local media started to shift their positive tone around 1983, from healing harbourer of medical advancement, to overcrowded, outdated, and dehumanizing. This was also around the time when Ontario government approved the second healthcare report, which concluded strongly recommending a major renewal of its premises.

> The joyless institutional block was as crowded as a subway station at rush hour, dingy, dim and shabby. I often came out thinking the building needed radiation worse than I did.[2]

In 1985, redevelopment was recommended, and in 1986, funding for

1 McCulloch, 2003, 100

2 Mays, John Bentley. "Tender Edge to Hospital Design – Functional Healing" *The Globe and Mail* (April 25, 1983) C

25. Princess Margaret Hospital construction site, spring 1957, courtesy PMH Archives

a move was approved. Health Minister Murray Elston announced his $200 million war on cancer on August 5, 1986, inside Princess Margaret Hospital. His decision to build a new hospital rather than modify the existing one meant that they were going to be able to conceive (again):

> ... a new structure that can be designed and equipped to house the most recent advances in cancer patient care, treatment and research.[1]

Four sites were initially considered, and partly because of a recurring feeling of relative geographic isolation, the OCI/PMH decided to relocate closer to the major downtown hospitals.

> It was the vision for improvements to interdisciplinary and inter-institutional cooperation in serving patients and optimizing research that inspired our plans to relocate to University Avenue.[2]

Princess Margaret Hospital wasn't decommissioned by the HSRC. Its Board decided that it was time to move, as the need to expand and modernize was not merely a matter of institutional self-interest but also a matter of sheer will. Hospitals had a mandate and, many believed, a social duty to expand, rebuild, and reequip. Building depreciation was only part of the reason, natural and potentially fixable as with the previous renovations. The accelerated drop in status combined with overcrowding prompted the change. As early as April 1991 the move to the 'location proper', on 610 University Avenue started its course. Soon afterwards, the location was closed down.

Between December 1999 and April 2000, the province made the site of the former Princess Margaret Hospital available to the City of Toronto to be used as a temporary emergency shelter for the homeless. A couple of months later the Ministers of Community and Social

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1 Minister Elston, as quoted in John Douglas "$200 million fund for cancer care launches Ontario health program", *The Globe and Mail* (August 6, 1986) A1

2 OCI/PMH Annual Report 1990-91, as quoted in D.H. Cowan, *Closing the Circles: A history of the governance of cancer control in Ontario*. 2004 < www.cancercare.on.ca> accessed April 2007

Services, and Municipal Affairs and Housing announced that Ontario was going to donate the site to the City of Toronto, providing in this manner, 500 rooms. Unable to sustain this use, the site was sold to a developer who decided to build high end high density residential units. The expectation was that the money obtained from the transaction to go towards building a homeless shelter somewhere else.

26. Princess Margaret Hospital operating site, spring 1960, courtesy PMH Archives

The only drawing preserved in the new Princess Margaret Hospital archives was a fragment of a basement plan, redesigned in the 1980s to accommodate a new X-ray machine.

At the Micro Controlled Access Room of the library, the water fountain was leaking and one could distinguish the peopled smell of salad. The flat ceiling lights settled again to quietly shudder their white signs of expectation. Chipping decay was more visible on the sunny parts of the pastry painted walls, and in the coiling ventilated air, carpet fabrics aped dust and silence. With every turn, the microfilm machine shrieked its plastic-cream knobs, creased and in their creased darker, not old enough, no. Every time I pressed the 'print' switch, a deaf short clap spread the murky smell of toners through the room. The pages primly stapled on excess of ink: sweltering, high contrast, soon to stain my fingers.

Signalled by a fresh sound, the machine jammed.

Eventually preferring it to meeting the people with the piled up archives of hospital history, I started going regularly to the site, ignoring the slowly emerging and slightly bothering thought that I should have looked for a different location.

There they were, the fragments of signs and the increasingly distinguishable voices: shrieks, barks, rattling, the short accelerated drillings, the long ones, the carping motor of the yellow arm with its low insistent clenching over the rusted, twisted, metal scrapes. I watched the cables and ducts dragging hissingly on the ground and the whiny vegetation fall with the wind rounding, hasting under the blue plastic sheets, bringing about stale smells.

After a while, only the can-sprayed fence kept standing, against the gaze of the others, hiding its ailing edifice, x-rayed into fruitlessness, through the skins of former patients and through floors and stairs and air returns, twelve hours a day, every day, for not even thirty, of which half crowded years.

The construction waste was gradually carried off site and the land was covered by winter. During that time, so as to mirror the tip-up trucks, I merely drove around and barely stopped.

At the city hall archives, the slides of the blueprints finally awaited me, with the owner's consent form waived, as the building was now demolished.

On my way to the underground office, the corridor floors were drearily waxed, glowing sweet and acrid at the same time, and unfamiliar, yet. After a hasty timid selection, the rolled-up plans were gleefully and uneasily sticking out of my hand.

