CHANGING PURPOSES AND MEANINGS OF HOSPITAL SITES AND GROUNDS IN MELBOURNE

1848-1948

Anne Bourke

Submitted in total fulfillment of the requirements of the degree of Doctor of Philosophy

July 2011

Melbourne School of Design, Faculty of Architecture, Building and Planning,

The University of Melbourne
Abstract

Hospitals have changed from charitable institutions to medical centres in the hundred years from 1848 to 1948. Hospital gardens which had been an important part of patient treatment and integral to the hospitals identity were diminished as part of this transition. Focus shifted to a medical model that neglected the purpose and use of the hospital grounds for patients and staff. Meanwhile, studies of the built environment of hospitals have focused primarily on building typologies, architectural styles and architects, particularly those of the northern hemisphere. The significance of changes to the grounds for patients, staff and the identity of the hospital has been ignored. This thesis examined their changing purpose and meaning between 1848-1948 by analysis of nine hospital sites in Melbourne, Australia.

The study is original in analyzing the hospital grounds themselves as material evidence. I argued that purpose and meaning can be read in the physical characteristics of hospital sites, location, size, configuration, ground elements such as ornamental garden beds, and the manner in which the grounds were spoken about, used and intended to be used. I further argued that an intensive and comparative analysis of hospital grounds and the ways they were used provides an enriched understanding of hospitals and landscape of this period that cannot be derived from attention to an individual site, architectural styles or building interiors alone. A wide range of text from newspapers, government reports, professional journals and hospital annual reports and publications supported the analysis. A cohesive history of hospital development in Melbourne from 1848-1948 was written from primary and secondary sources to provide context for the narrative of hospital grounds and sites.

This study contributed three major findings that make a significant contribution to the scholarly literature on hospital landscapes of this period. Firstly, hospital sites in Melbourne were a full generation ahead of North America in exhibiting International Style tendencies. Secondly, that existing hospital grounds adopted International Style Modernism before it was evident in the buildings and finally, that the belief in heliotherapy as a treatment justified the use of sun balconies and flat roofs after earlier gardens had disappeared. It also established the significance of hospital grounds to patients and staff in providing social and cultural activities and emotional connection to place that supported their well-being, an aspect of their built
environment which had been previously ignored. It also addressed the imbalance in hospital history that has concentrated on the history of European and North American hospitals. Finally, the study of hospital sites and grounds gave important insights into the influence of hospital landscape on human well-being that is relevant to the design of the built environment today and contributes to academic work on the role of landscape in human health.
Thesis declaration

1. The thesis comprises only my original work towards the PhD.

2. Due acknowledgement has been made in the text to all other material used.

3. The thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices

Author

Signature  

Date:
TABLE OF CONTENTS

Abstract ................................................................................................................................. ii
Thesis Declaration ................................................................................................................ iii
Table of Contents .................................................................................................................... v
Acknowledgements ............................................................................................................... viii
Figures ................................................................................................................................... ix
Tables .................................................................................................................................... xv
Abbreviations ....................................................................................................................... xv

CHAPTER ONE

INTRODUCTION

1.1 Introduction ....................................................................................................................... 1
1.2 Definitions .......................................................................................................................... 4
1.3 Landscape typology of Melbourne hospitals 1848-1948 .................................................. 7
1.4 Scope .................................................................................................................................. 14
1.5 Thesis Structure .................................................................................................................. 15

CHAPTER TWO

AN HISTORICAL OVERVIEW OF HOSPITAL SITES AND GROUNDS

2.1 Introduction ....................................................................................................................... 19
2.2 Hospital sites and grounds from ancient times to 1948 .................................................... 20
2.3 Purpose and meaning of hospital sites and grounds 1848 to 1948 ..................................... 56
2.4 Conclusion .......................................................................................................................... 72

CHAPTER THREE

METHODOLOGY

3.1 Introduction ....................................................................................................................... 75
3.2 Overview of approach ........................................................................................................ 75
3.3 Research questions and data collection ............................................................................ 79
3.4 Content analysis ................................................................................................................ 83
3.5 Methodological challenges .............................................................................................. 84
3.6 Summary ............................................................................................................................ 93
# CHAPTER FOUR

MELBOURNE HOSPITAL SITES AND GROUNDS 1848-1918

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Introduction</td>
<td>95</td>
</tr>
<tr>
<td>4.2</td>
<td>Historical overview of Melbourne</td>
<td>98</td>
</tr>
<tr>
<td>4.3</td>
<td>Hospital development in Melbourne 1848 -1918</td>
<td>102</td>
</tr>
<tr>
<td>4.4</td>
<td>Hospital sites 1848-1900</td>
<td>111</td>
</tr>
<tr>
<td>4.5</td>
<td>Hospital grounds 1848-1900</td>
<td>121</td>
</tr>
<tr>
<td>4.6</td>
<td>Hospital grounds 1900-1918</td>
<td>140</td>
</tr>
<tr>
<td>4.7</td>
<td>Purpose and meaning of hospital sites and grounds 1848-1948</td>
<td>151</td>
</tr>
<tr>
<td>4.8</td>
<td>Conclusion</td>
<td>162</td>
</tr>
</tbody>
</table>

# CHAPTER FIVE

MELBOURNE HOSPITAL SITES AND GROUNDS 1919-1948

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Introduction</td>
<td>163</td>
</tr>
<tr>
<td>5.2</td>
<td>From Charity Board to Hospital and Charities Commission</td>
<td>165</td>
</tr>
<tr>
<td>5.3</td>
<td>Patients, nurses and medical treatments</td>
<td>167</td>
</tr>
<tr>
<td>5.4</td>
<td>Hospital sites and modernism</td>
<td>173</td>
</tr>
<tr>
<td>5.5</td>
<td>Physical characteristics of Melbourne hospital grounds 1919-1948</td>
<td>181</td>
</tr>
<tr>
<td></td>
<td>Museum sites</td>
<td>184</td>
</tr>
<tr>
<td></td>
<td>Chaotic sites</td>
<td>192</td>
</tr>
<tr>
<td></td>
<td>Modernist site-Royal Melbourne Hospital</td>
<td>232</td>
</tr>
<tr>
<td>5.6</td>
<td>Hospital grounds and the new salubrity</td>
<td>237</td>
</tr>
<tr>
<td>5.7</td>
<td>Conclusion - Charitable institution to medical complex</td>
<td>243</td>
</tr>
</tbody>
</table>

# CHAPTER SIX

HOSPITAL GROUNDS AS PLACES OF HUMAN ACTIVITY

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Introduction</td>
<td>249</td>
</tr>
<tr>
<td>6.2</td>
<td>Front gardens and backyards</td>
<td>254</td>
</tr>
</tbody>
</table>
CHAPTER SEVEN
ALFRED HOSPITAL GROUNDS 1869-1948

7.1 Introduction........................................................................................................................................... 277
7.2 Alfred Hospital site and grounds from 1869 to WWI ........................................................................... 277
7.3 Alfred Hospital site and grounds after WWI to 1948 ......................................................................... 294
7.4 Alfred Hospital site and grounds 1948 ............................................................................................... 303
7.5 Hospital site and grounds as places of human activity ....................................................................... 304

CHAPTER EIGHT
HOSPITAL SITES AND GROUNDS IN TRANSITION

8.1 Introduction........................................................................................................................................... 307
8.2 Hospital sites and grounds in transition from charitable institutions to medical complexes ...... 308
8.3 Loss of purpose and meaning ............................................................................................................... 319
8.4 Implication for twenty-first century hospitals in Melbourne ............................................................ 320

CHAPTER NINE
CONCLUSION............................................................................................................................................... 333

REFERENCES

Primary references ...................................................................................................................................... 339
Secondary references ............................................................................................................................... 353
Acknowledgements

Completion of a thesis is dependent upon many factors, not the least of these being the academic, administrative and personal support of many people to whom I owe a deep gratitude. In the first category are my supervisors, Emeritus Professor Catherin Bull and Dr. Margaret Grose who at all times have demonstrated the best qualities of academic scholarship in being supportive, constructively critical and uncompromising in the standards demanded of this work. Importantly, they have also respected my viewpoints and approach whilst providing much needed encouragement in times of inevitable crises that are attendant upon a work of this scale. The Faculty of Architecture and Building and Planning at the University of Melbourne has provided excellent resources including work areas, funding for conferences and administrative support which have been invaluable. Support from fellow doctoral students and other academic staff has also been much appreciated. Beyond the university, I would like to make a special mention of hospital archives and archivists, particularly at the Alfred, Royal Children’s and St Vincent’s hospitals whose expertise and professional skill made available to me the vast and fascinating material for this thesis. Of particular significance is the Alfred Hospital Nurses League, a voluntary group of former nurses who have carefully preserved and collected material that would otherwise been lost. More than this, their hospitality and conversations over cups of tea alerted me to the significance of human beings in narrative of the built environment which formed an important theme of this thesis. The staff of the Public Records Office of Victoria and State Library of Victoria could also be included here for their assistance and interest.

Finally, I would like to thank my family who has endured, supported and encouraged me through every stage of this arduous process. From my four children, Jack, Emma, Nicholas and Rohan, I have received no less than total support and thank them for their humour, patience and interest. My husband Rod, I can only thank with love and gratitude and acknowledge the vital part he has played in this work.
Figures

Figure 1.1 Melbourne hospitals from charitable institution to medical complex
Figure 2.1 Model of the aesclepi a of Pergamon
Figure 2.2 Plan of valetudinarium
Figure 2.3 Plan of Ospedale Maggiore
Figure 2.4 Diagram of hospitals on main roads in London, c.1400
Figure 2.5 Plan of Kirkstall abbey, c.1200s
Figure 2.6 Site plan of St Bartholomew’s, 1617
Figure 2.7 St Bartholomew’s Hospital, 1720
Figure 2.8 Derby Infirmary, 1819
Figure 2.9 London Hospital, 1752
Figure 2.10 Gloucester General Infirmary, 1763
Figure 2.11 Old Leeds Infirmary, c.1792
Figure 2.12 Old Leeds Infirmary, view of grounds, 1867
Figure 2.13 Proposed pavilion plan of John Hopkins Hospital, 1876
Figure 2.14 Grounds of John Hopkins Hospital
Figure 2.15 Beaujon Hospital, Clichy France, 1935
Figure 2.16 Stevens and Lee, Hôpital Notre-Dame, Montreal
Figure 2.17 Middlesex Hospital, c.1935
Figure 2.18 Altmagelvin Hospital, Londonderry, 1949 - 60
Figure 2.19 Perspective rendering of Hospital for Sick Children
Figure 2.20 Birmingham Hospital Centre, c.1940
Figure 2.21 Royal Masonic Hospital, London, c.1940
Figure 2.22 Westminster Hospital, London, c.1940
Figure 2.23 Activities in grounds of Children’s Memorial Hospital, Montreal
Figure 2.24 Use of outdoor areas of St Thomas’ Hospital in 1947
Figure 2.25 Grounds of St Bartholomew’s Hospital, 1961
Figure 3.1 Conceptual diagram of data collection and research questions
Figure 3.2 Workspace in the Alfred Hospital Archives
Figure 3.3 Staged photograph of patient arriving at St Vincent’s Hospital
Figure 3.4 St Vincent’s Hospital ambulance bay in 1940s
Figure 4.1 Map of Australia
Figure 4.2 Engraving of Melbourne topography, 1854
Figure 4.3 Town Hall, corner of Collins and Swanston streets, c.1900
Figure 4.4 Engraving of Exhibition Buildings, 1901
Figure 4.5 Number of medical sites in Melbourne 1860 -1950
Figure 4.6 Grounds of Alexandra Hospital on Hospital Sunday, c.1910
Figure 4.7 List of Charitable Institutions in Victoria, 1870
Figure 4.8 Number of patients in each of Melbourne hospitals, 1880 - 1950
Figure 4.9 Location of hospitals in Melbourne, 1900
Figure 4.10 Map of healthy areas of Melbourne and hospitals, 1900
Figure 4.11 View of Children’s Hospital from Exhibition Gardens
Figure 4.12 Health reserve in Victoria Parade
| Figure 4.13 | Map of *Melbourne Hospital* site, c.1860s |
| Figure 4.14 | Contour map of Melbourne and hospital location, 1901 |
| Figure 4.15 | Children and nurse from *Children's Convalescent Cottage* at seaside |
| Figure 4.16 | Site plan of *Melbourne Hospital*, 1896 |
| Figure 4.17 | Grounds of *Melbourne Hospital*, 1870 -1880 |
| Figure 4.18 | Site plan of *Women's Hospital*, 1897 |
| Figure 4.19 | Grounds of *Women's Hospital*, 1897 |
| Figure 4.20 | Site plan of *Alfred Hospital*, 1896 |
| Figure 4.21 | Grounds at entrance of *Alfred Hospital*, 1900 |
| Figure 4.22 | Site plan of *Children's Hospital*, 1896 |
| Figure 4.23 | Grounds of *Children's Hospital*, 1892 |
| Figure 4.24 | Site plan of *Homeopathic Hospital*, 1895 |
| Figure 4.25 | Front grounds of *Homeopathic Hospital*, 1906 |
| Figure 4.26 | Site plan of *Eye and Ear Hospital*, 1899 |
| Figure 4.27 | Site of *Eye and Ear Hospital*, c.1900 |
| Figure 4.28 | Aerial view of *Austin Hospital* site, 1920 |
| Figure 4.29 | Grounds of *Austin Hospital* near General Wards, 1900 |
| Figure 4.30 | Site plan *St Vincent's Hospital*, 1898 |
| Figure 4.31 | Domestic terrace buildings of *St Vincent's Hospital*, c.1900 |
| Figure 4.32 | Site plan of *Queen Victoria Hospital*, 1899 |
| Figure 4.33 | Front garden of *Queen Victoria Hospital*, 1912 |
| Figure 4.34 | Three photographs of Melbourne charitable institutions, c.1900 |
| Figure 4.35 | Three site plans of Melbourne charitable institutions, c.1900 |
| Figure 4.36 | Nurses and patients on balcony of *Children's Hospital* |
| Figure 4.37 | Patients on balconies of *Melbourne Hospital*, c.1900 |
| Figure 4.38 | Engraving of patients on balcony of Homeopathic Hospital, 1889 |
| Figure 4.39 | Grounds of *Women's Hospital* with covered way |
| Figure 4.40 | Grounds of *Children's Hospital* with covered way |
| Figure 4.41 | Covered way on *Alfred Hospital* grounds, c.1915 |
| Figure 4.42 | Bowen Home for nurses, *Austin Hospital* |
| Figure 4.43 | Staff accommodation Genevieve Wing, *Women's Hospital*, 1899 |
| Figure 4.44 | *Alfred Hospital* tennis court, 1900 |
| Figure 4.45 | Night nurses’ home, *Alfred Hospital*, 1909 |
| Figure 4.46 | The Residency, *Women's Hospital* |
| Figure 4.47 | Marian Drummond nurses’ home, *Austin Hospital* |
| Figure 4.48 | Nurses’ home, *Melbourne Hospital*, 1913 |
| Figure 4.49 | Nurses’ home, *St. Vincent's Hospital*, 1913 |
| Figure 4.50 | Chimney stack on *Children's Hospital* site, c.1915 |
| Figure 4.51 | Garden area of *St Vincent's Hospital* adjacent to verandah, c.1910 |
| Figure 4.52 | *St Vincent's Hospital* grounds, c.1918 |
| Figure 4.53 | *Melbourne Hospital* grounds after reconstruction in 1913 |
| Figure 4.54 | Front entrance grounds of *Alfred Hospital*, c.WWI |
| Figure 4.55 | Balcony and garden of *Queen Victoria Hospital*, 1913 |
| Figure 4.56 | Garden in front of Druid’s Wing, *Women's Hospital*, 1912 |
| Figure 4.57 | *Austin Hospital* entrance and grounds |
Figure 4.58 Engraving of child and nurse in garden, 1881
Figure 4.59 Woodcut of Melbourne Hospital grounds, 1888
Figure 4.60 Woodcut of Austin Hospital grounds, 1888
Figure 5.1 Numbers of beds and nurses in Melbourne hospitals 1890-1950
Figure 5.2 Number of staff in Melbourne hospitals, 1900-1950
Figure 5.3 Outpatient attendances at Melbourne hospitals, 1890-1950
Figure 5.4 Average length of stay in Melbourne hospitals 1890-1950
Figure 5.5 Air conditioning for hospitals advertisement, 1949
Figure 5.6 Proposed Children’s Hospital, 1949
Figure 5.7 Architect’s drawing of Traralgon and District Hospital, 1948
Figure 5.8 Mildura District Hospital in 1923 and 1948
Figure 5.9 Cover of 1948 Queen Victoria Hospital Annual Report
Figure 5.10 Diagram of Royal Melbourne Hospital services, 1947
Figure 5.11 XVIth Olympiad Melbourne Postcard, 1956
Figure 5.12 Melbourne Hospital site, 1920-1948
Figure 5.13 Section of elevation of Block F, Melbourne Hospital, 1913
Figure 5.14 Tennis court and garden areas, Melbourne Hospital c.1920-1930
Figure 5.15 Melbourne Hospital grounds in 1920-1940s
Figure 5.16 Covered ways, Melbourne Hospital in 1940s
Figure 5.17 Children’s Hospital site, 1948
Figure 5.18 Outpatient building, Children’s Hospital c.1930-1940
Figure 5.19 Patients and nurses on flat roof of Children’s Hospital, 1938
Figure 5.20 Patients in beds on balconies of Children’s Hospital, 1938
Figure 5.21 Internal courtyard of Children’s Hospital, c.1921
Figure 5.22 Lawn in front of Splint Workshop, Children’s Hospital, 1936
Figure 5.23 Staff member in grounds of Children’s Hospital, 1940s
Figure 5.24 Site plan of Eye and Ear Hospital, 1948
Figure 5.25 Eye and Ear Hospital looking east, 1935
Figure 5.26 Site plan of Women’s Hospital, 1948
Figure 5.27 Garden area lost to Edward Wilson Wing, Women’s Hospital
Figure 5.28 Patients and staff on balconies of Edward Wilson Wing, 1930s
Figure 5.29 Internal courtyard of Women’s Hospital, 1936
Figure 5.30 5 storey nurses’ home, Melbourne Hospital
Figure 5.31 Garden area behind Genevieve Wing, Women’s Hospital
Figure 5.32 Internal courtyard of Women’s Hospital, late 1940s
Figure 5.33 Swanston street frontage of Women’s Hospital, 1940s
Figure 5.34 Laneway beside services block, Women’s Hospital
Figure 5.35 Alfred Hospital site plan, 1948
Figure 5.36 Elm Avenue, Alfred Hospital, 1922
Figure 5.37 Alfred Hospital grounds in 1912 and 1924
Figure 5.38 Aerial image of Alfred Hospital grounds, 1926
Figure 5.39 Front grounds of Alfred Hospital, 1924
Figure 5.40 Front grounds of Alfred Hospital, 1930-1960
Figure 5.41 New Edward Wilson Wing, 1920s.
Figure 5.42 Children in beds in hospital grounds of Alfred Hospital, 1929
Figure 5.43 Children in beds in hospital grounds of Alfred Hospital, 1933
Figure 5.44 Adult patients in beds in grounds of Alfred Hospital, 1940s
Figure 5.45 Grounds of Hamilton Russell House, Alfred Hospital, 1931
Figure 5.46 Tennis court, Alfred Hospital, 1925
Figure 5.47 Aerial photograph of Alfred Hospital site, 1933
Figure 5.48 Los Angeles County Hospital
Figure 5.49 Central Block, 1941. Alfred Hospital
Figure 5.50 Central Block and nineteenth Alfred Hospital buildings, 1940s
Figure 5.51 Aerial photograph of Alfred Hospital grounds, 1954
Figure 5.52 Aerial photograph of Prince Henry’s (Homeopathic) Hospital, 1946
Figure 5.53 Site of Homeopathic Hospital, c.1920
Figure 5.54 Front Grounds of Homeopathic Hospital, 1925
Figure 5.55 Front balcony of Homeopathic Hospital, 1920s
Figure 5.56 Grounds of Prince Henry’s Hospital, 1938
Figure 5.57 Grounds of Prince Henry’s Hospital, 1951
Figure 5.58 Prince Henry’s Hospital site, 1950
Figure 5.59 Site of Prince Henry’s Hospital, 1952
Figure 5.60 Aerial photograph of Austin Hospital site, 1946
Figure 5.61 Patients and staff in garden, Austin Hospital, 1930
Figure 5.62 Back cover of Austin Hospital Annual Report, 1927
Figure 5.63 Oak Drive, Austin Hospital, 1950
Figure 5.64 Front garden area of Austin Hospital, 1950
Figure 5.65 View from hospital grounds of Austin Hospital
Figure 5.66 Panorama of front grounds of Austin Hospital, 1939
Figure 5.67 Aerial photograph of Site, Austin Hospital, 1920
Figure 5.68 Garden of nurses’ home and children’s ward, Austin Hospital, 1927
Figure 5.69 Site plan of St Vincent’s Hospital, 1948
Figure 5.70 Site of St Vincent’s Hospital with cyclorama, 1920s
Figure 5.71 Grounds of St Vincent’s Hospital facing Victoria Parade, 1920s
Figure 5.72 Grounds of St Vincent’s Hospital facing Regent Street, 1920s
Figure 5.73 Healy Wing built on garden of St Vincent’s Hospital, 1934
Figure 5.74 View of ambulance bay on Regent Street, St Vincent’s Hospital
Figure 5.75 Lady Mitchell Wing, Queen Victoria Hospital, 1923
Figure 5.76 Lady Forster Wing, Queen Victoria Hospital, 1929
Figure 5.77 Jessie MacPherson Community Hospital and Mabel Brookes Wing
Figure 5.78 Mabel Brookes Wing, Queen Victoria Hospital, 1934
Figure 5.79 Site plan of Royal Melbourne Hospital, 1946
Figure 5.80 Aerial photograph of site Royal Melbourne Hospital, 1940s
Figure 5.81 Grounds at front entrance of Royal Melbourne Hospital, 1948
Figure 5.82 Nurse’s home, Royal Melbourne Hospital, 1943
Figure 5.83 Nurses on lawn area of Royal Melbourne Hospital, 1945
Figure 5.84 Grounds of Hampton Convalescent Cottage
Figure 5.85 Aerial of Frankston Orthopaedic Hospital
Figure 5.86 Children on balcony of Frankston Orthopaedic Hospital
Figure 5.87 Heliotherapy ward, Hampton Convalescent Cottage, 1927
Figure 5.88  Sr. Milburn with patients in bush landscape  241
Figure 5.89  Sherbrooke Convalescent Cottage and grounds  241
Figure 5.90  Garden of Caritas Christi Hospice, 1940s  242
Figure 6.1  Front garden of Melbourne Hospital, 1873  252
Figure 6.2  Front garden of Homeopathic Hospital, c.1910  255
Figure 6.3  Maids in backyard of Homeopathic Hospital, 1925  255
Figure 6.4  Gatehouse and front garden of Melbourne Hospital, c.1890  256
Figure 6.5  Front garden of Queen Victoria Hospital, 1909  257
Figure 6.6  Backyard of Queen Victoria Hospital, 1909  257
Figure 6.7  Front garden of Women’s Hospital, Cardigan Street, c.1900  257
Figure 6.8  Internal courtyard of Women’s Hospital, 1922  257
Figure 6.9  Backyard of Eye and Ear Hospital, 1915  258
Figure 6.10  Staff photograph, backyard of Women’s Hospital, 1900  259
Figure 6.11  Nurse Gwendolen Luly on verandah of Alfred Hospital, c.1920  259
Figure 6.12  Nurses and babies in backyard of Homeopathic Hospital  260
Figure 6.13  Nurse being visited in backyard of Children’s Hospital, 1925  260
Figure 6.14  Nurse drying hair, Melbourne Hospital, 1920s  260
Figure 6.15  Nurses dancing on flat roof of nurses’ home, Melbourne Hospital  260
Figure 6.16  Tennis party in grounds of Alfred Hospital, 1920s  260
Figure 6.17  Staff with babies in grounds of Women’s Hospital, 1920s  261
Figure 6.18  Staff in central courtyard of Women’s Hospital, 1900  261
Figure 6.19  Doctors washing babies on back verandah, Women’s Hospital, 1929  262
Figure 6.20  Nurses collecting milk in grounds of Children’s Hospital, 1940s  262
Figure 6.21  Nurse and clothesline, Children’s Hospital  262
Figure 6.22  Nurses washing furniture in grounds, Melbourne Hospital, 1925  262
Figure 6.23  Man mowing lawn in grounds of St Vincent’s Hospital, 1920s  262
Figure 6.24  Nurses in front garden of Melbourne Hospital, 1925  263
Figure 6.25  Doctors in Alfred Hospital front garden, c.1910  263
Figure 6.26  Excerpt from MMBW plan of Melbourne Hospital, 1899  264
Figure 6.27  Daniel Cullen Wing and grounds, St Vincent’s Hospital, c.1920s  265
Figure 6.28  Outpatients served tea in the grounds of St Vincent’s Hospital  265
Figure 6.29  Boy in grounds of Alfred Hospital, c.1920  266
Figure 6.30  Child patients playing in grounds of Alfred Hospital, 1936  266
Figure 6.31  Child patients and staff in garden of Melbourne Hospital, 1900  266
Figure 6.32  Patients in bed in grounds of Austin hospital, c.1900  266
Figure 6.33  Outpatients in grounds of Children’s Hospital 1908  267
Figure 6.34  Mother and Children in garden, Children’s Hospital 1912  267
Figure 6.35  Nurse and patients outside children’s ward, Austin Hospital  267
Figure 6.36  Patients in Girl Guide meeting in grounds of Austin Hospital, 1928  267
Figure 6.37  Father Christmas visiting balcony of Children’s Hospital, 1948  268
Figure 6.38  Man talking to children on balcony over fence, Children’s Hospital  268
Figure 6.39  Man on crutches looking into garden, St Vincent’s Hospital, 1920s  269
Figure 6.40  Patient on balcony looking into garden, Queen Victoria Hospital  269
Figure 6.41  Patients on balcony looking into garden, Austin Hospital, 1905  269
Figure 6.42  St Vincent’s Hospital bazaar in grounds of hospital, 1937  270
<table>
<thead>
<tr>
<th>Figure number</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 6.43</td>
<td>‘Apollo’ at St Vincent’s Hospital bazaar, 1941</td>
<td>270</td>
</tr>
<tr>
<td>Figure 6.44</td>
<td>Nurses on slide in Alfred Hospital grounds, 1929</td>
<td>270</td>
</tr>
<tr>
<td>Figure 6.45</td>
<td>Aerial photograph of Royal Melbourne Hospital site, looking north</td>
<td>271</td>
</tr>
<tr>
<td>Figure 6.46</td>
<td>Aerial photograph of Royal Melbourne Hospital site, looking south</td>
<td>271</td>
</tr>
<tr>
<td>Figure 6.47</td>
<td>Front grounds of Prince Henry’s Hospital, 1950s</td>
<td>271</td>
</tr>
<tr>
<td>Figure 6.48</td>
<td>Front garden of St Vincent’s Hospital, c.1915</td>
<td>273</td>
</tr>
<tr>
<td>Figure 6.49</td>
<td>Ambulance court of St Vincent’s Hospital, 1940s</td>
<td>273</td>
</tr>
<tr>
<td>Figure 7.1</td>
<td>Plan of front garden and backyard, Alfred Hospital, 1890</td>
<td>279</td>
</tr>
<tr>
<td>Figure 7.2</td>
<td>Alfred Hospital front grounds, 1890</td>
<td>279</td>
</tr>
<tr>
<td>Figure 7.3</td>
<td>Woodcut of Typhoid Camp, Alfred Hospital, 1889</td>
<td>281</td>
</tr>
<tr>
<td>Figure 7.4</td>
<td>Plan of front garden and backyard, Alfred Hospital, 1915</td>
<td>282</td>
</tr>
<tr>
<td>Figure 7.5</td>
<td>Front garden and backyard site plan of Alfred Hospital, 1910</td>
<td>282</td>
</tr>
<tr>
<td>Figure 7.6</td>
<td>Front garden of Alfred Hospital with nurses, c.1910</td>
<td>283</td>
</tr>
<tr>
<td>Figure 7.7</td>
<td>Memorial fountain, Alfred Hospital front garden, 1915</td>
<td>283</td>
</tr>
<tr>
<td>Figure 7.8</td>
<td>Front garden of Alfred Hospital with seat, 1918</td>
<td>284</td>
</tr>
<tr>
<td>Figure 7.9</td>
<td>Nurse and patient on front balcony of Michaelis Ward, 1901</td>
<td>284</td>
</tr>
<tr>
<td>Figure 7.10</td>
<td>Nurses in front garden near Michaelis Ward, c.1919</td>
<td>284</td>
</tr>
<tr>
<td>Figure 7.11</td>
<td>Covered way and bicycles in front garden of Alfred Hospital, 1910</td>
<td>284</td>
</tr>
<tr>
<td>Figure 7.12</td>
<td>Nurse and patients under covered way of Alfred Hospital, 1915</td>
<td>284</td>
</tr>
<tr>
<td>Figure 7.13</td>
<td>Cooking class held in grounds of Alfred Hospital</td>
<td>284</td>
</tr>
<tr>
<td>Figure 7.14</td>
<td>Backyard of Alfred Hospital, c. World War I</td>
<td>287</td>
</tr>
<tr>
<td>Figure 7.15</td>
<td>Nurse in front of ‘Cottage’ in backyard of Alfred Hospital, c.1900</td>
<td>288</td>
</tr>
<tr>
<td>Figure 7.16</td>
<td>Halfway House in backyard of Alfred Hospital, c. 1920</td>
<td>288</td>
</tr>
<tr>
<td>Figure 7.17</td>
<td>Alfred Hospital backyard with dog, c.1900</td>
<td>289</td>
</tr>
<tr>
<td>Figure 7.18</td>
<td>Track leading from nurses’ home to hospital buildings, c.1900</td>
<td>290</td>
</tr>
<tr>
<td>Figure 7.19</td>
<td>Grounds of nurses’ home, Alfred Hospital, 1910s</td>
<td>291</td>
</tr>
<tr>
<td>Figure 7.20</td>
<td>Elm Drive from Punt Road to Alfred Hospital, 1910s</td>
<td>291</td>
</tr>
<tr>
<td>Figure 7.21</td>
<td>Tennis court surrounded by trees, Alfred Hospital, 1910s</td>
<td>292</td>
</tr>
<tr>
<td>Figure 7.22</td>
<td>Doctor and nurses’ tennis party, Alfred Hospital, 1910s</td>
<td>292</td>
</tr>
<tr>
<td>Figure 7.23</td>
<td>Nurses and chair in grounds of Alfred Hospital, 1910s</td>
<td>293</td>
</tr>
<tr>
<td>Figure 7.24</td>
<td>Temporary huts in the grounds of Alfred Hospital, 1923</td>
<td>293</td>
</tr>
<tr>
<td>Figure 7.25</td>
<td>Site plan of Alfred Hospital grounds, 1948</td>
<td>294</td>
</tr>
<tr>
<td>Figure 7.26</td>
<td>Front grounds of Alfred Hospital, 1930-1960</td>
<td>296</td>
</tr>
<tr>
<td>Figure 7.27</td>
<td>Front grounds of Alfred Hospital on Commercial Road, 1923</td>
<td>296</td>
</tr>
<tr>
<td>Figure 7.28</td>
<td>Front garden of Margaret Coles Maternity Wing, 1942</td>
<td>297</td>
</tr>
<tr>
<td>Figure 7.29</td>
<td>Sr. Bell and patient in grounds of backyard, Alfred Hospital, 1926</td>
<td>297</td>
</tr>
<tr>
<td>Figure 7.30</td>
<td>Nurses, baby and cat outside Halfway House, Alfred Hospital, 1938</td>
<td>297</td>
</tr>
<tr>
<td>Figure 7.31</td>
<td>Aerial photograph of Alfred Hospital site, 1933</td>
<td>299</td>
</tr>
<tr>
<td>Figure 7.32</td>
<td>“Colourland Fete” for Alfred Hospital, 1927</td>
<td>301</td>
</tr>
<tr>
<td>Figure 7.33</td>
<td>At “Colourland” Fete</td>
<td>301</td>
</tr>
<tr>
<td>Figure 7.34</td>
<td>Patient at Alfred Hospital Fete, 1923</td>
<td>301</td>
</tr>
<tr>
<td>Figure 7.35</td>
<td>Linay pavilion and surrounding grounds, 1923</td>
<td>302</td>
</tr>
<tr>
<td>Figure 7.36</td>
<td>Aerial photograph of Alfred Hospital site, 1954</td>
<td>303</td>
</tr>
<tr>
<td>Figure 7.37</td>
<td>Cars parked in grounds, Alfred Hospital, c.1950</td>
<td>303</td>
</tr>
<tr>
<td>Figure 7.38</td>
<td>Central Block and nineteenth Alfred Hospital buildings</td>
<td>303</td>
</tr>
</tbody>
</table>
Figure 8.1  Four photographs of grounds of *Deaf and Dumb Institute*, 1997 311
Figure 8.2  Aerial photograph of *Royal Melbourne* and *Women’s* hospitals, 2010 322
Figure 8.3  Aerial photograph of *Royal Melbourne* and *Women’s* hospitals, 2011 323
Figure 8.4  Patient on footpath outside *Royal Melbourne Hospital* 323
Figure 8.5  Front entrance of *Alfred Hospital*, 2009 324
Figure 8.6  Helipad at *Alfred Hospital* 325
Figure 8.7  *Mercy Maternity Hospital*, 2005 325
Figure 8.8  Sunshine Hospital site, 2002 326
Figure 8.9  Artist’s impression of proposed *Royal Children’s Hospital* 328
Figure 8.10  Aerial view of proposed *Royal Children’s Hospital* 329
Figure 9.1  Melbourne hospitals from charitable institution to medical complex 331

Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 3.1</td>
<td>Data type and relationship to categories of data</td>
<td>81</td>
</tr>
<tr>
<td>Table 3.2</td>
<td>Sources of data used for case studies and ‘thick description’</td>
<td>82</td>
</tr>
<tr>
<td>Table 4.1</td>
<td>List of hospitals in Melbourne 1840-1899</td>
<td>103</td>
</tr>
<tr>
<td>Table 4.2</td>
<td>Number of in-patients and beds between 1890 and 1910</td>
<td>108</td>
</tr>
<tr>
<td>Table 4.3</td>
<td>Numbers of nursing staff 1890 and 1910</td>
<td>110</td>
</tr>
<tr>
<td>Table 4.4</td>
<td>Size of hospital sites</td>
<td>111</td>
</tr>
<tr>
<td>Table 4.5</td>
<td>Site and ground characteristics of Melbourne hospitals in 1900</td>
<td>122</td>
</tr>
<tr>
<td>Table 4.6</td>
<td>New buildings on hospital sites 1900-1914</td>
<td>141</td>
</tr>
<tr>
<td>Table 5.1</td>
<td>Hospital buildings constructed between 1918 and 1948</td>
<td>182</td>
</tr>
<tr>
<td>Table 5.2</td>
<td>Hospital site characteristics 1900 and 1950</td>
<td>243</td>
</tr>
<tr>
<td>Table 6.1</td>
<td>Characteristics of grounds of charitable institutions and medical complexes</td>
<td>272</td>
</tr>
<tr>
<td>Table 6.2</td>
<td>Activities and experiences in grounds of charitable institutions and medical complexes</td>
<td>274</td>
</tr>
</tbody>
</table>

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR</td>
<td>Annual Report</td>
</tr>
<tr>
<td>PROV</td>
<td>Public Records Office of Victoria</td>
</tr>
<tr>
<td>MMBW</td>
<td>Melbourne and Metropolitan Board of Works</td>
</tr>
<tr>
<td>SLVM</td>
<td>State Library of Victoria Map Collection</td>
</tr>
<tr>
<td>SLVP</td>
<td>State Library of Victoria Picture Collection</td>
</tr>
<tr>
<td>VPRS</td>
<td>Victorian Public Records Office of Victoria</td>
</tr>
</tbody>
</table>
Figure 1.1 Melbourne Hospital occupied this site on the corner of Lonsdale and Swanston streets between 1848 and 1944. This photograph taken in 1873 shows a typical garden layout for hospital grounds in Melbourne before World War I. Paths, seating, ornamental garden beds and perimeter fences provided places for exercise, socialization, fresh air and sunshine in a setting removed from the dirt and noise of the city. Gregory, 44.

Figure 1.2 The Melbourne Hospital in 1953, now called the Royal Melbourne Hospital, moved from its original site to a new location in 1944. The grounds were predominantly grass areas with minimal planting and provided no places for patient exercise or socialization. The paths and roads were designed for moving people and cars from the street to the buildings and the lack of perimeter fencing made the site open to the public and lacking in privacy. These images are typical of the change in hospital landscapes between 1840s and 1940s and suggest a major change in the purpose and meaning of hospital grounds during this period. Harold Paynting Collection. SLVPC.
# CHAPTER ONE
## INTRODUCTION

1.1 Introduction............................................................................................................................................. 1
1.2 Definitions.................................................................................................................................................. 4
1.3 Landscape typology of Melbourne hospitals 1848-1948......................................................................... 7
1.4 Scope....................................................................................................................................................... 14
1.5 Thesis Structure....................................................................................................................................... 15

### 1.1 Introduction

Between 1848 and 1948 hospitals changed in the western world from charitable institutions to modern medical complexes (Figures 1.1 and 1.2).\(^1\) A major change, largely unrecorded does not relate to medical technology or to architectural form but to the physical landscape of hospitals. Grounds and gardens previously used by staff and patients for convalescence and recreation were lost to buildings and car parks.\(^2\) Hospital sites changed from places of convalescence and human activity to that of spaces that conveyed goods, people and cars to the buildings as efficiently as possible.\(^3\) In Melbourne, International Style modernism emphasized a functional and machine aesthetic that neglected the emotional and restorative role of hospital grounds in patient treatment and staff well-being. Although, there has been scholarly analysis of hospital architecture during this period, the implications of changes to hospital grounds for patients and staff and what it reveals about attitudes to landscape and medical treatment has been neglected. This thesis addresses the purpose and meaning of hospitals sites and grounds during this period by analysis of nine hospitals in Melbourne, Australia. It provides original insights into the significance of hospital grounds for human well-being, the evolution of International Style modernism in Melbourne and changing attitudes to landscape and health that typified the interwar period. Further, it provides an historical a framework by which contemporary hospital landscapes can be

---


\(^2\) Ibid.

\(^3\) Ibid. Sloane, D.C. (1994).
assessed. This provides an understanding of the significance of hospital outdoor spaces that can inform and support successful and authentic design practices today.

1.2 Background

The changes in hospital landscapes for this period are encapsulated in Figures 1.1 and 1.2. Figure 1.1 shows Melbourne’s first hospital, *Melbourne Hospital*, which this thesis argues is an image of a charitable institution. This term is used by hospital historians to indicate an era in hospital history when the main purpose of the hospital was to care for the poor and indigent, often termed the sick poor. The institution was managed by community figures and funded by public subscription. The emphasis was on care rather than cure and the site in many respects resembled a domestic residence.