TRANSFORMATIONS

> Pavel Nikolayevich found everything in the place unpleasant: the path worn by countless pairs of feet on the cement floor of the porch; the dull door-handles, all messed about by the patients' hands; the waiting-room, paint peeling off its floor, its high olive-coloured walls (olive seemed somehow such a dirty colour), and its large slatted wooden benches with not enough room for all the patients.
>
> Aleksandr Solzhenitsyn – *Cancer Ward*

Preservation of the built environment, usually understood as a means to counter the natural wear and tear of time on materiality, is arguably not a new practice. Whether for symbolic, economic, or recently environmental reasons, societies have always considered actively updating the building stock, whether is was through conservation or conversion.

The use of the term *conservation* refers to the whole subject of the care and treatment of *valuable artefacts*, both movable and immovable.[1] Structures acquire length of use through a reframing of their position, not only in relationship with the future use, but also with their past. This modern concept of conservation developed in the eighteen century with the raise of Western historical thought and through the tension between the rationalism of the Enlightenment

1 Within the discipline conservation has two aspects: *the control of the environment to minimize the decay of artefacts and materials* and *their treatment to arrest decay and to stabilize them where possible against further deterioration*. Restoration is the continuation of the latter process, when conservation treatment is thought to be insufficient, to the extent of reinstating an object, without falsification, to a condition in which it can be exhibited.

and pre-Romantic and Romantic feeling. An earlier important step occurred in fourteen century Italy, when Renaissance humanism recognized in antiquity both a historic epoch of the past and an ideal model that could inspire contemporary culture and open it to future developments. This defined a new form of relation to the past, uniting the objectifying distance and the creative present.[1] The nineteen and twentieth centuries expanded the conservation domain to include sectors originally neglected by the classical tradition, like the Romanesque, the gothic middle ages, the baroque world, and then gradually historical ensembles, vernacular or popular production, as well as more recently, industrial landscapes.

Alongside the new sense of historicity and a romantic nostalgia for the past, grounds for the modern interest in heritage include the esteem held for specific qualities of past achievements, the desire to learn from past experiences, as well as from the shock caused by inconsiderate changes in familiar places, destruction and demolition of well-known historic structures or works of art.[2] However, the key issue in modern conservation is the question of values. The notion of value itself has undergone a series of transformations.

> Value can no longer be defined, as in the Classical age, on the basis of a total system of equivalences, and of the capacity that commodities have of representing one another. Value has ceased to be a sign, it has become a product.[3]

Today, the *perception* of the heritage value of a period's architecture is at the core of any preservation effort. Much modernist architecture was inspired by a collective optimism and a sense of opportunity

1 Jokilehto, Jukka. *A History of Architectural Conservation*. Oxford Elsevier: Butterworth-Heinemann, 2004

2 Much of this destructive change has been caused by the same technical and industrial developments that have founded the emerging modern society.

3 Foucault, Michel. *The Order of Things* 254

that embraced innovation and strove to use the achievements of the Industrial Revolution to provide aesthetic and social benefits through functional building for more and more people. However, the perception of modernist architecture, particularly from the postwar period, [1] has been characterized since the 1980s in extremely harsh terms, as indifferent to human scale, comfort, or well-being. The period's icons, while appreciated and praised by a professional audience for aesthetic or social values, have been rejected by the public at large, which has a great deal of negative perceptions about modern building design. The anti-modern bias resulting form the advocacy of the 1960s and 1970s is not yet overcome. It should not be surprising that those who fought so hard against urban renewal to preserve an earlier heritage are

1 Although reactions to urban renewal may not have been the only driving force behind the preservation movement, much of the legislation and standards in the US were certainly created against that backdrop, which resulted in a bias against modern architecture. Prudon, Theodore H. M. *Preservation of Modern Architecture*. Hoboken: Wiley, 2008

27. Jose Alday Hospital de San Rafael, Spain, 1791, restored in 1983 as regional government

not as easily mobilized to advocate for the preservation of buildings of the recent past. This perception remains a serious obstacle against preservation efforts.[1]

Further on, the way in which modernist architecture sits in relation to temporariness has presented another fundamental challenge for preservation philosophies, which are still infused with earlier concerns such as permanence and authenticity.

In addition, the modern life's ever-changing expectations have added new and unexpected demands on buildings, resulting in the emergence of another concept, specifically addressing the evolution of building use. Clearly distinct from physical depreciation,[2] building obsolescence[3] was first employed in relation to architecture in the wake of the twentieth century fast growing Chicago, and was used to explain the unusually short life of some modern office buildings. Causes for obsolescence were initially rather intuitive, running from "the influence of fashion, change of habit, competition, development of new territory and shifting of centres of population and business, altering of lines of transit."[4] In 1915, a new income tax deduction specifying two distinct categories, physical decaying and economic obsolescence, generated further empirical research into a building's 'legally recognized life time.'

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1 Against this new background, some suggested that the conservation movement, as it evolved from the 18th century, be considered as concluded, and that the modern conservation should be redefined in reference to the environmental sustainability of social and economic development within the overall cultural and ecological situation.