This is in contrast to the era of the hospital as scientific medical complex as portrayed in Figure 1.2. Medical technologies such as surgery, sterilization and x-ray emerged at the end of the nineteenth century and introduced new buildings and treatment approaches to the hospital. Parallel to the changes in medical treatment and in part driven by them, the hospital became bureaucratized and increasingly important in the professional development of doctors, nurses and administrators. The range of patients expanded as hospital treatment became accepted as more efficacious than private doctors in the home which had been the previous treatment preferred by middle and privileged classes. At the same time, the emergence of modernism in architecture with its ideology of scientific progress and functional minimalism became strongly associated with the idea of a modern medical complex. The hospital as a ‘machine for healing’ replaced the hospital as a charitable institution. The *Royal Melbourne Hospital* is an example of the scientific medical complex and when built in 1940, was widely

---

viewed as the paragon of a modern hospital and a fitting representation of the scientific medical era.⁸

The *Melbourne* and *Royal Melbourne* hospitals were built on new sites, approximately 90 years apart. Apart from the obvious changes in architectural styles, the grounds and layout represent two very different ideas of what constituted a hospital of the period. The *Melbourne Hospital* as a charitable institution built in 1848 is surrounded by extensive planting, with garden seats and paths for walking, secluded from the street by a boundary fence. The gatehouse and circular entrance drive contribute to the impression of a well-to-do home, set amidst ornamental gardens. In contrast, the *Royal Melbourne Hospital* as scientific medical complex has a minimal garden layout, with straight rows of trees, sparse planting, paths that lead directly to the building, no places for sitting in the grounds and direct access to the site from the street. The outdoor areas are primarily concerned with framing the building and complementing its modernist style. Human activity in the new hospital grounds was not encouraged. In the 90 year period that divided the building of the two hospitals, the purpose and meaning of hospital grounds had changed.

There have been a number of approaches to explain and describe these changes in hospitals depicted in Figures 1.1 and 1.2. Architectural, medical and social historians have examined the changing form of hospital design to explore building styles, architects, the history of medicine and social and political influences of the period. This thesis, in contrast, develops a spatial and cultural history of hospital sites and grounds in Melbourne, Australia to address three themes: Firstly, ideas of landscape and health and the ways these are interrelated through time; secondly, the significance of sites and grounds to the history of hospitals (particularly for patients and staff); and finally, the processes by which these landscapes evolved.

These themes are central to the study of landscape and the built environment and provide the basis for critical evaluation of the transition of hospitals from charitable institutions to medical complexes. This thesis does not draw causal links between attitudes to

---

health and the hospital grounds, recognizing that there are many factors that determine the spatial and visual qualities of the built environment. Rather it examines hospital sites and grounds as a neglected source of evidence to explore and enrich the themes surrounding hospital history, landscape and processes of change.

This chapter provides definitions for a number of key terms used in this thesis and describes the landscape typology of hospitals in Melbourne for the period of this study. Definitions are required because these terms are used to underpin the theoretical approaches of the thesis themes. A discussion of landscape typology provides a cultural context for the appearance and use of hospital sites and grounds, and also addresses their qualities as therapeutic landscapes. It examines the arguments of a number of writers that the decline in the therapeutic benefits of hospital landscapes in the latter half of the twentieth century reflected a failure of modernism to meet human needs important in health and well-being. This is followed by the research questions and thesis structure.

1.3 Definitions

Site

The site as the major focus of this thesis is interpreted as both a *place* and *space* according to the distinction articulated by landscape theorist Robert Beauregard.\(^9\) Site as *space* refers to a bounded area of land that has a particular location but is not necessarily restricted to the physical boundary of the land. Location, views, neighbourhood character are examples of contextual elements that are considered in relation to the site.

Site is also a *place* that is created through the meaning constructed through everyday experience of physical characteristics of *space* by people.\(^10\) The use and experience of the site and grounds by staff and patients for example, were the mechanisms by which personal meanings were constructed that connected people to the institution. This reveals a richer role


\(^10\) Ibid.
for the site and grounds beyond that of the space around buildings.\textsuperscript{11} This broader definition of site and its relationship to purpose and meaning underpin the rationale for this thesis revealed in the way hospital sites looked, were located, used and spoken about.

Grounds

The term grounds is used here to mean those components of the site that were not buildings, such as land, garden beds, trees, fountains, driveways, fences, car parks, recreation areas, tennis courts. In contrast with the definition of site, the grounds are confined within the site boundary. To clarify this point, the buildings are in the ‘grounds’ of the hospital, whilst the Alfred Hospital ‘site’ is located across the road from Fawkner Park, as an example of the different use of these terms.

Landscape

The term ‘landscape’, as has been observed by many authors is a complex and evocative term that has both physical and conceptual meanings.\textsuperscript{12} This thesis uses the term landscape in two ways. Firstly, in simple terms landscape is a physical reality of land, topography, buildings and vegetation that can be observed and used.\textsuperscript{13} An example of this first meaning is included in such terms as ‘rural landscapes’ or ‘urban landscapes’ where a particular type of physical formation of the land and built form is conveyed. Meinig has pointed out that even this use can be complicated by the associations in peoples heads of what is meant by rural or urban. This thesis employs this meaning nevertheless to convey a concrete physical reality that is generally recognized in common language to represent a physical

\begin{itemize}
  \item \textsuperscript{11} See Henderson, R. (Ed.). (1990). \textit{Alfred Hospital Reminiscences (1927-1947)}. North Balwyn, Vic.: R. Henderson, for an example of the meaning of the hospital site to staff and Chapter 2 for expansion of this point.
\end{itemize}
landscape.¹⁴ So for example, the landscape of Melbourne is a physical reality of streets, trees, buildings. Use of a term such as ‘surrounding landscape’ or ‘borrowed landscape’ indicates the physical characteristics of the surrounding land which may or may not include buildings.

The word ‘landscape’ is also used broadly within the cultural approach to landscape history that recognizes that ‘landscapes are products of human values, meanings and symbols of the usually dominant culture within society; they are cultural products.’¹⁵ Closely related to Beauregard’s idea of site as a place of human experience, this allows for a discussion of the physical, cultural and social elements of the built environment.

**Salubrity**

Salubrity is a nineteenth century concept of landscape that associated fresh air, sunlight, good drainage and beautiful surroundings with physical and psychological health.¹⁶ Famously promoted by Florence Nightingale in her design of hospitals, the concept of salubrity advocated the importance of environment in the treatment of patients.¹⁷ Salubrity was associated with four main attributes.¹⁸ An elevated site that would enable the hospital to evade disease-laden air known as miasma, suitable topography and soil type that would reduce the presence of miasma and maximize exposure to sunlight, proximity to clean air, and attractive scenery, outlook and ornamental surroundings that would lift the morale of the hospital patient and provide places for exercise. The importance of beautiful surroundings for patient treatment

---

¹⁴ Meinig, D. W., *op. cit.*, (1979), 34.
is generally overlooked in discussions of hospital environments but was an important element in nineteenth century attitudes to landscape.  

Hospitals

‘Hospital’ in this thesis refers to medical sites that treat physical diseases, including maternity, general, incurables’ and children’s hospitals. Medical sites such as sanatoriums, military hospitals and asylums are not included. These hospitals were public, not private, institutions and were listed in government reports initially as charitable institutions and later public hospitals.

Hospitals and modernism

The term ‘modernism’ or ‘modernist’ as with ‘landscape’ has attracted varied meanings and has been attributed to a wide range of cultural beliefs and time periods. In this thesis ‘modernism’ or ‘modernist’ refers to architectural style of the period 1910-1960. This time frame is generally recognized as a distinct period in hospital development dominated by a functional and minimalist design aesthetic closely associated with Le Corbusier, the design dictum of ‘form follows function’ and architecture of the International Style. Hospitals under this brand of modernism resembled office towers with minimal decoration. This is not true of all modernist hospitals however, as noted by Annmarie Adams in her study of hospital architects Stevens and Lee in North America in the interwar period. These hospitals, although with little outward resemblance to the streamlined buildings of the International

21 See Heynen, H. (1999). Architecture and modernity: a critique. Cambridge, Mass.: MIT Press, 9-18, for an overview of the different meanings and time periods which have been covered by the term ‘modernism’.
Style, adopted the principles of modernism. Spatial layout maximized efficiency and movement of people throughout the building and designs incorporated new technologies such as sound-proof materials.\(^{25}\) Architectural firms associated in Melbourne with modernist hospitals of this period: Stephenson and Meldrum, Stephenson and Turner, Leighton Irwin, Yuncken, Freeman, Griffiths and Simpson.

### 1.4 Landscape typology of Melbourne hospitals 1848-1948

Although the form of hospital grounds followed prevailing landscape fashion as Clare Hickman has pointed out, it is important to evaluate the significance of each landscape style.\(^{26}\) Of particular relevance is the relationship of ideas of health and well-being to their spatial and aesthetic forms. In relation to this study for example, the two types of grounds depicted in Figures 1.1 and 1.2, as well as revealing changes in medical practice and cultural attitudes to the hospital, are predicated on different ideas of the purpose of landscape. The following section discusses the landscape style for each of the hospital sites shown in Figures 1.1 and 1.2 and explains some of the ideas about their meaning and purpose.

The layout of the *Melbourne Hospital* shown in Figure 1.1 was influenced by the form of the English country estate which provided the model for nineteenth century hospital sites in the Western world.\(^{27}\) This type of setting was associated with two key ideas of landscape at this time.

Firstly, the landscape of the hospital site and grounds including the garden was an important element in patient treatment associated with nineteenth century medical beliefs in salubrity. Fresh air and sunshine, well-drained ground and access to beautiful surroundings were considered important and necessary elements for a hospital site.\(^{28}\) The prevalence of this association between landscape and health is evident in other medical settings of the time such as asylums and sanatoriums. These shared similar characteristics with hospitals with location

---


\(^{27}\) Hickman, C., *op. cit.*, (April 2006).

and outdoor areas carefully considered in relation to principles of salubrity.\textsuperscript{29} Secondly, the grounds were important to the identity of the hospital as a charitable institution which dealt with disadvantaged groups in society. The garden conveyed respectability and well-ordered management and linked it to the traditional values of the family and home. The garden as a link to domestic virtues of home was considered a civilizing influence for the indigent recipients of charity, particularly slum dwellers, deprived of a well-ordered home in their overcrowded living conditions.\textsuperscript{30} The grounds, particularly to the extent to which they recalled an ordered and middle-class residence, conveyed order and moral rectitude and were intended to imbue these qualities into its inmates who were viewed as disorderly and disreputable.\textsuperscript{31} Factory gardens, public parks and botanical gardens were other nineteenth century sites that were predicated on the understanding of moral and physical benefit of a garden aesthetic.\textsuperscript{32} Australia, as a colony of Britain produced designed landscapes based on these cultural beliefs with parks, garden landscapes and institutional settings similar to such sites in England.\textsuperscript{33}


Ideas of salubrity and the garden as a civilizing influence were embedded in a broader understanding of landscape as a representation of nature that provided physical, spiritual and moral benefit.34 This belief in the transcendental power of landscape was founded on eighteenth century philosophies espoused by Hume, John Locke and their contemporaries which ‘linked aesthetics, emotions, and behavioural response’.35 Landscape, according to these principles, could effectively influence behaviour by providing experiences of beauty that would transcend a mundane and flawed existence. People’s engagement with ‘picturesque’ or beautiful landscape would engender beautiful thoughts, and it was argued, therapeutic benefit through elevation of the mind above the squalor and disorder of their existence.36 These ideas were used by nineteenth century social reformers concerned about the impact of the industrial city on the behaviour and character of lower class citizens displaced from agricultural areas and employment to cramped and unsanitary living conditions of the city. The disconnection from rural life and nature were considered one of the factors that contributed to the moral decline of this new class of city dweller.37 Philanthropic reformers in England such as the influential editor of The Builder, George Godwin, described ‘town swamps’ of the industrial slums that bred immoral or anti-social behaviour.38 Slum dwellers could be rescued from depravity by ‘social bridges’ such as ‘reformatories, hospitals, missions, ragged school, model

---


36 Thompson, C. W., op. cit., (2011), See Van Eck, C. (2000). The splendid effects of architecture, and its power to affect the mind: the workings of Picturesque association. In J. Birksted (Ed.), Landscapes of memory and experience. New York: E & FN Spon, for a more detailed analysis of the way in which the mind was considered to be influenced by ‘picturesque’ landscapes.


dwellings, nurseries and public parks.\textsuperscript{39} James Buckingham's Model City of 1849 for instance was based on reconstruction of slums as a way of reforming the slum dweller and producing ‘model individuals from model environments’.\textsuperscript{40} In these model cities and reformatory institutions the garden was part of the beautiful surroundings that would provide both a refuge from the stresses of urban life, a connection with nature and an example of edifying respectability based on the moral authority of home.

These ideas are represented in the nineteenth century \textit{Melbourne Hospital} site and grounds shown in Figure 1.1. The garden provided a refuge from the city streets, a place for exercise, fresh air, sunshine, contact with nature and importantly conveyed middle-class respectability and gentility. Bound up with ideas of well-being and landscape were recreational areas of the grounds for staff who lived at the hospital, as an antidote to the depressing atmosphere of hospital wards (See Chapter 4).

This contrasts with the era of the hospital as scientific medical complex as portrayed by the \textit{Royal Melbourne Hospital} in Figure 1.2. While there are ample grounds, these function, primarily to move vehicles and people efficiently from the street to the interiors of the buildings. This style of site has been identified with the cult of the modernist architect, who was said to favour ‘discrete objects set in undifferentiated space’.\textsuperscript{41} In the modernist approach to the built environment, the surrounding grounds were no longer integral to the hospital’s purpose but now ‘served as the vegetal buffer between buildings.’\textsuperscript{42} As such, modernist sites as described by John Dixon Hunt, did not provide the ‘emotional-imaginative-intellectual’ experience that engendered well-being and moral improvement that had been important to eighteenth and nineteenth century institutional landscape.\textsuperscript{43} Instead, architectural concerns of

\textsuperscript{39} Ibid.
\textsuperscript{40} Ibid., 282.
\textsuperscript{42} Ibid.
problem-solving, an obsession with materials, pattern-making and matters of style determined the appearance of the grounds.\textsuperscript{44}

Further, rather than grounds and garden providing places for patient and staff activity and conveying moral rectitude and the traditional values of domesticity, modernist sites were designed to convey efficiency and scientific progress. Aesthetic vision based on ‘functional and rational conceptions of space’ reflected ‘industrial society’ rather than sought to create a refuge from it, as had been the case with nineteenth century landscape.\textsuperscript{45} The absence of places for human activity in modernist grounds has been argued by landscape theorist Catherine Howett to be evidence of the way modernism created a distance between man and nature unlike nineteenth century landscapes that intended to connect people with nature.\textsuperscript{46} Under these design principles the meaning of the site was reduced to the modernist dictum of ‘form follows function’, and the idea that one of the functions of the site was to provide therapeutic benefit or moral improvement in the language of the nineteenth century garden aesthetic was not considered.

The \textit{Royal Melbourne Hospital} is an example of the hospital as a scientific medical complex. Its site and grounds are examples of a International Modernist site in Australia which Philip Goad considers the dominant influence on architecture and landscape architecture in Australia after World War II.\textsuperscript{47} The simple site layout can be understood at a glance. Outdoor areas are primarily concerned with visually framing the buildings and complementing their modernist composition of space. Neither layout nor site elements encourage human activity or invite people to linger. Unlike their nineteenth century counterparts, there are no obvious places for patient exercise, sitting, social interaction or

\begin{flushright}
\textsuperscript{44} Ibid.
\end{flushright}
contemplation. Vincent Scully describes this type of site as a ‘[P]puritan fleshlessness’ and ‘utter separation of the building from the place.’\textsuperscript{48}

Kevin Thwaites \textit{et al.} describe the relationship between modernist hospital sites and landscape in the following terms:

\ldots advances in medical science combined with technical advances in high-rise construction, along with increasing demand for cost-effective efficiency, brought about more compact multi-storey medical complexes. If it was present at all, landscape became largely cosmetic and bore no relation to historic ideas that natural areas could have a bearing on the healing process, stress reduction and general well being of patients, staff and visitors.\textsuperscript{49}

For Thwaites \textit{et al.} ‘historic ideas’ of landscape refer to nineteenth century hospital sites that provided gardens and especially places for contemplation and socialization. Varied scenery and a sense of separateness from the outer world ‘where boundaries are not easily discernible’ were key elements of what they considered the therapeutic landscape of nineteenth century hospital grounds.\textsuperscript{50} These are in essence, the opposite of easily readable modernist hospital grounds previously described. Nineteenth century hospital grounds fostered social connection, contemplative responses and sensory experiences which were considered important to promote ‘emotional fulfillment’ leading to reduction in stress and increased sense of well-being.\textsuperscript{51} More recently, Catharine Ward Thompson has identified similar attributes based on ideas of salubrity in other nineteenth century landscapes as important to human well-being such as public parks.\textsuperscript{52} Both Thwaites \textit{et al.} and Ward Thompson refer to the seminal research of environmental psychologists Kaplan and Kaplan that identified complexity and mystery in outdoor areas as important attributes of restorative landscapes.\textsuperscript{53}

\begin{footnotes}
\item[50] Ibid., 529.
\item[51] Ibid.
\end{footnotes}
1.5 Research questions

As discussed above, landscape styles influenced the appearance of the hospital grounds. Underlying questions remain however about the process by which one idea of landscape gained ascendancy over another, the relationship between the practice of scientific medicine, International Style modernism and hospital landscapes and the impact this had on staff and patients. The exploration of these issues is based on the analysis of the evidence of the nine hospital sites in Melbourne from 1848-1948 derived from the following research questions:

1. What were the physical characteristics of hospital grounds from 1848-1948 and in what ways did they change?

2. What factors influenced changes to hospital grounds from 1848-1948?

3. How were hospital grounds used and experienced by staff and patients for the period of the study?

4. How were hospitals spoken about and represented in popular publications, newspapers, professional journals and hospital publications?

This thesis addresses these questions by a detailed analysis of a wide range of archival material that incorporates ‘thick description’, content analysis and case study in its approach, as outlined in Chapter Three.

1.5 Scope

The sites analysed in the themes of this thesis are nine public hospitals in Melbourne during the period 1848-1948. The Williamstown Hospital is the only site to be excluded from this survey as its small size and disconnection from the medical training provided by the University of Melbourne placed it more in the category of nursing home.54 All hospitals listed


by the Charities Board of Victoria during that period are examined. This provides a nuanced
and comparative study by which the differences and similarities between institutions can be
used to amplify and refine themes. This approach argues that a survey of all hospital sites
enriches the history of hospital development by revealing complexity and ambiguity that the
examination of one site could overlook.

The names of particular hospitals changed over the 100 year span that is the time frame
for this thesis. In the interests of clarity, the name most commonly associated with the
institution is used and only significant name changes are indicated as follows: Melbourne
Hospital, Women’s Hospital, Children’s Hospital, Eye and Ear Hospital, Alfred Hospital,
Homeopathic Hospital or Prince Henry’s Hospital after 1940, Austin Hospital for Incurables
or Austin Hospital, Queen Victoria Hospital for Women and Children or Queen Victoria and
St Vincent’s Hospital. The Melbourne Hospital moved site in 1944, and is from then, referred
to as the Royal Melbourne Hospital, in order to differentiate the two sites. The annexe of the
Children’s Hospital, known as the Children’s Convalescent Cottage is included.

This thesis examines the nine hospital sites as a means to explore and synthesize the
key themes across this period and provide robustness to the analysis. It is also hypothesized
that differences between hospital sites, especially differing types of hospitals, will provide
more insights into attitudes to landscape and human well-being during this period.

Although this thesis reviews hospital sites across a 100 year time span, two particular
time periods within that hundred years are used to provide points of comparison. The first time
point is 1900 in the period between 1848 and 1918. This is commonly accepted to be the era
of the hospital as a charitable institution with the period of World War I marking the advent of
rapid change in hospital spatial configuration. The year 1900 is representative of the hospital
as charitable institution because it predates important bureaucratic changes that
professionalized the hospital, and also the new technologies such as X-ray that typified

Williamstown, Vic., Williamstown Hospital for a detailed history of the Williamstown Hospital.
University of Chicago Press; Adams, A. (2008). Medicine by design: the architect and the modern hospital,
scientific medicine. It is important to acknowledge however, that the built environment of hospital sites did not immediately reflect social and cultural changes associated with World War I and that generally hospital developments do not fit into neat and discrete time periods. Although, this time frame is used, it is with the understanding that World War I does not represent a sharp division in hospital site development necessarily.