2 named now to match, physical obsolescence

3 Obsolescence is the process of an asset going out of use. It has been termed 'the forth dimension in building.' In a general sense, obsolescence is a measure of an object's usefulness over time. It indicates the tendency of assets and operations to become out-of-date, outmoded, or old-fashioned. It is the transition towards the state of being obsolete, or useless. An item that is broken, worn out or otherwise dysfunctional, however, is not necessarily obsolete.

4 Bolton, Reginald Pelham. *Building for profit: Principles Governing the Economic Improvement of Real Estate*. New York: De Vinne Press, 1911, 75

The Chicago based National Association of Building Owners and Managers (NABOM), whose interest was promoting the recognition of the dramatic impact of obsolescence, surveyed the local situation and generated one of the first North American documents specifying the length of use for existing construction, averaged at 32 years. The following year, the government published "tables of depreciation and obsolescence allowances" categorized by modes of construction and programme.[1] The real estate successfully turned the extreme cases of short life buildings in Chicago into national standards for the tax code.

The broader cultural achievement of this effort was however the discovery of the idea of architectural obsolescence: a building's value was measurable and representable in time and money and this value was always declining. This theory was aggressively pitched and soon became an accepted popular myth, resonating in the American consumer society, whose automobile industry introduced the idea of annual model changes, and whose marketers promoted 'progressive obsolescence': a readiness to scrap an article before its natural life or usefulness is completed, in order to make way for the newer and better thing. By the 1930s, the term obsolescence was ubiquitous in the fields of real estate, finance and planning. In UK, there was no discussion or similar law. Canada was itself more conservative, but the American ideals were slowly infiltrating especially in the urban and financial centres. [2]

For the architectural practice, it was difficult to ignore the 'hovering' threat of obsolescence. Architects struggled to adapt to what they perceived a situation of ceaseless accelerating unpredictable

1 20 yrs – wooden mill buildings, 50 yrs – fire proof homes and stores, 40 yrs – fireproof office buildings

2 For an in depth discussion on the birth of architectural obsolescence, see Abramson, Daniel M. "Obsolescence: Notes Towards a History." *Praxis: Journal of Writing + Building* 5, 2003, 108

change, in which obsolescence was the sure fate of all architecture. The frantic search for flexibility materialized in the open plan factory shed,[1] 'indeterminate architecture',[2] and even 'expendability'.[3] The latter however finally managed to change some of the discourse from 'progress' to 'waste', and obsolescence as a dominant way of thinking about change gave way to its opposite and successor term, sustainability, stressing the conservation of natural and cultural resources. However, while now,

> Obsolescence should be viewed as a function of human decision rather than a consequence of 'natural' forces[4]

sustainability has had little to say about postwar modernist landscape, other than most being inefficient in terms of building performance.

While the discourse of obsolescence emerged in the context of financial mobility and capital flows striving to match the economic demands of 'creative destruction,'[5] it nevertheless informed the rise of functionalism with increasingly relevant consequences

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1 this is a different open plan than that proposed by the early modernists, although, it does heavily borrow on its language in order to validate itself

2 English architect John Weeks' proposed concept was exemplified at Northwick Park Hospital – designed to be 'morphogenic', as it could change its shape in order to remain adaptable and therefore immune to obsolescence, accounting for both growth and shrinking (due to its variety of standardized spaces, you could just tear down the ends of it, according to need)

3 In reaction to the obsolescence threat, Cedric Price insisted that there was no need to have a long lifer; 'the short life building' was as valid an endeavour. None of the buildings he designed, built and then scheduled for demolition were torn down at their respective expiry dates.

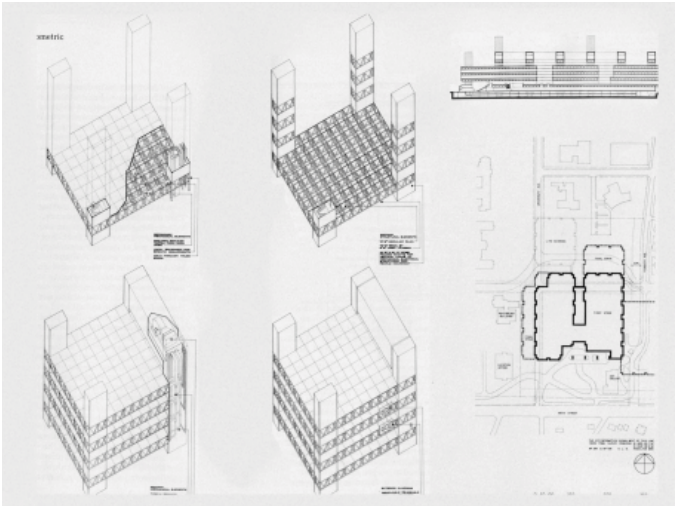
4 Nutt, B. "Obsolescence", as quoted in Douglas, James. *Building Adaptation*. Amsterdam; Boston; London: Butterworth-Heinemann, 2006, 25

5 "That which incessantly revolutionizes the economic structure from within, incessantly destroying the old one, incessantly creating a new one. This process of Creative Destruction is the essential fact about capitalism. It is what capitalism consists in and what every capitalist concern has got to live in." Schumpeter, Joseph. *Capitalism, Socialism, and Democracy*, 3rd edition, New York : Harper & Brothers, 1950, 83

for hospital design. The development of new types of studies, which were predicated on various forms of numerical empiricism, established and maintained the kind of professional practice that was increasingly expected of such a specialized field. The 1900s multi-storey typical health care structure soon quantified the different rates of growth and change of its components. So far, the hospitals were mostly designed according to the division of services, technologies, and wards, however health facilities planners realized that the "change" criteria was a more efficient organizational tool. Thus, hospital elements were classified as *permanent* and *temporary* instead. Then, given further medical advancement, 1930s design strategies began to include flexibility of space, to allow for change also within the 'permanent'. Alongside, the new practical studies and models began to quantify the useful life expectancy of health care facilities. A frequently suggested figure was a fifty year span for the structure.

In the early 1960s, the main conclusion was that it was better to design a building that inhibited change of function least, and not one that fitted specific functions best.[1] This prompted health care architects to orient their design based on a *dynamic concept* rather than a static one. The McMaster Health Sciences Centre (MHSC) in Hamilton, designed in 1972 by Craig, Zeidler, & Strong Architects, can be cited as such an example. Adhering to the use of the fashionable system approach for hospital design, Zeidler created an infinitely flexible space, deliberately designed never to be finished. Everything from MHSC's design, function and image as a prototype of the "plug-in machine" demonstrates its utopian vision. Its most important design principle was growth. The building components were planned in advance for both horizontal and vertical expansion, the structure of the building was designed to support the extra weight, the elevators and stairways

1 Bendali-Amor, Redha Yassine, *Hospital obsolescence: Its perception, effects on facility planning*, PhD Thesis Michigan: University of Michigan, 1993



were extended to the level of the future floors, and areas in the building were left unfinished to accommodate inward growth. For flexibility, Zeidler designed the famous modular system, whose function was the integration of the building structure with the primary electrical and mechanical services, making use of 'interstitial spaces', complete engineering sub-floors (nearly 2 meter high) sandwiched between two regular floors.

> Function is more ephemeral than structure, and a building must not be integrated with a single set of functions.[1]

At the time, the design was considered extremely efficient, not only in reducing future adaptation costs, but also in terms of organizational and timesaving intentions. However, MHSC didn't expand as envisioned. In 2002, when additional space was needed, the Hamilton Health Sciences

1 Zeidler, Eberhard H. *Healing the Hospital: McMaster Health Science Centre, Its Conception and Evolution*. Toronto: Zeidler Partnership, 1974

28. Zeidler Partners, McMaster future expansions, unrealized, Hamilton Ontario 1972

Corporation chose to invest in a new building, constructed near the hospital, instead of completing the initial plan. Many of MHSC's changes happened at cross-purposes from the original design, with patient wards redesigned to suit specific needs and not taking advantage of the uncompromising similarity of shape and hierarchy with which they were designed.[1]

Later on, it was the 'patient centred approach' that required another thorough reorganization of hospital components. New departmental adjacencies and an increased emphasis on the public areas of hospitals generated different designs, often at cross purpose to the way existing hospitals were organized. In general, it was acute care that suffered the most changes. In the case of the long term care or hospice design, the comparatively reduced scale of the technological apparatus allowed for longer-living solutions.

Recently, unable to escape technological advances, environmental concerns orient increased effort towards better building performance. All these factors contribute to increase the rate of functional obsolescence of buildings which are also among the most considerable investments in a given urban fabric. In response, contributions from the architectural field have proposed to transform the model of design built, in order to add functioning and maintenance, closely coupled again with quantifiable notions of life-span, now reduced to 30 years, without addressing current hospitals however.

While dealing with significantly different built stock, both the preservation and obsolescence models described above have come to arguably similar conclusions. Today, we don't think of instantly demolishing buildings, we think first of revaluing them. Nonetheless, what is problematic in this revaluation of modernist architecture, and to a certain extent, visible in the way Princess Margaret Hospital was

1 Pilosof, Putievsky N. and March, McGill (2005), *Planning for Change: Hospital Design Theories in Practice*, The American Institute of Architects, Academy Journal, October 19, 2005

'revaluated',[1] is the degree in which the 'reassessment' discourse is employed to preserve the status quo of those with direct but narrower interests.[2] And, although the political forces activated in Princess Margaret Hospital's case also include less traditional players, such as the outspoken grassroots homeless organization groups or the demolition company hygienist agenda, in the end, what is actually missing from this negotiation is a meaningful 'revaluation' of a functionally obsolete yet potentially far from over building.