The second time point is 1948. This marks the introduction of a new bureaucratic structure for hospitals that officially transferred oversight of individual hospitals from multiple voluntary boards to the single government board of the Hospitals and Charities Commission. It marks the symbolic and literal end of the hospital as a charitable institution and is a valid endpoint in examining the transition of hospitals from charitable institution to medical complex. It also covers the period of introduction of modernism in Melbourne hospitals.

1.5 Thesis Structure

The thesis is structured to provide a general background on international hospital site development before focusing on hospital sites in Melbourne in particular. Chapter 2 provides an overview of hospital site development from ancient times to the twentieth century relating these to social changes and medical ideas of patient treatment as discussed in the scholarly literature. The focus of this chapter remains on western hospital development as being of most relevance to hospitals in Melbourne with its colonial ties to England. This is followed by a review of the explanations given by architectural historians and others for changes in the built environment of hospitals for the period 1848-1948. This review is then contrasted to institutional histories, as a way of indicating the dissonance between personal accounts of the built environment and expert analysis.

Chapter Three provides details of the research design, types of data, data collection methods and methodological issues. It focuses on ideas that determined the research design and also barriers and contingencies that influenced the outcome. Finally, it discusses the ways in which particular analytical techniques enriched the development of the thesis.

---

Chapter Four surveys hospitals sites as charitable institutions in Melbourne between 1848-1918 within the context of the city’s cultural and social development. Melbourne’s hospitals sites are explored in relation to government policy, medical ideas of treatment and attitudes to the hospital as a charitable institution. The grounds of hospitals are compared to other charitable institutions such as benevolent asylums as a way of determining the contribution of health theories to hospital landscape. Government reports, newspaper accounts, images, tourist publications and hospital annual reports are employed in this process. The idea of salubrity is introduced as representing the medical and social ideas considered appropriate for the location and the appearance of hospital grounds. This is juxtaposed with detailed analysis of hospital sites in order to identify the relationship between medical, bureaucratic and social ideas of the hospital and physical characteristics of the site. The implications of changes in hospital medical practice for the grounds are also explored. A comparison between inner urban sites and outer urban sites is made to emphasize the different purposes of hospital grounds for different types of patients.

Chapter Five continues the examination of social, medical and cultural influences on the physical characteristics of the site for the period 1919-1948 as hospitals evolved into medical complexes. The influence of bureaucratic changes in hospital administration and modernist architectural ideology on hospital building in Victoria is discussed. Elements that were typical of modernist sites and grounds are identified. The theme of change to hospital sites is approached through examination of the empirical evidence of patient and staff numbers and number and types of buildings that were constructed after World War I. This information is presented in a number of tables and related to the appearance and configuration of hospital grounds. Hospital sites and grounds are analyzed within the framework of four main types identified during the preliminary analysis undertaken for this thesis: museum sites, chaotic sites, transitional sites and modernist sites. Comparative analysis of elements in the grounds related to salubrity between 1900 and 1948 is summarized by a table, establishing that modernist elements were introduced to hospital grounds before modernist buildings. This is significant finding which enhances the understanding of changing attitudes to well-being and landscape in general and the history of the built environment of modernism in particular. The differences between hospital grounds are discussed within the context of purpose, meaning and the significance of site characteristics to site development.
INTRODUCTION

Chapters Six and Seven examine the ways in which hospital grounds were used by staff and patients as hospitals changed from charitable institution to medical complexes. The changing meaning and purpose of the grounds are examined in relationship to the changes in the built environment. An overview of types of activities on hospital sites is followed by two tables that summarize changes in physical characteristics and staff and patient experience of the grounds. This is followed by detailed case study of the Alfred Hospital in Chapter Seven which amplifies these points. This hospital was chosen as a site that was representative of hospital grounds for the period of the study. The Alfred site is analyzed within the context of a domestic residence typology of front garden and backyard and with the associated activities that took place in each of these zones over the time period of the study. The residential typology is used to emphasize the loss of residential characteristics as the hospital moved from a charitable institution to a medical complex. This is important to conceptualization of the hospital as place. The changing purpose and meaning in hospital sites is then discussed as a decline in the quality of experience for patients and staff as the site evolved from place for people to a space for buildings.

Chapter Eight draws on the findings of the previous three chapters in order to explore changing purpose and meaning of hospital grounds within the main themes identified in this thesis. Finally, it contextualizes hospital sites in Melbourne in 2011 in relation to the historical analysis to question the relevance of hospital landscapes in Melbourne to human health and well-being. This also interrogates claims of a new era in present day hospital landscapes that have developed in reaction to sterile mid-twentieth century hospital sites.

In summary, this thesis looks at hospital sites over a one hundred year period at the time of change from hospital as charitable institution to hospital as medical complex to interrogate changing attitudes to landscape, health and well-being. It addresses the lack of detailed study of the grounds of urban hospitals, particularly within a Melbourne context and in relation to patients and staff who used the site. Finally it demonstrates the importance of the site both in enriching the history of hospitals and in the design of the built environment and in the final discussion links this to contemporary hospital sites.
CHAPTER TWO

AN HISTORICAL OVERVIEW OF HOSPITAL SITES AND GROUNDS

2.1 Introduction

Places for treatment of the sick have been associated with a wide range of sites from the aesclepias of ancient Greece to the medical complexes of the twenty-first century. The changing form of the hospitals and sites reveal cultural attitudes not only to treatment of the sick but also to its built environment and landscape. This chapter reviews the built form of the hospital from ancient times to the present day to examine this relationship between hospitals, landscape and society. This is undertaken to focus on the hospital as a cultural product. This is then followed by a closer analysis of the purpose and meaning of hospital landscapes for the period of the study, 1848-1948. Attitudes to landscape that have influenced hospitals sites and grounds are a particular emphasis.

The development of hospitals however rarely follows a neat chronology, respects convenient time periods or is uniform across or between geographic areas.¹ Further it has been noted by Annmarie Adams and others that different hospital types may co-exist rather than there being a smooth transition from one style to the next.² The six categories used in this thesis: aesclepias, valetudinarium, religious institution, villa, pavilion and multi-storey block incorporate categories used by architectural historians of hospital typology.³ This typology is led by building form rather than social, medical or political time periods. The category of

AN HISTORICAL OVERVIEW OF HOSPITAL SITES AND GROUNDS

religious institution for example covers medieval and renaissance periods up to 1700 and the emergence of the villa hospitals. Although this span of time included important social and political changes, the hospital form remained based on that of the religious institution, so has been used as the defining form. Allocating categories to the form of the site rather than focusing on time periods avoids this over-simplification.

This review of hospital sites concentrates on urban hospital sites associated with cities and towns as the most relevant to the topic of this thesis. Although care of the sick was associated with a range of other sites including leprosaria, asylums, prisons, workhouses, sanatoriums, and cottage hospitals, to include these sites would unnecessarily dilute its focus. Further, the literature review is predominantly of English hospital sites, reflecting the strong connection between the English hospital system and architecture and Melbourne’s hospitals, particularly in the nineteenth and early twentieth century. Melbourne hospitals largely adopted the English system of charity hospitals and looked to Britain for its doctors and models of hospital types. As will be seen in Chapter 5, after World War I North America became an increasingly important influence on Melbourne hospital sites but prior to that time, England provided the preferred model for hospitals in Melbourne. A focus on English hospital sites is by definition a study of hospitals associated with Christianity. This is not to deny the significance of hospital sites of other religious faiths such as Islam and Judaism but is to acknowledge that western Christian tradition of hospitals has the most relevance to Melbourne.

2.2 Hospital sites and grounds from ancient times to 1948

*Aescelpia* sites

The first sites associated with treatment of illness have been identified with the *aescleopia* of Greece and Rome between 1000 B.C. and 100 A.D., and the development of the *valetudinarium* in the first millennium. The *aescleopia* of ancient Greece, later adopted by

---

Rome, was a temple closely aligned with the cult of the Greek healing god Asclepius. The siting of the aesclepia ‘on clean, elevated sites outside cities’ was associated with a broader understanding of the importance of climate, access to clean water and scenic beauty on health and well-being in the ancient world. Mental illness was not conceptualized as a separate condition from physical illness, both conditions being treated in a holistic approach that included rituals, interpretations of dreams, bed rest, medications, baths, diet, and exercise.

Guenter Risse, a former psychiatrist, describes at length these treatments, stressing the importance of the site in providing psychological, spiritual and physical benefit to patients. Siting of aesclepia for example was carefully selected in accordance with cultural and religious understanding of contact with nature as promoting health and curing disease. Risse describes the land surrounding the aesclepia, emphasizing the importance of topography and ‘natural’ elements in its location, which in turn reflected the importance attached to ‘nature’ in the treatment of illness:

... Asclepia, were mostly erected in valleys at favourable wooded locations near hot or cold springs but also near caves outside towns. While water had obvious symbolic cleansing qualities in ancient Greece, the existing springs also possessed oracular powers since good spirits were said to live in the mountains and groves of cypress or olive trees surrounding them. The sacred land or hieron was always marked off by an enclosure called a temenos, separating it from the profane space by stones or a wall surrounding the whole complex. At Epidaurus, a special path or “sacred way” linked the town...
with the temple. Most enclosures had a temple, image, and altar, but others simply consisted of a grove, spring, or cave in the countryside.\textsuperscript{11}

\textbf{Figure 2.1} Model of the aescelpia of Pergamon showing the patient treatment building (F) outside the boundary wall of the aescelpia providing easy access to the surrounding natural landscape of wood and springs, considered important to the healing process. Thompson and Goldin, 5.

Thompson and Goldin reproduce a model of the aescelpia of Pergamon by H. Schleif (Figure 2.1) as an example of the aescelpia site although it is not indicated as typical. Of particular importance, is the location of the treatment hall (F) outside the walls of the aescelpia. Presumably, in the context of Risse’s description of the siting of aescelpia, this would have given direct access to woods and possibly a spring. In this reconstructed model, the emphasis of Thompson and Goldin is on buildings and their relationships to each other rather than to the relationship of buildings to the surrounding land and its implications for treatment. It is reasonable to assume however, in the consideration of Risse’s account that the topography, natural elements such as trees and springs were integral to the idea of a hospital at this time. This is supported by W.M. Gesler who points to the location of the sanctuary at Epidaurus in north-eastern Peloponnese as indicating the importance attached to the environment in the ‘creation of physical and mental well-being’.\textsuperscript{12} The site which included an

\textsuperscript{11} Risse, G.B., \textit{op. cit.}, (1999), 45.


an historical overview of hospital sites and grounds

Aesclepias was remote from the town in an elevated location surrounded by pine forests giving patients access to the natural world that was considered integral to patient treatment.

Valetudinaria sites

The valetudinarium was a Roman military hospital site built near the front line of the Roman empire throughout Europe and Near Middle East until the fall of Rome in 340 A.D. The siting of the valetudinarian was carefully considered in terms of noise and dust reduction with hospitals far from the centre of the barracks and near an outer wall. Risse notes the insistence on a healthy site for the camp itself and quotes Flavius Vegetius in outlining the physical characteristics that were considered important for the location of the military camp:

Figure 2.2 Plan of a valetudinarium (military barrack). Elevated sites, shade trees and distance from stagnant water were favoured by Roman army in siting the barracks as effective means of treating disease. Thompson and Goldin, 5.

with hospitals far from the centre of the barracks and near an outer wall. Risse notes the insistence on a healthy site for the camp itself and quotes Flavius Vegetius in outlining the physical characteristics that were considered important for the location of the military camp:

...as far as situation is concerned, do not keep the troops in an unhealthy region in the vicinity of marshes that bring diseases, on arid plains or hills lacking trees to provide shade.\textsuperscript{15}

The plan of the barracks at Vindonissa reproduced by Thompson and Goldin, illustrates a typical arrangement of a \textit{valetudinarium} (Figure 2.2). The plan and reconstructed elevation reveals a utilitarian structure with no direct views of the outdoor grounds from the patient rooms (D). The only light is provided by a clerestory in the corridor, which itself is assumed in the reconstruction under the justification of the need for natural light. It is possible although not probable that the hospital barracks were without natural light.\textsuperscript{16} The only concession granted to a particular environment for treatment of the sick is the arrangement of the rooms which did not open directly onto the corridor but are entered via a vestibule considerably reducing dust and noise.\textsuperscript{17} As there is some conjecture however, as to whether this plan is that of a hospital or a barracks, the arrangement of the patient rooms may simply reflect a common building plan rather than a factor in patient treatment. This evidence suggests that \textit{valetudinaria} marked a change in attitudes towards outdoor grounds in treatment of the sick from the classical period. On these sites contact with nature and scenic beauty became less important than elevated topography and avoidance of unhealthy landscape features such as swamps.

\textbf{Religious institution sites}

Continental Hospitals

Medieval and renaissance hospital sites were associated with the growing influence of the Catholic Church in the provision of health care from the fifth through to the eighteenth centuries.\textsuperscript{18} These hospitals widespread throughout Europe, founded on Christian ideas of charity and services for the poor, represented both spiritual care of the soul and physical cure

\begin{flushleft}
\textsuperscript{15} Risse, G.B., \textit{op. cit.}, (1999), 49.  \\
\textsuperscript{16} Thompson, J. D. & Goldin, G., \textit{op. cit.}, (1975), 5-6.  \\
\textsuperscript{17} Ibid., 6.  \\
\end{flushleft}
of the body as part of the hospital’s purpose. Medieval monasteries were one of the early sites associated with hospitals evolved from hospices which offered shelter to ‘pilgrims, the monastic sick, and possibly the sick from the surrounding area’. Hospital buildings were one component of the site which provided a number of charitable services including shelter for indigent people, board for wayfarers and the giving of alms. In consequence, the term ‘medieval hospital’ includes leper houses, almshouses and shelters for the sick poor and hospices for poor wayfarers and pilgrims.

Italy is closely associated with the development of the cruciform configuration of hospital buildings that became widespread throughout continental Catholic countries. Filarete’s Ospedale Maggiore (1456) which is considered a landmark in hospital architecture served as model for other Italian hospitals as late as the seventeenth century. Ospedale Maggiore demonstrates the chief characteristics of a renaissance hospital in continental Europe with its cruciform ward configuration, four-winged structure around a colonnaded court and loggia (Figure 2.3). An altar at the cross-section of the two wards was designed to allow patients a view of religious services as part of their spiritual care. John Henderson notes in his study of Florentine hospitals, that the design had both a spiritual and medical purpose as it allowed nursing staff a clear view of patients whilst allowing patients to see Mass being celebrated.

---

19 Ibid, Thompson & Goldin; Risse, op. cit., (1999), 73-75.
24 Ibid.
Henderson, a social and medical historian has given insight into hospitals of religious institutions beyond the building configuration and in consequence indicates the relationship between the site and the lived experience for occupants of the site. He lists the live-in staff for the larger Florentine hospitals as including director and his assistants, nursing staff and gardeners. These people are described as housed and maintained on the hospital grounds by produce coming from the hospital orchards, vegetable garden and poultry yards. In the early sixteenth century for instance, Henderson calculates that the St. Maria Nuova had 1000 chicken, hens, geese and ducks. Other Florentine hospitals built after St. Maria Nuova included market gardens to supplement the kitchen. Messer Bonifazio and the Incurables hospital for instance had large gardens behind the hospital frontage on Via S. Gallo. Other elements of the hospital grounds included a herbarium which supplied medicinal herbs to the hospital pharmacy and a cemetery. Plants grown in the herbarium for the St. Maria Nuovo included honeysuckle, wild sage, rosemary, betany, lavender, chamomile, dill, bay tree and pine trees (for resin and turpentine).

In France, during the 1600s the hospital buildings began to differ from the traditional Italian model by greatly increasing in dimensions and scope, although the basic renaissance

---

AN HISTORICAL OVERVIEW OF HOSPITAL SITES AND GROUNDS

influence is still evident.\textsuperscript{29} Paris produced \textit{Hôpital de la Charité} (1608), \textit{Hôpital des Incurables} (1635-49), \textit{Hôpital de la Salpêtrière} (1657) and the famous \textit{Hôpital St-Louis}.\textsuperscript{30} Intended for plague victims, the \textit{Hôpital St-Louis} was considered the most impressive of the French hospitals by the Englishman John Evelyn in the 1640s. Built as part of Henri IV’s urban renewal program, this hospital was in the chateau style and exhibited the major elements of hospital sites of that period: chapel, gatehouse, closed quadrangle, surrounding walls and open-ended court side to allow for free circulation of air.\textsuperscript{31} These grand buildings were two to three stories high, often with open arches surrounding rectangular courts. The change to the closed court marks a departure from the closed quadrangle of the early renaissance period. The layout and style of these hospitals was indistinguishable from chateaus and public building with an element of civic pride invested in their imposing facades.\textsuperscript{32}

Hospitals in England

England’s early hospitals were formed as part of religious institutions such as monasteries that offered shelter to travellers and other groups in the community. The emergence of a large number of hospitals occurred in the twelfth and early thirteenth centuries as a consequence of economic prosperity and population growth.\textsuperscript{33} Not merely an institution for the care of the sick’, as historian Carole Rawcliffe has indicated, it performed a wide range of social functions.\textsuperscript{34} Although largely funded by prominent citizens and civic organizations such as worker’s guilds, these looked to ‘existing religious institutions as both recipients and dispensers of charity’ and so continued the association between church and hospitals.\textsuperscript{35}

Attendance of medical men was relatively rare. Carlin reports only one reference to specialist medical attention before the sixteenth century in London and could find no reference for medical or surgical professionals outside of London. Similarly, evidence of purchase of

\textsuperscript{29} Leistikow, D., \textit{op. cit.}, (1967), 66.
\textsuperscript{30} Ibid.
\textsuperscript{31} Thompson, J. D. & Goldin, G, \textit{op. cit.}, (1975), 144-149
\textsuperscript{32} Ibid.
\textsuperscript{33} Rubin, M., \textit{op. cit.}, (1989), 43.
medicine or the attendance of an apothecary is not apparent. After the thirteenth century urban hospital sites were more closely associated with non-contemplative orders such as the Augustinians. These orders founded in the mid-eleventh century on the basis of serving God through active service, differed from the monastic traditions of the Cistercians and Benedictines who had previously provided care for the sick. The Augustinian hospitals became the nucleus of the treatment of the sick in England.

After the thirteenth century with its consequent economic downturn and decreased population, many hospitals disappeared or were converted to more profitable ‘retirement homes, chantries (offering liturgy rather than charity) or colleges of priests.’

In the sixteenth century, the religious reformation of Henry VIII and Edward IV led to the dissolution of the monasteries and religious institutions and disrupted the existence of many hospitals in England. The hospitals that eventually emerged at the instigation of the Henry and Edward, known as the Royal Hospitals in London were on the sites of the former monastic institutions of St Bartholomew’s, St Thomas’, Christ’s, Bridewell and Bethlem. Although the Royal Hospitals are most commonly cited as the only hospitals resurrected after the Dissolution of the monasteries, Henderson et al, point out that in fact, provincial cities outside London experienced a similar re-establishment.