At one end, taxation incentives for developers to reconsider a 'proper' revaluation of postwar modernist buildings can only work so far. On another level, the myth of a short-life span does advantage the architectural practice, as is currently defined, so, if only tacitly, we are often complicit with its propagation. It is worth remembering that formalized research was first undertaken in the 1960s and gave particular attention to the problems created by the transformation of institutions.[3] The brainchild of second wave modernism, the studies suggested that most buildings could be physically suitable for adaptation to most uses, generating the

1 In the case of the former Princess Margaret Hospital, the available useable space was deemed inadequate in terms of both layout and size. Upgrading the structure to comply with building and fire regulations was declared non-viable because of the extent of remedial as well as improvement works required. The presence of extensive deleterious materials such as asbestos was an influencing factor. When construction has any kind of value, whether symbolic or emotional for some (affluent) community or organization, the technology exists and the spending is not the first issue

2 a Bourdieuian analysis would reveal that whether standing to gain symbolic, economic, or cultural capital, they do have precise vested interests and would advocate for them, not at the expense of everything, but against an extremely vague and rather invisible concept of 'architectural potential'

3 Cowan, Paul. "Studies in Growth, Change and Ageing of Building." *Transactions of the Bartlett Society* (1963): 56-58, as quoted in *Building Adaptation*. They focused in fact on the rapid growth of hospitals.

infamous 'long life – loose fit' proposition.[1] The construction industry already crudely exploited the most economically advantageous of these findings, marked by an overused 'flexibility' mantra, and the resulting structural neutrality ended up generating an overall blandness. This resulted in the concept being abandoned from architectural discourse. Without a sustained and repeatedly revisited dialogue on the subject, there is no language formation that allows for approaching this issue.

In recent years however, the view of longer use potential has been experiencing something of a revival under the tenets of certain models of sustainability agenda, adding an ecological imperative to retrofitting the existing built. This means working not only with historically valuable structures, but more and more with ordinary buildings, not only with centuries old foundations, but equally with comparatively recent construction. The generic modernist landscape is increasingly becoming recognized for being more structurally sound and even more 'loose-fit' than its traditional counterparts, therefore considered a significant candidate for sustained convertive solutions. In its updated form, the current 'reskinning' of larger scale buildings[2] in order to meet

1 When all sizes of spaces used for a generic set of human activities were plotted against frequency of occurrence, the peak of the curve occurred at around 20sq. m.

2 "Concrete high-rise possesses an extremely durable armature that can accommodate a succession of building skins, provided they are designed for obsolescence (i.e., ease of replacement.) Historically, buildings were designed with excellent durability characteristics. This was largely due to the traditional nature of the structural and envelope systems employed. As a prime example, load-bearing masonry construction integrated armature and skin; hence the façade inherited the durability of the structure. Modern building have departed from this traditional approach, but designers have not yet fully appreciated that with the separation between armature and skin, facades should be designed as sacrificial layers tat will be replaced or rehabilitated several times during the useful life of a building. Magically, this DNA was incorporated into Canada's concrete high-rise stock." Kesik, Ted. "Durability Is Only Skin Deep", in McClelland, Michael, and Graeme Stewart, E.R.A. Architects eds., *Concrete Toronto: A Guide to Concrete Architecture from the Fifties to the Seventies.* Toronto: Coach House Books, 2007, 312

both new environmental standards and fresh aesthetic expectations is however still predicated on local interest and resources, and in some ways it doesn't seem to go far enough, its model possibly generating another 'blandification' of our cities. Nonetheless, is the singularity of this current heavily 'participatory' advocacy adequate in dealing with the vast amounts of ubiquitous modernist landscape?

On a conceptual level, it is hardly difficult to see that we are still struggling (blindly or not) with the striking paradoxes surrounding the modernism paradigm, seductive and menacing, overcome and yet present again. Architectural critics like Anthony Vidler[1] have already considered the modernity as an unfinished task of a historical and heroic but also deferred project,[2] while questions like the one posed by the recent Documenta 12 abound: "Is modernity our antiquity?"[3] The past tells us that there was a long wait until antiquity ceased to be problematic; and it was only after it was perceived as fully 'terminated' in its pagan dimension that it could be revived through a reappraisal of the ancient ideals, which allowed Christian consciousness to work on the stabilization

1 Vidler, Anthony. *The Architectural Uncanny : Essays in the Modern Unhomely*, Cambridge: MIT Press, 1992

2 In *Philosophical Discourses of Modernity* (1984), Habermas claimed that the project of modernity was 'unfinished' and contained unrealised capacity for emancipatory potential

3 Documenta 12 <http://www.documenta.de/leitmotive.html?&L=1> "It is fairly obvious that modernity, or modernity's fate, exerts a profound influence on contemporary artists. Part of that attraction may stem from the fact that no one really knows if modernity is dead or alive. It seems to be in ruins after the totalitarian catastrophes of the 20th century (the very same catastrophes to which it somehow gave rise). It seems utterly compromised by the brutally partial application of its universal demands (*liberté, égalité, fraternité)* or by the simple fact that modernity and coloniality went, and probably still go, hand in hand. Still, people's imaginations are full of modernity's visions and forms. In short, it seems that we are both outside and inside modernity, both repelled by its deadly violence and seduced by its most immodest aspiration or potential: that there might, after all, be a common planetary horizon for all the living and the dead." Roger M. Buergel, December 2005

of interiority through its reform movements.