The Reformation in England, although representing a break with the Catholic Church, did not introduce a new type of hospital site, which continued to be associated with site configurations of religious institutions and many of its former practices such as religious

---

37 Rawcliffe, _op. cit._, (1984), 5.
40 Rosen, G., _op. cit._, (1963), 15.
Hospitals remained as part of religious institutions until the eighteenth century with the emergence of the civil villa hospital.\textsuperscript{44}

In England, there were two main types of medieval hospitals associated with monastic traditions - Cistercian and Benedictine institutions. Both offered hospitality to pilgrims and wayfarers and were established on the outskirts of cities and rural areas.\textsuperscript{45}

The location of monasteries next to streams or rivers, particularly with Cistercian sites in rural settings, is characteristic of these early hospitals.\textsuperscript{46} Although this had a practical basis in terms of provision of fresh drinking water, it is also an indication of the monastic understanding of the importance of environmental factors for health.\textsuperscript{47} Carole Rawcliffe argues that the recognition by the monastic orders of the importance of fresh water, adequate drainage and fresh air is evident in the location of the hospital sites in London and the installation of piped water to these sites\textsuperscript{48} In support of this is Rawcliffe's information that at the insistence of the Bishop of Winchester, St Thomas' in Southwark was rebuilt after a fire in 1213 on a site where the water and air were considered purer and thus suitable for an institution of this type.\textsuperscript{49}

Architectural historian Dankwart Leistikow notes that early hospitals were usually associated with streams but adds that another factor that influenced their siting was the proximity of the town gates on main roads.\textsuperscript{50} The reason for this is founded in the early role of hospitals as shelters for wayfarers and pilgrims. Andrews et al. have demonstrated the relationship of hospitals to the main roads in England as can be seen in the plan of the main thoroughfares of London, c.1400, reproduced in \textit{The History of Bethlem}, where 9 out of 12 hospitals are located on major roads (Figure 2.4). Similarly, in rural areas the location of

\begin{itemize}
\item \textsuperscript{43} Rosen, G., \textit{op. cit.}, (1963), 16.
\item \textsuperscript{44} Henderson, et al, \textit{op. cit.}, (2007), 23.
\item \textsuperscript{46} Braunfels, \textit{op. cit.}, (1972), 74.
\item \textsuperscript{48} Rawcliffe, \textit{op. cit.}, (1984), 10.
\item \textsuperscript{49} Rawcliffe, \textit{op. cit.}, (1984), 10.
\item \textsuperscript{50} Leistikow, D., \textit{op. cit.}, (1967), 53.
\end{itemize}
hospitals and settlements was also associated with land and sea travel with sites on main roads and close to sea ports.\textsuperscript{51} Other local environmental factors may have influenced site location. Martha Carlin in her study of English medieval hospitals notes for example, that ‘[T]he hospitals of St. John the Baptist, Bath, and St. Michael at Welton, Northumberland ‘…were established for the reception of the sick poor who came to have the benefit of the medicinal waters.’\textsuperscript{52}

\textbf{Figure 4.1} The main thoroughfares of London, c. 1400

\begin{verbatim}
Key: A Charterhouse      G St Thomas of Acon Hospital
B St Bartholomew’s Priory/Hospital H St Anthony’s Hospital
C White Friars            I Austin Friars
D Black Friars            J St Mary Bethlem
E Grey Friars             K St Helen’s Priory
F St Paul’s               L Holy Trinity Priory (Christ Church)
\end{verbatim}

\textbf{Figure 2.4} Diagram showing the relationship between hospitals and main roads in London in 1400. St Thomas of Southwark is not shown but is on the south side of the Thames adjacent to London Bridge. Andrews et al., 37. (No scale included on original).


\textsuperscript{52} Carlin, op. cit.,(1989), 33.
Thompson and Goldin focus on *Fountains Abbey*, Yorkshire England to illustrate a hospital site based on monastic design which included a complex collection of buildings and grounds such as cloisters, church, kitchen yard, cemetery, living quarters for staff, guest house for pilgrims and infirmary hall for treatment of the sick.\(^{53}\) The section of the monastery that is popularly associated with the care of the sick, that is the cloister quadrangle and medicinal garden, would not under normal circumstances be open to the public or the inhabitants of the hospice.\(^{54}\) As Risse relates, the healing provided by monks in the contemplative orders had officially ended in 1130 following the Council of Kent, as it was believed that it distracted

![Figure 2.5 c.1200s Plan of Kirkstall abbey, Yorkshire, England showing a separate zone for sick monks. The infirmary cloister for sick monks is indicated by the smaller rectangle. The elaborate cloister garden popularly associated with treatment of sick citizens was available only to monks. Monasteries were invariably located near waterways as indicated in this plan. Cassidy-Welch, 135.](image)

\(^{53}\) Thompson & Goldin, *op. cit.*, (1975), 42-43.

monks from their spiritual goals.\textsuperscript{55} Megan Cassidy-Welch in writing about thirteenth century Cistercian monasteries in England has demonstrated that not only was the hospice separated from the main cloister but the infirmary for monks was located in a separate zone (Figure 2.5).\textsuperscript{56} The physical separation of the sick monks from the rest of the monastery complex has been attributed to concerns with cross-infection as well as medieval understanding of sickness as a judgment from God that made them unwelcome companions to the other monks.\textsuperscript{57}

Monastic hospital sites in England resembled those of the continent in having associated agricultural land. The complexity and layout of such grounds is evident in the 1617 plan of London’s St Bartholomew’s (Figure 2.6). The hospital on the site is described by Whitteridge and Stokes in \textit{A Brief History of the Hospital of Saint Bartholomew} as ‘wards and offices’ intermingled with houses and shops.\textsuperscript{58} It was commonplace for servants and artisan staff to live on site with hospital records referring to clerks, cooks and servants as resident within the institution.\textsuperscript{59} Sites such as St Bartholomew’s also provided shelter for unmarried mothers after the birth of their child and in some cases children were educated in the school on site.\textsuperscript{60} This would have involved buildings to house the children and schoolroom. While it is rarely mentioned in documentation, a cemetery was almost certainly associated with hospitals, and is sometimes indicated on plans.\textsuperscript{61} The 1617 plan of London’s St Bartholomew’s for instance, is a rare example of a plan indicating a graveyard.

\textsuperscript{56} Cassidy-Welch, \textit{op. cit.}, (2001).
\textsuperscript{57} Ibid., 137 and 143.
\textsuperscript{60} Rawcliffe, \textit{op. cit.}, (1984), 2.
The hospital was not an isolated structure but part of a wider complex of buildings. Martha Carlin describes the physical arrangements of the hospital site as an ‘enclosed
precinct’, the access to which was controlled by one or more gates with gate keeper and gate house to monitor access.\textsuperscript{62} The sites were marked by a clear boundary wall and the gates were locked at night.\textsuperscript{63} There are no plans of English hospitals that equate with the elaborate configurations and extensive gardens laid out in intricate parterre that were associated with hospitals in other parts of Europe. \textsuperscript{64} The relationship of the hospital building to the complex site is evident in the \textit{St Bartholomew’s} plan and also in the description provided by Whitteridge and Stokes in \textit{A Brief History of the Hospital of Saint Bartholomew}:

The plan of 1617 shows the Smithfield gate and the church of Little St Bartholomew. To the south of this stood the old Great Hall with cloisters and courts on either side. Further south, another court contained the drying galleries; then came the burial grounds for patients and parishioners. Near them was the Little Britain gate:...Scattered among the wards and offices of the hospital were houses and shops. In the southern part of the hospital, leading through it and in to Christchurch was the Long Walk.\textsuperscript{65}

The quadrangle design was again a dominant design feature. \textsuperscript{66} The engraving of \textit{St Bartholomew’s} for the 1720 edition of Stow’s \textit{Survey} reproduced by Harriet Stevenson, shows courtyards that had evolved from the medieval design (Fig. 2.7). Later, the great hall and cloisters were demolished in 1734 to make way for the new buildings which again were based on a quadrangle design.\textsuperscript{67} Leistikow mentions a British variation on the courtyard design in which the buildings are arranged either side of a narrow court as at such as \textit{Ford’s Hospital} at Coventry (1529) and \textit{Christ’s Hospital} at Aberdeen but generally the quadrangle site layout was dominant \textsuperscript{68}

\begin{flushright}
\textsuperscript{63} For instance, see Whitteridge, G., & Stokes, V., \textit{op. cit.}, (1961).
\textsuperscript{64} See the plan of the Hopital St. Louis in Stevenson, C., \textit{op. cit.}, (2000), 14 and Henderson, \textit{op. cit.}, (1989), 80-81 for a description of the elaborate layout and related residential population, agricultural and farming activities and that were associated with Florentine hospitals.
\textsuperscript{66} Ibid.
\textsuperscript{67} Whitteridge, G., & Stokes, V., \textit{op. cit.}, (1961), 34.
\textsuperscript{68} Leistikow, D., \textit{op. cit.}, (1967), 70.
\end{flushright}
The cruciform design of the hospital buildings within the complex although widespread on the continent was relatively rare in England and almost all hospital infirmaries in England were long rectangular halls. The emphasis remained on care of the soul however with chapels included at the eastern end so that patients could witness mass from their beds.\footnote{Carlin, M, \textit{op. cit.}, (1989), 28.}

During the period of the 1600s when the French hospitals were proliferating, no significant hospital structure was built in London apart from the new building associated with Bethlem, the lunatic hospital. Except for the Savoy, the hospitals in London were medieval institutions re-constituted after the Reformation. As architectural historian Christine Stevenson has pointed out, England did not develop a recognizable building type or style.\footnote{Stevenson, C., \textit{op. cit.} (2000), 12.} The London hospital, the Savoy (1505-7) which was modeled on the cruciform design of St. Maria Nuova in Florence was considered a radical departure from the norm.\footnote{Rawcliffe, C., \textit{op. cit.} (1984),12.} Stevenson notes that the lack of hospital building at this time reflected a lack of interest in the theory of hospital building in
England. The continuing presence of elements such as quadrangles in England reflected the strong association between hospital sites and religious institutions which remained until social changes in the 1700s disrupted the relationship between church and community.

**Villa sites**

The eighteenth century is usually characterized as the period of transition from the 'hospital' as a refuge, in which there was incidental treatment of illness into an institution whose prime function was care of the sick. In keeping with social changes instigated by increasing industrialization of the eighteenth century, hospital treatment became enmeshed with economic and political motives associated with the worker's capacity to contribute to the community and maintenance of social order. In England, which had reduced its allegiance to the Catholic Church during the Reformation, a new approach to provision of medical treatment to the poor emerged. This was based on civil rather than religious notions of charitable assistance. Religious ideas of charity were still evident but within a civic rather than ecclesiastical model of hospital site. Medical practice was also changing with a greater emphasis on clinical medicine based on anatomical science, analysis of bodily functions and the role of the doctor in diagnosis and treatment. These attitudes, together with economic and population growth and combined with architectural and medical interest in hospitals, led to a large increase in ‘voluntary’ hospitals after 1720 in England. These were called voluntary hospitals because of the funding system of voluntary contributions by subscription and donation from the general public. Medical and civic concerns formed the major influence on location, site configuration and building form of new hospital sites and grounds during this period.

---

77 Ibid., 236-300.
78 Ibid., 69.
Although the new hospitals in England moved away from the sites of religious institutions, they did not develop a distinctive style but rather adapted vernacular typologies of the domestic residence during this period. Instead of a religious institution layout, the new type of hospital replicated many of the features of a home including domestic architecture, garden areas, front drives and boundary fences. Particular architectural forms of the typical country house and Palladian villa became important in conveying civic pride and moral order.

The new hospitals had an 'explicitly familial organization and recognized function as surrogate houses'. The domestic hospital site was intended to instill inmates with the civic...
AN HISTORICAL OVERVIEW OF HOSPITAL SITES AND GROUNDS

virtues of order and control, associated with the family values of a home.\textsuperscript{82} Christine Stevenson points to the front cover of a popular magazine, \textit{The philosophy of domestic economy} in 1819 featuring the \textit{Derby Infirmary}, as evidence of the strong association between the hospital and the domestic sites at this time (Figure 2.8).\textsuperscript{83} This domestic form illustrated the concern of hospital authorities to impose social order on the emerging industrial classes who now formed the hospital patient population.\textsuperscript{84} For this reason Sloane et al, describe the hospital as home as a ‘moral site’.\textsuperscript{85}

By 1800, there were 38 voluntary hospitals in England supported by individuals, including doctors, prominent citizens and architects.\textsuperscript{86} Corporate bodies as well as individuals made regular payments for the rights to 'nominate in and out-patients and to call themselves, variously, governors, donors, sponsors, or subscribers.'\textsuperscript{87} The involvement of citizens in the oversight and funding of the hospital was not a new development. As Henderson \textit{et al.}, have pointed out, patronage by wealthy citizens, supported by donations from people living in the parish had been a feature of hospitals both in England and other parts of Europe from medieval times.\textsuperscript{88} The novel feature of voluntary hospitals was the way in which the relationship between patronage and the right to nominate patients was formalized.\textsuperscript{89} Under this new system, purchase of a subscription to support the hospital entitled the purchaser to nominate patients for the hospital. This has been characterized by Henderson et al, as the era of the power of the patron.\textsuperscript{90}

The relationship between the patron and the hospital influenced the character of the hospital site in which its physical appearance became important in attracting funding and

\textsuperscript{83} Stevenson, C., \textit{op. cit.}, (2000), 227.
\textsuperscript{84} Ibid.
\textsuperscript{85} Ibid., 40.
\textsuperscript{86} Porter, R., \textit{op. cit.}, (1989), 150.
\textsuperscript{87} Ibid., 106.
\textsuperscript{88} See Rubin, M., \textit{op. cit.} (1989) for a detailed description on the relationship between civil authorities, patronage and hospitals in England from 1100-1500.
\textsuperscript{89} Henderson, J., et. al, \textit{op. cit.}, (2007), 24.
\textsuperscript{90} Ibid.
bolstering prestige of benefactors. The hospital, now a civic building, needed to be perceived as a worthy institution deserving of its patronage, particularly from wealthy patrons, whilst at the same time allaying contributor’s fears about unnecessary waste and ornamentation. Similarly, the Palladian style of the buildings, conveyed ‘[A]n association with members of the aristocracy’ which enhanced its appeal to patrons.

Figure 2.9 London Hospital. A later engraving of William Beller’s painting of 1752, sold by subscription. Healthy landscape was distant from the pollution of the town and associated with simple rural life as an antidote to the evils of the city. Stevenson (2000), 134.

Increasingly doctors were involved in hospital treatment and came to influence the layout, siting and configuration of hospitals. Medical ideas of a suitable environment for

92 Ibid.
94 Ibid., 107.
hospitals included a location away from the polluted air of industrial towns which were perceived to be unhealthy by medical and civil authorities. Clare Hickman for instance, has indicated in her study of the Leeds General Infirmary, that fresh air and a garden aesthetic were significant concerns for emerging industrial suburbs such as Leeds, anxious to counter the perceived detrimental impact of new factories and congested housing on human health.

The outcome of these considerations was the siting of new hospitals outside of London, on the fringes of urban centres.

Ideas of landscape and health were evident in the siting of the hospital and the way the site was portrayed to the public. Stevenson points to the construction of domestic style villa hospitals and the general siting on the fringe of towns as evidence of a belief in the therapeutic value of ‘rural simplicity and virtue’ in contrast to the ‘city’s complexity and vice’ in the general population. This became particularly relevant as towns became more crowded and unhealthy as a result of increasing industrialization. In this sense the hospital site was a refuge from the evils of the outer world much as the monastery hospital had been in the medieval period. Hospital sites as a consequence were associated with country life and rural landscape in promoting themselves, as is illustrated in a number of engravings of hospitals from the eighteenth century. Stevenson illustrates this with an engraving of London Hospital sold by subscription to raise funds for the hospital. She argues the emphasis on bucolic aspects of the site and use of perspective to create a distorted sense of distance and spaciousness indicates the appeal of this type of hospital site and grounds to the general population (Figure 2.9).

Misleading bucolic portrayals of hospitals continued to be used even after the city had encroached. An example of this also pointed out by Stevenson is an engraving of the Gloucester General Infirmary in 1763 which emphasized its rural aspect and location amidst...
rolling hills, hedgerows and agricultural land without reference to its urban context or the working population for whom it existed (Figure 2.10).  

Figure 2.10 Gloucester General Infirmary set amidst a rural landscape. First published in the 1763 Annual Report. Promotion of the hospital with landscape that was outside of the city amidst fresh air and country scenes persisted even after the hospitals became surrounded by urban development, as is the case in this example Stevenson (2000), 147.

101 Ibid., 147.
Typical villa hospital gardens were closely associated with a domestic site but as Clare Hickman has indicated, there was a medical purpose for the grounds as well (Figure 2.11). In support of this, she has referred to the survey of hospitals undertaken by doctors John Bristowe and Timothy Holmes for the British Parliament in 1864, to indicate the status of hospital gardens at this time. This comprehensive survey undertaken as a call for reform in hospital sites was taking place in Britain, provides an invaluable record of hospital sites that existed in the early 1800s. Hickman notes that three London hospitals are mentioned in negative terms in this survey for lack of a garden, and of the 67 hospitals listed in England, the grounds of 46 were commented upon. She also makes the more general point however, that this may be a distorted view of hospital sites, as the lack of the mention of the grounds in other institutions may indicate that the grounds were unremarkable rather than non-existent. Hickman suggests that provincial hospitals sites were usually mentioned in connection with some form of airing court or garden for use of the patients and that Birmingham Hospital was listed as having a bowling green.

Figure 2.11 Old Leeds Infirmary after an additional floor and two wings were added in 1792. The garden areas are domestic and enhance the impression of a private villa. The garden for patients and the public is at the back and to the side of the building. Anning, Figure 13.


\[104\] Ibid.

\[105\] Ibid., 135.
The clearest idea of the significance and use of the garden of the early nineteenth century however, is from a hospital history written by former doctor who had worked in the twentieth century Leeds Hospital (Figure 2.12).\textsuperscript{106} His description of the garden is quoted at length as it demonstrates not only that the grounds were important in terms of civic pride but also contributed to the social and community life of the hospital and the town:

\begin{quotation}
The garden of the Infirmary, which lay to the south of the building, was from the first an important feature, and more so from 1817 when the trustees acquired a large area of open land to the south of the property. … As a result the land of the Infirmary now extended to the newly opened Wellington Street and was bounded in the west by King Street ‘The land’, wrote Mayhall later,’ is tastefully laid out as a garden and pleasure ground, and is enclosed by a substantial wall, surmounted with iron palisades, and forms an ornament to the western part of the town’
\end{quotation}

From 1805 part of the garden had been appropriated for the planting of such medical Herbs & shrubs as are frequently wanted in the practice of ye Infirmary’ and benches with backs were provided for the use of patients. The enlarged garden was soon in danger of being lost for the use of patients on account of the expense of laying it out. In 1819 it was decided to let it as a kitchen garden but the Board changed this decision a few weeks later and resolved to lay it out as an ‘ornamental pleasure ground’. It was also resolved ‘that every person (whether Trustee or otherwise) shall pay an annual sum for the privilege of walking in the said ground’....The levelling, planting and laying of gravel paths was completed by April 1821, a special subscription fund for the purpose having being raised, and in 1849 the Leeds Horticultural and Floral Society (founded in 1837) held ‘a grand horticultural and floral exhibition’, lasting two days, in the Infirmary garden.\footnote{Anning, \textit{op. cit.}, (1963), 19-20. John Mayall quoted in this excerpt is cited as \textit{The Annals of Yorkshire}, Leeds, 1861. The other quotes are not directly attributed but elsewhere in his book Anning has indicated that unattributed quotes are generally taken from the hospitals reports. The Horticultural Society held its annual show in the hospital grounds for the next twelve years.}

Anning then goes on to describe the hospital garden as fitted out with platforms that could used by paying citizens to watch Queen Victoria open the new Town Hall in 1858, the storage of a statue of the Duke of Wellington for a period of time and the granting of permission for medical students to use the gardens as a play-ground as long as care was taken not to injure the grass plots or shrubs.\footnote{Ibid., 20.} All these functions indicate the importance and integration of the hospital site into the life of the community who used its grounds as a public place.

**Pavilion sites**

The period 1850-1950 is characterized by the emergence of the pavilion hospital layout with its gradual decline in favour of high rise hospital sites of multi-storey block buildings by the mid-twentieth century.\footnote{Cortiula, M. (May 1995). \textit{Houses of the Healers: The Changing Nature of General Hospital Architecture in Hamilton, 1850-1914}. \textit{Histoire Sociale/Social History}, 28(55), 27-50; Sloane, D. C. (1994). \textit{Scientific Paragon to Hospital Mall: The Evolving Design of the Hospital, 1885-1994}. \textit{Journal of Architectural Education}, 48(2).} The pavilion design was widespread throughout Europe including England, North America, Australia and New Zealand.\footnote{Ibid., 20.} Unlike the villa hospitals which were adapted domestic sites, the pavilion hospital which emerged in the nineteenth
century has been identified by Adrian Forty as the ‘first type of building to be unmistakable as a hospital building (Figures 2.13 and 2.14). This refers to its particular configuration which was based on medical and architectural theory of the best way to treat medical conditions founded on the growing understanding of causes and treatment of disease.

Figure 2.13 Pavilion plan for the proposed John Hopkins Hospital in 1876. Land between the pavilion buildings was considered necessary to provide fresh air and sunshine to mitigate the effect of miasmas. Florence Nightingale recommended that they be planted out as a garden to lift the spirits of patients and encourage exercise. Thompson and Goldin, 184.

The pavilion hospital configuration based on miasmic theories of disease transmission famously promoted by Florence Nightingale, was a series of low rise buildings connected at right angles to a central spine. As described by Anthony King and others, it consisted:

112 Thompson, J.D. & Goldin G., op. cit., (1975), 159-169.
preferably of single storey, or failing this, two-storey ward blocks, usually placed at right angles to a linking corridor which might either be straight or enclosing a large central square; the pavilions were widely separated, usually by lawns or gardens. In the wards, complete cross-ventilation was achieved by opposite rows of tall, narrow windows reaching from floor to ceiling. Natural ventilation, from doors, windows and fireplace was the rule.”

Design criteria specific to miasma theories were related to the attributes of salubrity, fresh air, sunshine and beautiful surroundings. These were evident in the requirements for a north-south orientation of the pavilion to maximize access to sunshine, building heights that did not block sun and air in intervening courtyards and provision of ornamental grounds. Topography and proximity to built-up areas were other considerations that influenced the character of the site. Although, the building layout required large sites it nevertheless became the dominant hospital type by the 1880s and 1890s.

---

113 Ibid.
114 Ibid., 142.
The relationship between the hospital buildings and the site, and the site and its immediate environment were carefully considered in expert writing on hospitals, with preference afforded to sites that were elevated and adjacent to open land.\textsuperscript{117} For example, late nineteenth century commentaries such as the detailed Mouat and Snell’s \textit{Hospital construction and management} and Oppert’s \textit{Hospitals, infirmaries and management} refer to the hospital site in relation to open space, elevation and topography as an integral part of the hospital.\textsuperscript{118} Numerous references to location of parks and open fields in relation to hospital sites demonstrate the importance of elevation, fresh air and healthful surroundings.

Land between the buildings was an important part of the site as is evident in the attention given to this aspect of the site in expert texts of the time.\textsuperscript{119} Thompson and Golding indicate the importance attached to the grounds of the hospital in a quote from \textit{Notes on Hospitals} in which Florence Nightingale stipulates that the space between buildings ‘should be laid out as gardens for convalescents, and there must be sheltered exercise grounds.’\textsuperscript{120} The important point here is that Nightingale recommends not space for fresh air and exercise but a garden to lift the spirits of patients. This is a point further emphasized by Hickman who refers to Florence Nightingale’s emphasis on the importance of ‘cheer’ and bright surroundings in the care of the sick as indicated in the following quote from her influential work:

\begin{quote}
Among kindred effects of light I may mention, from experience, as quite perceptible in promoting recovery, the being able to see out of a window; instead of looking against a dead wall; the bright colours of flowers; the being able to read in bed by the light of a window close to the bed-head. It is generally said that the effect is
\end{quote}

\begin{itemize}
  \item \textsuperscript{117} Taylor, J., \textit{op. cit.}, (1991), 22–33.
  \item \textsuperscript{119} See for example Mouat, F. J., & Snell, H. S., \textit{op. cit.}, (1883), which makes numerous references to this aspect of hospital sites.
  \item \textsuperscript{120} Thompson, J.D. & Goldin G., \textit{op. cit.}, (1975), 159.
\end{itemize}
upon the mind, perhaps so; but it is no less so upon the body on that account.\textsuperscript{121}

The emphasis on the grounds as important in patient treatment is further evident in the case of the new hospital at Eppendorf in Germany. Dr. Curschmann who was responsible for the layout and design of the \textit{Eppendorf Hospital} (1884-1889) wanted patients to have the healing experience of a garden house.\textsuperscript{122} As pointed out by Risse, Curschmann in keeping with medical science theories of the time, strongly believed that pure air, light, and pleasant surroundings would have a favourable influence on mind and body. This was to be just as important as antisepsis and medical therapies.\textsuperscript{123}

Similarly, Dr. Caspar Morris, in putting forward a plan for the new John Hopkins Hospital in Massachusetts, articulated the value of the grounds in the treatment of patients:

A hospital should have an expression of comfort inspiring a sense of repose, and tranquillity, and hope of restoration of health. The very exterior should be attractive to the approaching sufferer. Wounded men, brought to the hospital of the Protestant Episcopal Church in Philadelphia, from the terrible discomforts of field exposure, declared it was "like the approach to paradise."\textsuperscript{124}

Morris recommended that on the site of the new \textit{John Hopkins Hospital}, the morgue should be located in such a way that patients would not be depressed by a reminder of death. Again, this reinforces the idea that psychological aspects of patient treatment were thought of in relation to hospital design. The importance of pavilion sites in England and North America is evident from their construction along with new hospital forms well into the twentieth century.\textsuperscript{125}

\textsuperscript{121} Quoted in Hickman, \textit{op. cit.}, (2006), 156.
\textsuperscript{122} Risse, \textit{op. cit.}, (1999), 428.
\textsuperscript{123} Ibid.
Multi-storey block sites

Thompson and Goldin and others identify the early twentieth century as marking a shift in hospital building away from low-rise pavilion sites to skyscraper construction. The multi-storey blocks under the influence of modernist ideas represented by architects such as Le Corbusier still reflected ideas of sun and fresh air but services were now under one roof, rather than spread out over the site (Figure 2.15). Sloane et al. has described the new type of building configuration as ‘vertical pavilions’, which by the 1920s had become an accepted approach to the practice of scientific medicine in the twentieth century.

![Beaujon Hospital at Clichy near Paris, 1935. An example of the skyscraper hospitals inspired by American models of interwar hospital construction. The scale of the building gave little connection between patients and staff and the outdoor grounds. Thompson and Goldin, 197.](image)

Modernist minimalist towers were not the only type of modernist hospitals built during this period, particularly outside of America. Other types of hospital buildings that were

---

126 Thompson, J.D. & Goldin G., *op. cit.* (1975). This is a accepted interpretation of hospital site development. Other writers to reflect this view are for example, Forty, *op. cit.* (1980), 83-84; Sloane & Sloane, *op. cit.*, (2003), 57-61.
modernist in intent, if not in the recognizable International Style were built in Canada and Britain. In these sites the spatial layout conformed to modernist principles of functions centralized under one roof rather than spread across the site in a series of buildings (Figures 2.16 and 2.17). As described by Annmarie Adams these hospitals contained all the elements of modernist design within their interiors:

… in its structure, its endorsement of aseptic medical practice, its sanctioning of expert knowledge, its appeal to new patrons, its encouragement of new ways of working, its response to urbanization, its use of zoning, its acceptance of modern social structures, its resemblance to other modern building types, its embrace of internationalism, and its endorsement of standardization.

Figure 2.16 Stevens and Lee, Hôpital Notre-Dame, Montreal, 1923, was a modernist hospital that did not conform to the functional tower stereotype in its outward appearance, although its spatial layout was based on accepted modernist principles of function in. Adams (1999), 43.

---

130 Ibid., 43.
Figure 2.17 Middlesex Hospital built between 1926 and 1935, showing that all modern hospitals were necessarily skyscrapers. Hughes, 36

**Beyond 1950**

Figure 2.18 1949-60 Altnagelvin Hospital, Londonderry. Derry was the first example of the ‘matchbox on muffin’ design that dominated British hospital architecture. It was built regardless of the site and the availability of land that could have adopted a more low-rise hospital. Hughes, 42.
After World War II the modernist hospital, aligned with the International Style of architecture, became the predominant hospital site and was widely implemented, particularly in America.\textsuperscript{133} In contrast Britain developed its own modernist hospital type, known as a ‘matchbox on a muffin’, for its typical form of tower block on a podium (Figure 2.18).\textsuperscript{134} The fact that the this high-rise configuration was built on sites that had enough land to accommodate other forms of building is evidence, as Jonathon Hughes has argued, of the tendency of architects to uncritically accept formulaic solutions, regardless of the site.\textsuperscript{135} It could also be claimed as evidence of the continued disregard of the role of the grounds for patient treatment during this period.

The increasingly large and complex sites however both in America and England became the focus of a growing criticism as ‘too costly…unfeeling, uncaring, and impersonal’ and by the late 1960s there was a backlash against the post-World War II modernist complex.\textsuperscript{136} The architectural emphasis on ‘the hospital’s scientific foundation and functional operation’, considered threatening and impersonal, contributed to the severe criticism of the site as ‘no longer a place that cared for people, just for machines that treated diseases.’\textsuperscript{137} In consequence, post-modernist hospitals were designed as environments that were to be non-threatening and recognizable places, referring to everyday activities, playful and reverting to a residential aesthetic and a de-centralized site configuration.\textsuperscript{138} The proposed 	extit{McGill University Health Centre} in Montreal for instance, is to be ‘a hospital….like a university campus, with an arrangement of inter-connected low-rise pavilions in a landscape of parks, walkways and playgrounds’.\textsuperscript{139} Although Annmarie Adams suggests that this in unlikely to be the reality with

\begin{itemize}
  \item \textsuperscript{133} Verderber, S. & Fine, D., \textit{op. cit.}, (2000), 23.
  \item \textsuperscript{134} Hughes, J., \textit{op. cit.}, (2000), 35.
  \item \textsuperscript{135} Ibid., 43.
  \item \textsuperscript{136} Sloane, D., \textit{op. cit.}, (1994), 88.
  \item \textsuperscript{137} Ibid., Sloane, D., 88. 89; Thompson, & Goldin, \textit{op. cit.}, (1975), 151; Verderber, S. & Fine, D., \textit{op. cit.}, (2000), 23-26.
  \item \textsuperscript{139} Adams, A., \textit{op. cit.}, (2007), 231.
\end{itemize}
the number of buildings proposed for the site, it indicates a renewed interest in the grounds of the hospital as part of patient treatment.\footnote{140}

In an approach aligned to a more humanized hospital form, retail, hotel and restaurant designs are used as sources for developing a more welcoming, entertaining space.\footnote{141} It is the design of hospitals as shopping mall however, that has dominated North American sites (Figure 2.19).\footnote{142} These sites, which intermingle restaurants, businesses and retail shops with medical facilities, are viewed there as a solution to the isolation, unfamiliarity and inhospitality that typified post World War II hospital.\footnote{143}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{hospital.png}
\caption{Perspective rendering of the Hospital for Sick Children, Toronto illustrating post-modern ideas of a hospital in response to the sterile hospital architecture of the 1945-1970s. This hospital building is intended to look like a commercial complex rather than a traditional medical facility. This is intended to reduce the stress for patients commonly associated with hospital treatment. Adams, (2007), 231.}
\end{figure}

\footnotesize
\begin{itemize}
\item[\footnote{140}] Ibid.
\item[\footnote{141}] Sloane, D., \textit{op. cit.}, (1994), 90.
\item[\footnote{142}] Ibid.
\item[\footnote{143}] Ibid., 94-96.
\end{itemize}
Consistent with the post-war anti-hospital critique of hospital sites, the 1960s are also characterized as the emergence of a ‘counter-movement to bring back the open spaces and the human-scale of earlier hospitals.’ In this approach academic research that demonstrates the role of gardens and ‘nature’ in reducing hospital stays and improving health outcomes for patients is used to support the inclusion of outdoor areas on hospital sites.

The impact of these changes on the hospital grounds has been challenged by J.M. Westphal who points out that the ‘hype and hyperbole’ that accompanies the literature on the design spaces for health pays little attention to how or if these garden spaces are actually used by patients and staff. In cases in which surveys are undertaken as for example by Yuko Heath, outdoor areas are found to be not accessible and lack of grass areas and ‘soft’ landscaping were viewed negatively by patients and staff. Other surveys have found similar results with Marcus and Barnes reporting on the Center for Child Health Outcomes in San Diego in which 50% of those surveyed requested more trees, vegetation and greenery in the outdoor grounds. Significantly, it was also found that people were not using the garden and this was linked by the authors to the lack of garden features identified by survey participants as desirable.

---


In Britain, the status of the grounds and patient use has also been questioned in the literature which argues that the rhetoric of humane hospital design is not always evident in the built hospital site. Wil Gesler for example, has suggested that despite the language of welcoming spaces and patient-centred care, hospitals remain emblems of professional power and prestige, much as the modernist hospitals of an earlier era. For this reason, ‘expert discourses that emphasize efficiency in terms of costs and clinical functionality’ are more influential in determining the physical characteristics of medical settings than patient preferences that favour elements such as gardens. As evidence for this statement Curtis et al reported a patient survey of a new hospital facility where the garden was reported to be too small in which, ‘Wishes were expressed for a large garden with trees and grass and places to sit in the fresh air to read a newspaper or enjoy a cigarette.’

Literature on therapeutic hospital environments is extensive and growing from the 1990s and into twenty-first century, the question as to whether the renewed interest in hospital grounds by hospital architects and bureaucrats results in salubrious places for patient and staff use will be discussed in the concluding remarks in relation to Melbourne hospitals.

2.3 Purpose and meaning of hospital sites and grounds 1848-1948

Hospital sites and grounds for the period 1848-1948 have been linked by both Mark Cortiula and Annmarie Adams to a ‘multiplicity of social, economic, and scientific mechanisms. Cortiula analysed hospital sites in Hamilton, Ontario to demonstrate the ways in which ‘economics of providing hospital services, the variances in support for public charities and social interaction within the institution’ influenced the architecture of general hospitals. Medical theories of disease transmission and medical technology, once given overwhelming credence as the cause for the emergence of modernist hospitals, are given less prominence by recent writers such as Adams and Adrian Forty, who have argued that any causal link between disease theory and hospital design is not straightforward. Adams refers to the continued construction of pavilion hospitals into the twentieth century, well after miasma theories had been discredited, as evidence of the weak link between medical theories and hospital form. Cultural influences are far more influential in hospital form than architectural or medical theories, it is argued by Adams. Similarly, she criticizes theories of hospital development that place the architect as the prime agent of hospital form, arguing instead that it reflects cultural ideas rather than architects conceptions of hospitals. In contrast, Jeremy Taylor has addressed site directly in relation to pavilion hospital design and architects in referring to public and expert debates over the suitable location, size and layout. Professional prestige, widespread use of architectural competitions and the subsequent


marketing of pavilion hospital form are other themes in Taylor’s work discussing pavilion sites. Alternatively, the demise of the pavilion design has been described by Forty as an indication of reducing confidence afforded medical justifications for building characteristics. He argues that instead, these became driven by patient preferences. In this interpretation, the changing clientele of the hospital from the urban poor to the middle class subtly altered the focus from provision of care to deliverance of a product that needed to appeal to the paying customer, which in turn determined the hospital form.

Social and cultural theories of hospital sites look to demographics, social attitudes, medical treatments philanthropy and development of the city as important influences on the built form. Increasing patient populations, rising land prices and densification of cities are identified as factors that contributed to overcrowded hospital sites by Morris Vogel and Charles Rosenberg. In related arguments, spatial layouts of hospital buildings are interpreted as representing the norms of a society favoring social and medical elites by Brandt and Stone. In further spatial analysis, Thomas Markus working within Lefebvre’s analysis of space as a social construction uses diagrammatic spatial maps to describe hospitals in terms of class, gender and social control. While the particularities of site elements such as garden elements or other uses of outdoor space are not emphasized, Markus focuses on location in context of urban development and social interpretations of the hospital.

A number of authors have argued that an increased emphasis on medical education and training together with a privileging of experimental science and the medical profession altered the intent of hospitals and to some extent building configuration at the beginning of the

164 Ibid., 84–88.
168 Ibid., 102.
twentieth century. Some early users of this approach, Lindsay Prior and Adrian Forty for instance, analyzed the pavilion hospital form as an example of medical power, which legitimized the building in terms of medical theories. More broadly, nineteenth century hospitals have been placed within the context of philanthropic and social attitudes which advocated ‘institutional design as a mechanism in the production of reformed and healthy individuals’ Florence Nightingale and George Godwin, closely identified with the pavilion hospital, are examples of the type of enlightened individuals who believed in the power of the built environment to both cure disease and influence behaviour.

Specifically, increasing prestige of the medical doctor and scientific medicine has been identified by Forty as leading to an increase in research facilities such as pathology laboratories and buildings to house therapeutic equipment, “the ‘instruments of cure’, which provide the means to still greater medical successes and further public esteem.” The need to accommodate these new technologies on existing nineteenth century sites has been linked by Forty to the ‘landscape of huts and semi-permanent buildings surrounding most older hospitals.’ The influence of medical technologies on spatial layout has been expanded upon by Adams and Schlich who analyzed the location and form of operating theatres at Royal Victoria Hospital, Montreal ‘as material evidence of ongoing changes in the status and self-image of surgeons’. Less obvious implications of the increasing influence of experimental

174 Ibid.
science in hospital surgery was the emergence of facilities for animal experiments on the hospital site.\textsuperscript{176}

Nurses’ homes on hospital sites have separately been highlighted by Adams and Dianne Dodd as indicative of the changing status of the nursing profession as a result of technical developments in medical treatment such as surgery and clinical observation for which nurses were needed.\textsuperscript{177} The middle class domestic form that typified nurses’ homes has also been discussed by Adams as providing an appropriate substitute home for middle class single women living away from parental control.\textsuperscript{178} The location of the nurses’ home and its association with a romantic landscape of wooded areas at Royal Victoria Hospital has been used as an example by Adams of a late nineteenth century need to connect women with nature to alleviate contemporary anxieties about the societal changes of an increasingly urbanized world.\textsuperscript{179} Adams argues that the ‘blatant domestic imagery’ of the ‘big house’ smoothed the transition or middle-class women to the world of paid work, while at the same time offering the promise of gentle protection in that realm.\textsuperscript{180}

Adams argues that the symbology of the hospital as a ‘big house’ was particularly important for middle-class patients to convince them that the hospital would provide similar care to that they had previously received when treated in their own homes.\textsuperscript{181} In a similar interpretation, the introduction of private patients to hospital sites has been argued by Forty as influencing the layout of hospitals from the early twentieth century who now required private rooms.\textsuperscript{182} Previously, hospitals had treated the sick poor who had been segregated by gender and diagnosis in large open wards. Only contagious patients had been nursed separately in private rooms away from the large 18 to 40 bed pavilion wards.\textsuperscript{183} Middle class patients were unwilling to be subject to the ‘lower social class and an ethos of charity’, of the shared wards,

---

\textsuperscript{176} Adams, A., & Schlich, T., \textit{op. cit.}, (2006), 305.
\textsuperscript{178} Adams, \textit{op. cit.}, (2008), 74.
\textsuperscript{179} Ibid., 78.
\textsuperscript{180} Adams, A., \textit{op. cit.}, (March, 1999), 56.
\textsuperscript{181} Ibid.
\textsuperscript{182} Forty, A., \textit{op. cit.}, (1980), 85.
\textsuperscript{183} Adams, A., \textit{op. cit.}, (March, 1999), 51.
and as a result were accommodated in private rooms or buildings. This contributed to increased building and differentiation between classes across the site.