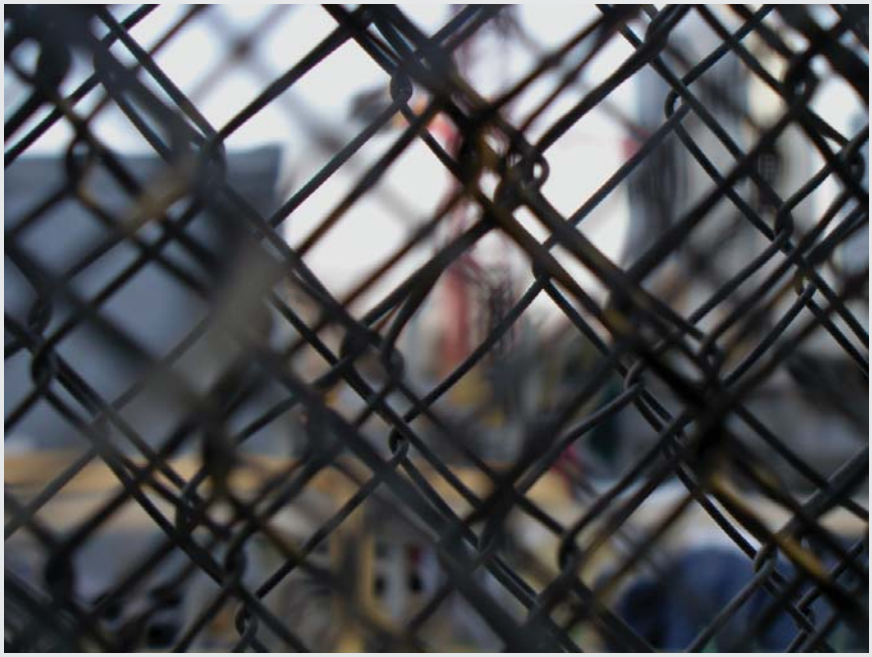
Societal perceptions of obsolete institutions seem to say that we're not there yet.

On Sherbourne, large sheets of poster-covered plywood were now outlining their block sized box of unearthed soil. Machinery began drilling rhythmically, cranes came in place, and the ground finally split, birthing its new skeleton.

29. 'The 500 on Sherbourne' Condominiums construction site, winter 2007, by author

30. 'The 500 on Sherbourne' Condominiums construction site, winter 2007, by author

31. 'The 500 on Sherbourne' Condominiums construction site, winter 2007, by author



32. 'The 500 on Sherbourne' Condominiums construction site, winter 2007, by author

The units were selling. New eyes flooded the streets where the patient wings were, passing by the gardens ready to be infested with usual blossoms, leaping out of limely undergrown trees. It was still winter, yet somebody had already painted them white waist down.

CONCLUSION

> The book was very right, of course, so long as everyone started living by it at the same time. … [He] realized he couldn't do as he wanted and go back to bed. He had to get himself ready for discharge.
>
> Aleksandr Solzhenitsyn – *Cancer Ward*

In her famous 1978 monograph *Illness as Metaphor,* American essayist Susan Sontag set out to challenge the 'blame the victim' mentality she found prevailing behind the language society often used to describe illness and those suffering from it. In a textually depersonalized reaction to her own medical condition, she advocated for the expulsion of all metaphorical thinking from responses to disease, in order to "de-link illness from normalizing judgements."[1] It was not only the established discourse of the medical institutions that she wanted to reform. She insisted that one must also keep wary of the popular meanings certain diseases take on and acknowledge the negative effects of their trafficking other discourses as well.

> To think of an event or situation in terms of illness, is to impute guilt, to prescribe punishment. This is particularly true of the use of cancer as a metaphor. It amounts to saying first of all, that the event or situation is unqualifiedly and unredeemably wicked.[2]

Ten years later, adhering to the tone of a different decade, she revisited

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1 Diedrich, Lisa. *Treatments: Language, Politics, and the Culture of Illness,* Minneapolis: University of Minnesota Press, 2007, 28

2 Sontag, Susan. *Illness as Metaphor,* New York: Farrar, Straus, and Giroux, 1978, 5

and expanded her argument, going as far as confessing of having prefaced her original book with "a brief, hectic flourish of a metaphor, in mock exorcism of the seductiveness of metaphorical thinking."[1] "Of course one cannot think without metaphors," she was now writing, but

> I didn't think it would be useful – and I wanted to be useful – to tell one more story in the first person of how someone learned that he or she had cancer, wept, struggled, was comforted, suffered, took courage … though mine was also that story. A narrative, it seemed to me, would be less useful than an idea.[2]

Sontag's critique of the social and moral meanings attached to certain illnesses has been part of a larger cultural work pertaining to the confrontation and transformation of societal values. From the 1960s on, the increasing institutional alienation generated strong discursive currents in Western culture, advocating a reassessment of modern society's values, not in the least to enable the individuals some control over the institutions affecting their lives.[3]

> The remedy proposed by the New Left for the prison of bigness was cultural. Emotional declaration, made face to face, in small groups, would spawn a more humane order; the lessons of intimacy would be applied to society as a whole. The history partially granted their wish.[4]

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1 Sontag, Susan. *AIDS and its Metaphors*, New York: Farrar, Straus, and Giroux, 1989, 3. The metaphor she's talking about is in itself telling: "Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. …We all prefer to use only the good passport."

2 Sontag, 1989, 13. This attitude is not popular these days: identity politics and recycling of national myths all belong to what American literary theorist Stanley Fish has named "interpretive communities", in which (questionably unintentional) vested interests reproduce (in Bourdieuian sense) themselves.

3 It is perhaps worth noting that grassroots tendencies were only possible in those political environments in which democratic practices have had long standing traditions, and whose institutions possessed the necessary definitions and leverage to change.

4 Sennett, Richard. *The Culture of New Capitalism*. New Haven, Conn.: London: Yale University Press, 2006, 182

In healthcare, the emergence of 'illness as event' was proposed by a new mode of discourse focusing on the political. Consequently, the previous understanding of passive patienthood was transformed by this rise of grassroots activism around health issues which permeated the exclusive circles of the medical establishment.[1] However, Sontag's polemic already hints at its instrumental use. This politicization (and the implicit assumption that 'one is always free to chose'), writes Lisa Diedrich,

> gets covered by a neoliberal mode of being ill and doing illness that emphasizes the discourses and practices of *personal* responsibility in matters of health.[2]

Sontag's impatience with what she perceived was a constructed need to make illness meaningful can be understood as the political attitude of an already formed subject, coming out of the 'good end' of Michel Foucault's series of 'disciplinary strategies' which are not only the producers of 'docile bodies' but are also a way to capacitate oneself, allowing for a dimension of subjectivity defined as situated freedom.[3] It is with this in mind that I have tried to 'inhabit' what I call the 'proper histories' of my case study. This allowed me a sort of understanding that what is occluded, when it comes to postwar modernist epigones, is less a conspiracy and more how the overall negative attitude is the product of a shared sense of the current way to do and see architecture. So far, the disciplines seem to

1 Cassell, Eric J. The Nature of Suffering and the Goals of Medicine. New York: Oxford University Press, 1994, 14

2 Diedrich, 2007, 27

3 Foucault goes on asserting that this type of subject, produced at the point of intersection of various forms of knowledge, developed in relation to a new form of governing, which he situates in lineage with the liberal tradition. It is liberal governmentality that developed a fundamental critique of the former policing of State Reason and its emphasis on control, thus discovering that limiting the State's activity is a way of rendering it efficient. In Foucault's view, the emphasis on negative freedom is in fact a tactical moment in a strategy for increasing production, for rendering individuals useful.

endorse this conclusion. Writes Adams:

> The preservation issues surrounding hospital buildings and properties are complex. Expensive and notoriously difficult to convert, hospitals are often abandoned and fall quickly into disrepair and even ruin. (...) today's experts demonize interwar and postwar modern hospitals and even encourage their demolition.[1]

In response, architectural critic Andrew Ballantyne argues that we still need to understand the architectural object only with the aid of the knowledge of its context furnished by textual evidence, and to be constantly aware that what it conveys is more about its perception in a certain framework rather than a trans-historical truth.[2] Meanings of buildings are produced and transformed as the result of complex interactions of social and economic forces that put only some perspectives and decisions within reach.[3] The Princess Margaret Hospital case speaks not only of the resources allocated in its early days, but also of the fact that the deleterious condition in which it found itself 25 years later is an indication of their suppression by government financing. It also speaks of the absence of a practice that is used to engage with it. Given the current politico-economic coordinates, it 'makes sense' to demolish a structure that has ceased to be productive and has become increasingly costly. But what gets built in return?!

Currently, 'revitalization of an area' means more often than not almost exclusively high-rise condominiums. The case of Wellesley-Sherbourne area is far from unique. Other blocks have been demolished

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1 Adams, Annmarie. *Medicine by Design: The Architect and the Modern Hospital, 1893 – 1943*, Minneapolis: University of Minnesota Press, 2008, 129

2 Ballantyne, Andrew. "Architecture as Evidence." *Rethinking Architectural Historiography* Routledge, 2006, 46

3 "If we cannot find the evidence to reconstruct the outline of a culture, then we are highly inclined to imagine one and to project our own experience and intuitions onto what we see." Ballantyne, 2006

in the downtown core, in order to make way for them. With voguish names like *Verve*, *The Steam Plant*, *The Star of Downtown* and of course *The 500*, the projects are all advertising floor-to-ceiling windows, marble accents, laminated flooring and Euro-style kitchens, and in PMH's case, right across the street from St. James town, Canada's most densely populated and among the poorest neighbourhoods. An apple orchard designed by landscape architect Cornelia Oberlander draws inspiration from the trees once planted on the land of the previously sited Homewood Mansion. Designed by award-winning architect Paul Northgrave, the 500 has "the city at your feet."[1]