Garden and landscape historians have provided the major contribution to the study of hospital grounds and other medical institutions. Asylum sites have attracted the most attention with nineteenth century sites in relation to ideas of medical treatment and history of landscape as prominent areas of analysis. The examination of garden layouts and elements of sanatoriums grounds particularly in England, has been undertaken by Margaret Campbell. Commentary on site elements of North America sanatoriums by Deborah McBride provides a broader overview of the significance of the site location, topography, seclusion and landscape elements. Attributes of sanatorium sites considered healthful and therefore important by McBride, included distance from the city and proximity to conifer woods, for the benefit of the antiseptic qualities attributed to coniferous resin. Aligned to sanatoriums, the landscapes of preventoriums for children at risk of developing infectious diseases, have received particular attention from Margaret Grose. The landscape of preventoriums is placed within the context of city planning influences such as Public Parks Movement, whilst the layout of the grounds are associated with landscape concepts based on ideas of ‘nature’ as an antidote to the industrial city.

Landscape architects Clare Cooper Marcus and Marni Barnes have highlighted the importance that influential American hospital architect Edward Stevens at the beginning of the twentieth century placed on hospital grounds in providing pleasure to patients and staff and

---

184 Ibid.
188 Ibid.
190 Ibid, 95.
shortening convalescence.\textsuperscript{191} Citing his book chapter ‘Landscape Architecture as Applied to Hospitals’ in \textit{The American hospital of the twentieth century}, published in 1918, they note his frequent references to ‘extensive grounds, parklike settings, courtyards for convalescence, outdoor sleeping porches, vistas, sunlight, and fresh air.’\textsuperscript{192} Making the point that these features were considered important for treating a wide range of conditions including physical and mental illness, they counteract the perception that they were mainly associated with sanatoriums.\textsuperscript{193} Instead, these ideas of hospital landscape were applicable to hospitals generally. This provides an insight into cultural ideas of the relationship between hospital treatment and hospital landscape at this time.

The most substantial contribution of purpose and meaning of hospital gardens, particularly in terms of an historical account from 1848 to 1948, is an unpublished doctoral thesis by Clare Hickman.\textsuperscript{194} Her thesis examines both hospital and asylum sites in England from 1800 to the late twentieth century. It concentrates on a number of different types of medical institution sites, namely three general hospitals, one orthopaedic, one convalescent, one sanatorium and one homeopathic hospital site and a number of asylums. Hickman’s thesis documents the importance of gardens to particular hospital sites in the nineteenth and early twentieth century and provides a commentary on the decline of aesthetics of hospital grounds as the century progressed. Her work does not provide a survey of all hospital sites in England, nor is that the intent. Rather it used a number of site examples to support a discussion around general ideas of therapeutic environments. Emphasis of this work is on gardens rather than the hospital site as a whole or its relationship to the geography of the city, it nevertheless makes a valuable contribution.

There a number of observations made by Hickman which are useful to assist the examination of hospital grounds in relation to purpose and meaning. Firstly, in keeping with architectural historians such as Christine Stevenson, Hickman has noted that provincial

\begin{itemize}
\item \textsuperscript{191} Marcus, C. C., & Barnes, M. \textit{op. cit.}, (1999), 16.
\item \textsuperscript{192} Ibid., 15 referring to Stevens, E. F. (1918). \textit{The American hospital of the twentieth century: a treatise on the development of medical institutions, both in Europe and in America since the beginning of the present century}. New York: Architectural Record Publishing Company.
\item \textsuperscript{193} Ibid.
\item \textsuperscript{194} Hickman, C., \textit{op. cit.}, (2006).
\end{itemize}
hospital sites that developed during the early to mid nineteenth century in England resembled domestic villas that were indistinguishable from domestic residences. Hickman linked these to popular garden styles of the period such as advocated those by J. Loudon in *The suburban gardener, and villa companion*, published in 1838. Hickman then suggested that the emergence of the pavilion plan, with its arrangement of semi-detached buildings from a central spine, offered opportunities for gardens between the buildings. The implications of this are subtle but nonetheless significant. For instance, as Hickman has identified, hospital grounds were gender segregated in the early eighteenth century even to the extent of the restricted hours when women and men separately used the grounds. The introduction of the pavilion wards which were also gender specific meant that each building could now have its own outdoor space for women and for men. This is an interesting example of the way in which the building form interacted with the grounds to shape behavior in specific ways. Instead of a large general garden area as at *Leeds Infirmary* shown in Figure 2.14, the courtyards formed by the pavilion buildings were discrete and private and could be easily appropriated for specific groups. This is not taken up by Hickman as a point of discussion but in terms of this thesis is an example of the ways in which changes in the building form and the grounds impact on patient and staff experience of the hospital.

Hickman also indicates that the grounds by the end of the nineteenth century had become identified as important to the resident staff for the purpose of exercise ‘essential for the health and consequently to the well-being of the whole establishment.’ Staff resident at *Royal Victoria Hospital* at the beginning of twentieth century for example have been described by Adams as including nurses, gardeners, wardsmen, carpenters, medical superintendents and maidservants. Despite this being a common feature to hospital sites of this period, the ways in which staff living on site interacted with the grounds and the ways in which the grounds

---

196 Ibid., 155-156.
197 Ibid., 135.
shaped behaviours has not been addressed in the literature which is generally restricted to descriptions of the configuration of nurses’ home.200

The final point of relevance here is the use of the garden as a signifier of respectability and order as suggested by Hickman, with the garden serving a ‘rhetorical function’ in promotion of the hospital as a charity, worthy of patronage.201 Hospitals in the nineteenth century were linked to public donation through voluntary contributions in England, America and Australia and Hickman suggests that this placed an emphasis on the garden as a means to ‘both display and to encourage new subscribers’.202 Under the voluntary system, hospitals became symbols of civic pride which needed to maintain a public image that would attract funding whilst reassuring subscribers that their money was being bestowed on a worthwhile cause.203 In support of the symbolic meaning of the physical appearance of the grounds, Annmarie Adam analyzed postcards of the Royal Victoria Hospital, Montreal to illustrate the showcasing of the grounds in the promotion of it as a civic monument in 1893.204 The link between the appearance of the hospital and its charitable function has been articulated by David and Beverlie Sloane in the following terms:

The grand facades that adorned most early hospitals reflected this need to reassure the public of the hospital’s purpose and role in society. They were not an escape from responsibility, nor a refuge for the immoral. Instead, they were civic institutions, public charities, necessary in a civilized society. Hospitals were places of propriety and moral purpose. Their design reflected this social mission rather than any specific notion of the nature of the disease, its transmission or medical practice.205

202 Ibid., 4.
The relationship between hospital architecture and the public perception of the purpose of the hospital however, was not straightforward. As Jeremy Taylor argues there needed to be a fine balance between hospital architecture as a source of civic pride and means of encouraging funding and the counter-productive impression of misspent public funds. The placement of many gardens at the rear of the building away from public view in England during this period however, has been raised by Hickman as a possible confounder to this interpretation of the garden and instead distinguishes its meaning from that of public display and civic pride to that of purposes for patients. In a related observation Adams noted the similarity of many nineteenth century institutions, such as orphanages and benevolent institutions, to hospitals in ‘plan, section and elevation’ and raises the question of the meaning of the grounds to these establishments. Can a particular therapeutic or civic intention be attributed to hospital grounds if they resembled all other institutions, or were there differences?

Similar questions are raised by Forty’s description of the mid-nineteenth century pavilion hospital as an unmistakable design form, distinct from previous hospital models of villa hospitals. This is a commentary on the typical form of the pavilion hospital building of long wards attached to a central spine. The grounds however, are not included in this analysis and it is of interest to examine these to determine the extent to which the pavilion hospital evolved as a distinctive site. Did the pavilion hospital produce its own form of garden layout for instance, or did the grounds continue to be based on domestic gardens?

Adams has argued that exteriors of interwar hospitals were purposely designed in the ‘historicist’ style typical of hospital architects Stevens and Lee to ally fears of the hospital as a ‘modern factory of healing’ which was ‘simply too sterile or too scary for post World War I society.’ Extending the discussion by Cooper and Barnes who ascribe a therapeutic intention by Stevens to this type of grounds, Adams concentrates on a broader meaning. In this perspective, hospitals continued to refer to the imagery of the ‘big house’ to reassure patients

---

206 For a discussion of the interaction between the physical appearance of the hospital, civic pride and funding implications see Taylor, op. cit., (1997), 33-47.
209 Ibid., 58
through the traditional values of the home and domesticity of the benignity of the hospital experience:

The overall image of the modern factory for healing was simply too sterile or too scary for post-World War I society. Good health was still related in a real way to traditional values, through the symbols of home and the values associated with traditional architecture.\textsuperscript{210}

This had particular resonance in the case of children’s hospitals where the domestic idiom in hospital sites continued to be a preferred model. Children’s hospitals are discussed by David Sloane as essentially a feminine institution, organized and run by women using domestic architecture as a method of social control.\textsuperscript{211} Although Sloane does not refer to the outdoor areas explicitly in his analysis, the grounds of the hospital are implied as integral to the domestic atmosphere.

Adams and Theodore argue that another of the purposes of hospital grounds was to represent moral good, particularly as a refuge from the disorder and filth of the industrial city. In this context, the hospital garden with its connotations of simplicity and benign nature was important to the hospital identity as a place of cure and refuge.\textsuperscript{212} In their study of \textit{Montreal Children’s Hospital} which opened in 1903, the hospital grounds still recalled an old-fashioned domestic aesthetic well into the twentieth century, of which the garden layout was an example, whilst the elevated site fulfilled ‘its benevolent vocation…to enhance the healing of sick poor kids by removing them from the crowded and damp quarters in which they lived.’\textsuperscript{213} The location of the site of the \textit{Montreal Children’s Hospital} on the wooded slopes of Mount Royal conveyed ‘lingering, somewhat out-dated notions of social reform and maternal benevolence, founded on a nostalgic view of childhood.’\textsuperscript{214} Further, Adams and Theodore establish that whilst both the \textit{Montreal Children’s Hospital} and the nearby adult hospital the \textit{Royal Victoria Hospital} were both situated in picturesque surroundings, the children’s hospital grounds were

\textsuperscript{210} Ibid.
\textsuperscript{212} Adams & Theodore, \textit{op. cit.}, (2002), 211.
\textsuperscript{213} Ibid., 212.
\textsuperscript{214} Ibid.
significantly different in functioning as outdoor wards with children’s beds wheeled into the grounds. Both these hospitals reflected nineteenth century ideas of hospital grounds well into the twentieth century and are in marked contrast to the minimalist hospital grounds usually associated with International Style modernism after World War I.

Verderber and Fine have attributed the particular aesthetic of the International modernist hospital site and grounds under four major influences. Firstly, the architects and administrators who were largely responsible for the modernist hospital form did not prioritize the needs of people who used the site. Secondly, the notion of ‘function’ as a design principle preferencing the machines within the buildings rather than people. Thirdly, architects based their designs on a reductive and regimented model of human behaviour and finally, lacked interest in the way in which their designs impacted on patients. Whether and how these influences produced the minimalist planting schemes and lack of privacy typical of modern hospital grounds is not addressed directly by Verderber and Fine, whose focus is on buildings. The ways in which modernist hospital grounds were used by staff and patients is also omitted.

![Figure 2.20 Birmingham Hospital Centre 1933-38 reproduced in Richardson. Built on a greenfield site on the outskirts of the city of Birmingham, the grounds were expansive but not intended for patient use. Richardson, 42.](image)

215 Ibid., 212-213.
Similarly, discussion of twentieth hospital grounds in England by architectural historians generally neglects an assessment of their significance to hospital design or for patients and staff. *Birmingham Hospital Centre* for example which opened in 1938, is suggested by Harriet Richardson as demonstrating the British hospital planning authority’s preference for European models of relatively low rise pavilion plans over the North American multi-storey block (Figure 2.20).\(^{217}\) Although not stated by Richardson, it is apparent from articles in the architectural journal *The Builder* that the Ministry of Health preferred new hospitals ‘set out in green fields’ as late as 1950.\(^{218}\) Their grounds are modernist with expansive grass areas and minimal planting. In contrast, the *Royal Masonic Hospital* London, built between 1931-1933 and also discussed by Richardson, has an ornamental garden with shrubbery, large trees and bird bath which suggests that despite the modernist sites elsewhere, association of hospitals with a garden was still important (Figure 2.21). These differences between sites are not addressed and it is unclear as to reasons for the variations in design and what this indicates about the grounds and patient treatment at this period.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure2_21.jpg}
\caption{1931-1933 Royal Masonic Hospital, London, reproduced in Richardson is evidence of a garden aesthetic associated with English hospitals in the interwar period. Richardson (1998), 39.}
\end{figure}


Richardson’s discussion of the design of Westminster Hospital provides further insight into the range of hospital grounds associated with modernist hospitals, although their purpose is not explicitly articulated (Figure 2.22). Westminster Hospital is described as on either side of St John’s Gardens with as many wards as possible facing the gardens as a feature of the site. Its siting and gardens suggest that ideas of salubrity in patient treatment were still considered in hospital treatment at this time. It is important to note however, that Richardson does not discuss the use made of the gardens by patients and staff which may indicate that the purpose of the garden was reduced to a view, in keeping with modernist principles of site design. It may also be typical of the prevailing concentration by historians on buildings.

*Figure 2.22 1933-39 Westminster Hospital London, reproduced in Richardson faced St John’s Gardens in Westminster. The importance of these gardens to patient treatment is difficult to determine as there is no information on patients experience of the built form of the hospital and its site. Richardson (1998), 41.*

Such examples suggest two issues. Firstly, the history of hospital sites in the twentieth century is complex, at times contradictory and does not necessarily follow the accepted

narrative of a smooth trajectory from charitable institution to medical complex. This would support Adams contention that critiques of twentieth century hospital sites are simplistic and overlook the site specific historical evidence of the hospitals themselves.\textsuperscript{220} Secondly, attention to specific sites and inclusion of hospital grounds can more closely inform ideas of health and landscape and the history of hospitals than has previously been recognized. Variation across sites demonstrates the importance of examining the particular in hospital sites as a way to provide accurate assessments of practice which can enrich the study of the built environment in general, and hospital landscapes specifically.\textsuperscript{221}

\textbf{Figure 2.23} Image of activities in grounds of the Children’s Memorial Hospital, Montreal reproduced in Adams and Theodore’s article on the hospital. This is one of the few images of people using the grounds in academic articles on the history of hospital development. Adams and Theodore, 212.

The purpose and meaning of the grounds to patients and staff has also been relatively neglected in the academic literature on the built environment of hospitals as has already noted in relation to the example of Westminster Hospital. Risse, a former hospital psychiatrist, has noted this deficiency which he has addressed in his own work which includes patient accounts of hospital experiences. He also acknowledges the relative dearth of available material of this

\textsuperscript{220} Adams, \textit{op. cit.}, (1999), 45.
\textsuperscript{221} See introductory chapter for a discussion of the importance of specific sites in studies of the built environment as argued by Meyer, E., Beauregard, R., and others.
kind.\textsuperscript{222} Similarly, the oral history of \textit{Cook County Hospital} by Sydney Lewis makes apparent the importance of the site in the experience of the hospital to both patients and staff.\textsuperscript{223} In their article on the \textit{Children’s Memorial Hospital} Adams and Theodore allude to some of the activities in the grounds. This is one of the few reports on hospital architectural history to discuss their use (Figure 2.23). This lack of recognition contrasts with institutional histories of hospitals which indicate the rich lived experience of hospital grounds and its significance to patients and staff. Although J.T.H. Connor has criticized institutional histories for lack of synthesis and objectivity, these subjective accounts provide detail about personal meanings as well as material evidence of the grounds themselves (Figure 2.24).\textsuperscript{224}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{st-thomas-hospital-outdoor-areas-1947.png}
\caption{Use of the outdoor areas of St Thomas’ Hospital in 1947 shown in Charles Grave institutional history of the hospital. Graves (1947), 7.}
\end{figure}

\textsuperscript{222} Risse, G., \textit{op. cit.}, (1999), 11-12.
The images of the exterior of the hospital in institutional histories for example, usually include people engaged in day-to-day hospital activities. The photograph of patients in the garden of St Bartholomew’s Hospital in London (Figure 2.25) in 1961 for example contradicts the story of post- World War II hospitals as places of scientific technology and ruthless functionalism.

Figure 2.25 Hospital grounds of St Bartholomew’s Hospital in 1961. The use made of the grounds by staff and patients is at variance with ‘expert discourse’ of hospital buildings that focuses on hospital interiors and functionality written in the same period. Whitteridge & Stokes.

or chaotic disorder argued by a number of authors. Further it complicates the narrative of medical advances as breaking the connection between patient treatment and use of outdoor areas. Such images also imply, as Gesler et al. have argued, that patients and staff attach a significance and use to hospital grounds that may be overlooked by the ‘expert discourse’ of architects and hospital bureaucrats.225 Instead, institutional hospital histories make evident that the grounds and site were places of significance not only to the hospital as an institution but to

the people who worked or were treated at the hospital. The frequency with which images of people in the grounds are included in hospital histories indicates that both were places of personal meaning and that their reality was more complex and personal than architectural discourses of building typology alone would suggest. Hospital histories then, frequently written by former medical staff provide another layer of evidence that can be validly applied to a history of hospital grounds for the insight provided of the everyday experience, as opposed to architectural historians, meaning of the site and grounds.226

2.4 Conclusion

This chapter has demonstrated the relationship between physical characteristics of hospital sites and grounds to the social, cultural and political structure of the societies that produced them. The location and configuration of the site of the aescelpia for instance, revealed a belief in the capacity of nature and a rural landscape to heal both physical and psychological diseases in the classical world. The emergence of valetudinaria, Roman military hospitals, which lasted until the fourth century A.D., continued to recognize the importance of landscape to health with topography with locations that provided clean air and water. The built form of the valetudinarium however, was less concerned with contact with nature as part of the healing process.

As Christianity became the main influence on hospital in Europe, sites and building form reflected the association with religious institutions, with hospitals as part of complexes such as monasteries or convents. Hospitals emphasized the importance of spiritual healing through a new built form that allowed patients and staff a view of the altar in order to participate in religious practices. This instigated the cruciform hospital plan in Europe and the location of hospital beds in church naves in England.

Hospitals in England after the Reformation became largely civic institutions. In this new relationship the church was no longer the dominating influence on hospital sites and instead the domestic residential form became influential. The domestic grounds of 1700s villa

hospital as sites of secular medicine were important in promoting meaning of hospitals as respectable public institutions and places of moral benefit to the patient. Similarly, the grounds of the pavilion hospital in the nineteenth century were formed in response to medical ideas of the physical and psychological benefit of access to fresh air, places for exercise and beautiful surroundings. Finally, twentieth century sites revealed an increased value placed on hospital buildings as providers of scientific medicine. This in turn impacted on site configurations and gradually reduced the priority given to the grounds as places of patient treatment.

As this chapter reveals, hospital sites and grounds manifest the interrelationship between landscape, society and culture. For this reason, hospital sites in Melbourne can be interrogated as evidence of the dynamic relationship between these themes in this region. Of particular interest is their purpose and meaning to staff and patients as a neglected area of study and the impact changes had on well-being of patient and staff and their emotional connection to the hospital. A further question suggested by this review of the literature is the extent to which hospital grounds in Melbourne were determined by cultural ideas of the garden and the hospital as an institution, and what does this say about the relationship between health and landscape, here? Did the lack of ornamental grounds with shrubberies, trees and flower beds on sites reflect a shift in the understanding of landscape that has something fundamental to say about International Style modernism? Do differences between sites indicate different ideas of landscape and health or are they illustrative of other factors that influenced hospital grounds? How did the changing hospital landscape impact on patients and staff? Finally, what do the changing purposes of Melbourne hospital grounds have to say about meanings of health and landscape, particularly in relation to ideas of modernist sites as lacking in human purpose?