Maybe it is only between this 'relentless bright-siding' of living, through Ikea Modernism and toned-down Postmodernism, and the dull facades of Princess Margaret Hospital, that a certain problematic sense of loss is still discernable. At the periphery of this, engaged writers like John Martins-Manteiga, decry the facts in his recent study on what he calls *aedificium novum exstinctum*, raising awareness toward participatory action:

> Indifference and hostility have led to the demolition of modern buildings across Canada.[2]

On the other hand, architectural theorist Jeremy Till employs a more cynical rhetoric:

> Architects will have no business with demolition contractors; to control them would be to associate with disorder. We like to come to a cleared site, *to start again from the foundations*. This way we can exorcize the spectre of demolition (previous and potential) that haunts all construction.[3]

Urban critic Francoise Choay is less convinced. Her historical tracing of

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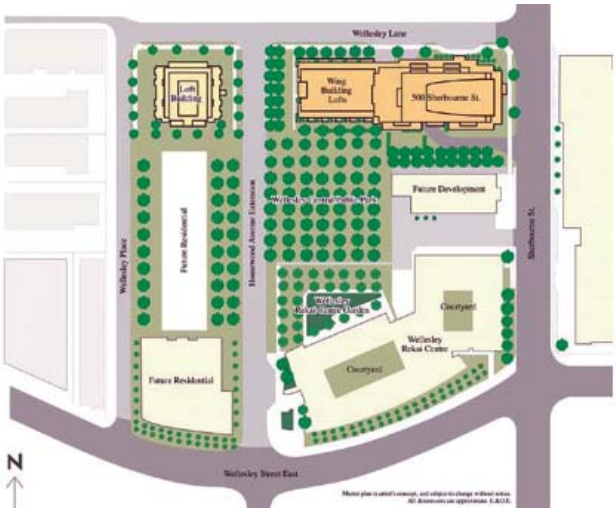
1 promotional website, the500condos.com

2 Martins-Mantiega, John ed., *Endangered Species*, Dominion Modern: Toronto, 2007, 14

3 Till, Jeremy. *Architecture Depends*, 2009, 68, emphasis in original



architectural attitudes towards demolition is indicative of how they are formed, revisited, inhabitued, practiced, and even discarded.[1] It is only in the recent times that neo-liberal rhetoric has been promoting the privatization of the costs associated with 'creative destruction,' through a re-engagement with the private sector, in which presence or absence of private interest is the only denominator of an institutionally obsolete building's value. If developers or heritage organizations are not interested, there is no alternative to demolition. Currently, these costs have become more and more visible. A new shift therefore seems possible from the current over-politicization (and its gripping instrumental stories) to the de-politicization of the relationship with the existing institutional built. This will entail an emphasis less on 'participation' and more

1 Choay, Françoise. "De la Démolition." *Métamorphoses Parisiennes*. Bruno Fortier ed. Paris : Editions du Pavillon de l'Arsenal, 1996

33. 'The 500 on Sherbourne' Condominiums proposed site plan, www.500sherbourne.com

on the responsibility to develop both a language and an adequate methodology to address its ubiquitous mass, through creating a stronger normative framework that stands to add to the value of concrete structures their capacity to carry 'architectural potential.' Transposing Giorgio Agamben's concept of 'bare life,'[1] as situated in relation to what its author perceives to be a gap in Foucault's workings of power, would mean striving towards a different kind of revaluing of these structures, that might allow the architectural

1 the comparison between Agamben's 'bare life' concept and the (symbolic) skeleton of modernist built environment is quite the stretch, pointing in itself at what Warwick Fox considers to be a current lack of language and theory able to address an ethics of the built environment in its artefactual dimension, which is essentially different from that of the natural world. However, the rather narrow concept of 'responsive cohesion' he attempts to develop in *A Theory of General Ethics* seems to fall short of that, indirectly highlighting the heroic radical dimension of the modernist project, as well as its no less spectacular, painful, and at times still evident failures. Agamben, Giorgio. *Homo Sacer: Sovereign Power and Bare Life*. Stanford, CA: Stanford University Press, 1998

34. 'The 500 on Sherbourne' Condominiums rendering, www.500sherbourne.com

practice to engage with them in different terms.

However, in my attempting to address the way in which current practices and discourses discard the value of decommissioned postwar hospitals, it becomes evident that this is only something of a discursive compromise, reflecting rather the way I navigated the information pertaining to the specifics of my case study. Thus, giving up both a conceptual solution and an undue critical stance, I have resolved to construct this lumbering artefact, made of some historically oriented elements, some political, some mimicking the normative tradition of architectural research, and some first person narratives considering the fraught experience of witnessing. In the end, mine wasn't an experience of the spatiality inherent inside Princess Margaret Hospital, and I had to rely on Matthew's pictures to grasp the sense of scale and spolia of the building. Therefore, the other conclusion to all this, and one I tried to avoid for a while, is that all I could do was to witness a dismantling.

to the East, the mirror
to the West, stone and the song of silence

Octavio Paz – *Envoi* (fragment)

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