The history of site development from charitable institution to scientific medical site is complex and multi-layered rather than a single trajectory of smooth transition. The study of particular hospital sites however, has the capacity to enrich an understanding of the sometimes contradictory influences on hospital site development and provide insights into attitudes to landscape and health. The study of hospital site development in Melbourne 1848-1948 will take up the themes suggested by this overview and provide specific insights into ideas of
landscape and health, the significance of the lived experience on the meaning of hospital sites and the process by which hospital sites both reveal and shape purpose and meaning.
CHAPTER THREE

METHODOLOGY

3.1 Introduction

The discussion of the research into the built environment of hospital sites in the previous chapter identified a bias in favour of buildings over outdoor space. The significance of the spatial and physical characteristics of the site and grounds and their impact on patients and staff was left largely unexplored. This chapter describes the methodological approaches this research takes to address this imbalance. This research is predicated on the hypothesis that purpose and meaning in landscape research is revealed through analysis of specific geographical, social and cultural circumstances. The research design, including the approach, types of data, collection of data, analysis tools and finally the methodological challenges are discussed in the light of this hypothesis.

3.2 Overview of approach

The research approach used in this thesis employed case studies and ‘thick description’ to address the research themes. This method was based on a synthesis of approaches used in landscape and architectural history that use the physical evidence of the site as a means of informing its history and interpreting cultural significance. Iain S. Black for example, a cultural geographer, used ‘thick description’ and the case study of the Hong Kong buildings in both Shanghai and Hong Kong between 1919-1939 to discuss symbolic landscapes which he then links to the power of the British colonial empire. He argues for the importance of the specificity provided by particular physical sites in revealing cultural and symbolic meaning.

3.5 Methodological challenges

1 Cosgrove, Denis E. Social Formation and Symbolic Landscape. London ; Sydney: Croom Helm, 1984, xi.
and also stresses that examination of the architectural form alone, that is images, architectural plans and the building, is not sufficient to develop ‘convincing explanations about questions.’ Instead, ‘detailed historical and geographical contexts’ from archival and historical sources are required to supplement the case study in order to interpret the complexity of architectural forms. For this reason Black advocates the use of ‘thick description’ which recognizes the importance of multiple sources of specific information related to a particular site. He uses the example of the case study by Mona Domesh of the Empire State Building which whilst using newspaper accounts, magazine articles and images used ‘existing accounts of land values and skyscraper technology that were not specific to the building.’ Black argues that this work was weakened by its use of general data rather than specific records for the building which could have been obtained from sources such as ‘corporate archives, fire insurance plans, assessment records, property transfer records, mortgage records.’

‘Thick description’ as a method which incorporates ‘detailed historical and geographical contexts’ is associated with the anthropologist Clifford Geertz, who formulated it as an alternative to strategies that interpreted the history of the built environment without reference empirical data. Although, Black focuses on building form rather than the site, a similar approach for landscape architecture has been advocated by Michael Leslie, a garden historian who argued for its application to the study of garden rather than architectural history. Both support the value of ‘thick description’ and case study for their focus on 'what happens on the ground' and the way in which the archival and historical texts are used to provided context for the material evidence of the site. Using the example of Wells Cathedral Green for instance, Leslie argues that in order to understand the garden history of the site, factors such as the social structure of the town, the culture of the clergy, the relationships between various

---

3 Ibid., 28.
4 Ibid., 27.
5 Ibid.
6 Ibid.
users of the cathedral and the way the landscape responded to the liturgy need to be taken into account.\(^9\)

An example of the application of a combined methodological approach to the study of hospitals is the work of Annmarie Adams.\(^{10}\) In *Medicine by design: the architect and the modern hospital, 1893-1943*, Adams uses the *Royal Victoria Hospital* in Montreal as a case study to ‘track the dynamic relationship of architecture and medicine.’\(^{11}\) As an architectural historian, Adams was primarily concerned with the building in her research but included aspects of the grounds to analyze the promotion of the hospital as a place of civic virtue and as a refuge from the industrial city and perceived threat of modern medicine. As data, postcards, architectural drawings, site plans, letters, annual reports, city guidebooks and photographs were analyzed in order to ‘understand hospital buildings as artifacts of material culture.’ This thesis uses a similar approach but strengthens its validity by employing a comparative database of nine hospital sites rather than drawing on one example to investigate purpose and meaning.\(^{12}\)

This thesis used ‘thick description’ in developing the nine case studies from archives of each hospital site, collecting and analyzing data on their social and political context, changes in medical practice and staffing, and relating this to their built form and the geography of Melbourne. The method used here differed from that employed by Black, Leslie and Adams however, in its detailed focus on the physical characteristics of the site and its interest in understanding its impact on people who used it, rather than the buildings. The focus on the site is related to landscape architecture theory which argues that interpretation of landscape needs to be explicitly ‘historical, contingent, pragmatic and ad hoc’ in order to reflect its history rather than the ‘received wisdom’ inherent in the usual explanations and generalizations that often represent landscape history.\(^{13}\) In support of the use of specific historical data relevant to the site, Wendy Redfield has critiqued the ‘received knowledge of

\(^9\) Ibid., 104.
\(^{11}\) Adams, A’, ibid. (2008), xix.
\(^{12}\) Ibid., xxv.
\(^{13}\) Cosgrove, Denis E., *op. cit.*, (1984).
METHODOLOGY

modernism’, arguing that the lack of site-based reading has distorted its narrative.14 Using the same approach Paul Hess has enriched the history of suburbia by his analysis of apartment sites in contrast to previous studies that have assumed detached villas as the defining suburban form.15 A similar example of the distorting effect of broad assumptions has also been demonstrated by Adams who challenged the exclusive association of modernist hospitals with International Modernism by reference to specific site details of Canadian hospitals.16 Specifically in relation to historical analysis, Elizabeth Meyer argues that landscape architecture theory in focusing on physical characteristics of the site reveals an enriched understanding of the built environment than is possible by attention to the building alone.17 The strength of the landscape theory approach is the inclusion of geographical location, land form, site character and site configuration in the examination of the built form of the hospital. These physical characteristics which are frequently overlooked in cultural interpretations of landscapes, especially those dealing with historical sites, are important in understanding the specific meaning relating to the built environment.

Another point of difference in the methodology used in this research compared to the work of Black, Leslie and Adams is the emphasis on the impact of the site and its changing form on users, that is, the staff and patients. This further analysis of the site is closely linked to a body of work known as ‘phenomenology’ which has focused on human experience of landscape as an authentic but neglected aspect of revealing meaning.18 Its emphasis is on the 'the affective and social experience of space'.19 This theme in cultural geography has been particularly concerned with landscape as a human experience, as a 'world to live in not just a scene to

---

19 Ibid.
view. Based on the work of the philosopher Merleau-Pointy and human geographer Edmund Husserl, this critiques the Cartesian objective (mind) view of the world that disregards the subjective (body) experience. It is argued that historical analysis that neglects human experience and the relationship of the site to people, does not adequately reflect the truth about landscape. The phenomenological approach to landscape is valuable for its emphasis on the landscape as a lived experience and not only as a product of economic and social constructs or as a 'way of seeing the world'. Michael Leslie however has argued that the emphasis on personal experience of the landscape and on imaginative reconstruction by researchers has laid phenomenological approaches open to charges of subjectivity and ahistorical failings. Despite this criticism, the idea of the lived experience of landscape is acknowledged as a valid aspect of the study of hospitals sites and an important factor in attributing meaning. This approach recognizes that what happens on the ground is as important as plans, images, annual reports, architectural theory, medical practice, newspaper accounts, government reports in enriching the history of hospital sites. Exploration of the lived experience of hospital grounds will be based on activities, photographs, official recorded accounts and personal reminisces.

3.3 Research questions and data collection

Three categories of data were identified as important in providing context and specific information to answer the research questions, namely: site characteristics; the background the medical, social and political context of hospitals in Melbourne; and, how the hospital sites were used and talked about (words and actions). Each of the hospital sites in Melbourne was developed as a case study, namely: Melbourne Hospital including the new site of Royal Melbourne Hospital, Women’s Hospital, Children’s Hospital including the Convalescent Cottage, Eye and Ear Hospital, Alfred Hospital, Austin Hospital, Homeopathic Hospital, St

23 Ibid.
RESEARCH QUESTIONS

1. What were the physical characteristics of hospital grounds from 1848-1948 and in what ways did they change?

2. What factors influenced changes to hospital grounds from 1848-1948?

3. How were hospital grounds used and experienced by staff and patients and what does this reveal about the purpose and meaning of hospital grounds?

DATA FOR CASE STUDIES AND ‘THICK DESCRIPTION’

SITE CHARACTERISTICS
- Location
- Proximity to open space and elevated topography
- Size of site
- Site layout
- Type of buildings
- Landscape style
- Architectural building styles
- Site elements

MEDICAL, SOCIAL AND POLITICAL BACKGROUND TO HOSPITAL DEVELOPMENT
- Social factors in establishment of hospitals as charitable institutions
- Bureaucratic development of hospitals within the Department of Health
- Medical theories on hospital sites
- Architectural styles and hospital development
- Medical practices and influence on staffing, hospital configuration and type of buildings
- Promotion of the hospital to the public

WORDS AND ACTIONS IN RELATION TO HOSPITAL SITES
- How hospital site were used
- What was said about hospitals in newspapers, annual reports and promotional material
- How were hospital sites thought about by staff and patients

RESEARCH THEMES

Landscape and health and the ways in which these are interrelated

Significance of sites and grounds to the history of hospitals (particularly for patients and staff)

Process by which hospital landscapes evolved

PURPOSE AND MEANING OF MELBOURNE HOSPITAL GROUNDS 1848-1948

Figure 3.1 Conceptual diagram demonstrating the relationship between research questions, data, research themes and the way in which this method establishes purpose and meaning of hospital sites and grounds.
Vincent’s Hospital and Queen Victoria Hospital from establishment until 1948 (Figure 3.1). Case study data included site characteristics and the ways in which the site was used and talked about, drawn from particular data sets and sources as indicated in Tables 3.1 and 3.2. Maps and architectural drawings were used to document the location and physical layout of each hospital site for the key years of 1900 and 1948 and information on type of buildings and year of construction was also indicated. Tables derived from this data indicated the type and number of buildings constructed on hospital sites between 1900-1914 and 1918 and 1948 (Tables 4.3 and 5.1), and a comparison of hospital site characteristics in 1900 and 1950 (Table 5.2). The relationship between landscape styles and the identity of the hospital was also examined. This information was relevant to both the processes by which hospital sites evolve and the ways in which health and landscape are interrelated.

<table>
<thead>
<tr>
<th>DATA TYPE</th>
<th>SITE CHARACTERISTICS</th>
<th>MEDICAL, SOCIAL AND POLITICAL BACKGROUND</th>
<th>WORDS AND ACTIONS IN RELATION TO HOSPITAL SITES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contour plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Architectural plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMBW Plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local area plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual reports - hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postcards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Souvenir Publications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional journals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital publications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Images -archival</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Images-Institutional histories</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic texts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newspaper reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal accounts -written</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal accounts - oral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Histories of Melbourne</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Table 3.1* Data type and relationship to categories of data required to address the research questions using the method of ‘thick description’.
### METHODOLOGY

#### 1. Hospital Archives

<table>
<thead>
<tr>
<th>Alfred Hospital Archive</th>
<th>St. Vincent’s Hospitals Archives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Hospital Archive</td>
<td>Austin Hospital Archive</td>
</tr>
<tr>
<td>Women’s Hospital Archive</td>
<td>Eye and Ear Hospital Archive</td>
</tr>
<tr>
<td>Alfred Hospital Clinical Reports</td>
<td></td>
</tr>
</tbody>
</table>

#### 2. State Library of Victoria

| State Library of Victoria Picture Collection |
| Historic Plan Collection including Stephenson and Turner Collection and MMBW series |
| Microfilm Newspaper Collection |
| Picture Illustrated Newspaper Collection |
| Postcard Collection |
| Imaging nineteenth century Victoria Digitising project |

#### 3. University of Melbourne

| Archives – architectural drawings (J.J and E.J Clark Collection 1883-1929) |
| photographs (Lillias Alice Collins Collection 1915-1925) |
| Cultural and Special Collections |
| The Australian Medical Journal (1856-1950) |
| The Australian Modern Hospital (1949-1955) |
| Historic Map Collection |
| Metropolitan Melbourne Collection |
| Victorian Parliamentary Papers |
| Charitable Institutions, Charities Board of Victoria, Hospitals and Charities 1860-1951 |
| Allen, H. B. (1891). *Final General Report on Hospital Construction and Management, No. 175* |

#### 4. Public Records Office of Victoria

| Government Files – |
| 15899 Historic Plans Collection 1836-1984 |
| Public Building Department (Building Services Files), 1874-1998 |
| 609/P0000/04 *Austin Hospital’s Matron Reports* (1915-1923). |
| 609/P0000/5. *Austin Hospital Reports 1891-1923*. Melbourne |
| 1016/P0000/13 Miscellaneous Correspondence Files. Melbourne Hospital Site. 1843-1886 |

#### 5. National Library of Australia

| Digital Archives Collection |

---

**Table 3.2 Sources of data used for case studies and ‘thick description.’**

A range of data in relation to how the site was used and thought about (words and actions) was collected from a variety of sources. This information provided evidence for interpretations of the meaning and significance of the hospital sites and grounds to staff and patients in Chapter 6. The *Alfred Hospital* was used as the prime site for more detailed documentation and analysis because of its features typical of an urban hospital and its log-term
occupation of the site over the period. Information on the medical, social and political background of hospital development in Melbourne from 1848-1948 demonstrated the impact of social change, changing medical practice and the increased bureaucratization and professionalisation of the hospital and its staff on the hospital grounds. Information derived from Hospital and Charitable reports on the number of staff, outpatients, patients and beds stays demonstrated the influence of these factors on hospital sites and the way these were experienced by staff and patients. (Figures 4.8, 5.1 5.2, 5.3, 5.4).

3.4 Content analysis

Maps, images, architectural drawing and texts were analysed using content analysis. Employment of both quantitative and qualitative content analysis has been identified as producing a ‘more comprehensive, valid, and reliable analysis’ than using either in isolation. Both forms of content analysis were applied in this research. Implementation of content analysis involves a hierarchy of elements that are called Sampling units, Units of analysis and finally Units of observation.

For the quantitative analysis, the hospital site was the Sampling unit, the Units of analysis were maps, plans and images, and Units of observation were number of buildings, types of buildings, types of spaces as private or public zones, location of buildings and site elements (fences, gatehouse, garden beds, car parks, tennis courts, balconies, covered ways). This data was presented in a series of tables that allowed a comparative analysis of each hospital site as a charitable institution or as a scientific medical centre.

Qualitative analysis was used as a way of designating areas of the site as either domestic site or modernist site. This was based firstly, on the analysis of hospital sites that identified the hospital site as either a domestic residence associated with a charitable institution or modernist site associated with the scientific medical centre. The definition of hospital as domestic residence was based on site characteristics identified as typical of domestic residences. Site elements such as ornamental front garden, screen fencing, private

---

25 Ibid., 385.
26 Ibid., 382.
backyard, narrow paths, informal planting, grass areas, public or private places and restricted entry to the site were established as typical of a domestic residence in preliminary work undertaken in investigating this thesis. Similarly, the modernist hospital site was typified by absence of perimeter fencing, lack of private areas and minimalist planting that showcased both the building and path network that led from street to building. Sampling units were also the hospital sites. The Units of analysis were maps, plans, images, hospital annual reports and publications, personal accounts, oral histories, archival records and institutional histories. The Units of analysis were previously identified as those relating to the site as a domestic residence and those relating to the hospital as scientific medical centre.

Case studies are a way of researching themes within ‘contextual conditions’, in which there are multiple factors and interactions to be considered as articulated by Robert Yin.\textsuperscript{27} In this thesis each hospital site in Melbourne was a case study for exploration. The approach provided a basis for comparison and synthesis of the data, enabling differences and similarities between sites to be highlighted which provided valuable insights into the main themes. For example, it was established that different types of hospitals had different site characteristics which were linked to cultural ideas of the garden, which in turn was influenced by geographical location. Overall, the use of multiple case studies was considered to add validity to findings and enrich the understanding of themes of the thesis.

3.5 Methodological challenges

There were three main methodological challenges to the approach used in this thesis. These challenges were associated with issues relating to archival research and the use of images as data for interpretation.

1. Archival research

Discussion in the literature on archival research has centred on problems of incomplete records, ethics, censorship and the tensions between ‘official’ and ‘unofficial’ archival material, the latter referring to informal types of data that may not be usually included in

institutional histories. Many of these issues were encountered in the archival research undertaken for this thesis, particularly the challenges associated with incompleteness. The archival material was collected from individual hospital archives, the Public Record Office of Victoria, newspaper and historical map collections in the State Library of Victoria and University of Melbourne. There was an unevenness of material available from each of these sources which required an analysis of the baseline of data for each site to ensure that comparisons were valid. This was particularly so in cases in which hospitals no longer existed, had moved site or had been amalgamated which resulted in loss or dispersal of the archival material. In order to amalgamate a comparable quality and quantity of material for analysis each site, sources beyond hospital archives were investigated. A comparison between the Alfred Hospital Archive and the Austin Hospital archive illustrates this point.

The Alfred Hospital remains on its original site. It has an active nurses’ association, the Alfred Hospital Nurses’ League who administer the nursing archive voluntarily three days a week and catalogued many of the images and accounts of nurses’ experience. It also has a part-time archivist who assists with finding records and providing advice on the archive material. I was provided with a space to work, albeit cramped but also had daily contact with volunteers who provided invaluable background and anecdotes of nursing at the hospital (Figure 3.1). Unfortunately, the informal background to the hospital provided by the retired nurses could not be used in this thesis as no prior ethics approval had been granted and further the information pertained to the period after 1950. It did however, provide an understanding of the ways in which the official story of hospitals may lack the personal and detailed accounts of the lived experience of the institutions that adds complexity to the narrative. This was important in developing the theme of the hospital site as a place of public and private spaces, which informed the interpretation of site as more than a place for buildings.

On the other hand, although on its original site, the *Austin Hospital*, had amalgamated with a nearby hospital in 1990s. In this case, all its records were placed in an unused laundry on its second site with two other hospital archives, uncatalogued and deteriorating amidst the dust. A lone volunteer, an ex-staff member had been attempting to order and catalogue this material for a number of years but the task, which would usually be expected to employ the
services of a professional archivist and considerable time and financial resources, was beyond
the capacity of one person to accomplish. I was allowed to inspect but the disorder was so
great that I unable to obtain suitable material for the case study of the Austin Hospital from
this source. Material on the Austin site was further compromised by the withdrawal of
nineteenth century records of its establishment by Public Records Office of Victoria (PROV)
due to mould. The lack of material was compounded by the lack of a Melbourne and
Metropolitan Board of Works (MMBW) Detail plan which had proved to be an invaluable
source of detailed information for all the other hospital sites. It would have been pragmatic to
discontinue research of the Austin but a preliminary survey of all Melbourne hospital sites had
indicated the importance of the site and its unique site characteristics. Despite the difficulties it
was decided to include the hospital site even though a site plan for 1900 was not located and
images of the hospital were restricted to newspaper articles, annual reports, institutional
histories and postcards. In this case therefore, aerial and panoramic photographs were used to
provide the information that would have been provided by plans and maps had they existed.
The lack of a working hospital archive was also compensated by files in the Public Records
Office of Victoria (PROV) that contained newspaper clippings and the Rose Stenograph Series
of postcards from the State Library of Victoria that featured hospital sites and grounds. In this
manner a clear idea of the hospital grounds were obtained sufficient to contribute to a coherent
narrative.

Collecting the data from the Queen Victoria Hospital presented other difficulties. This
hospital had not only moved sites but had ceased to exist as an institution. Again, the omission
of this important site would have skewed a significant understanding of hospital site
development, particularly as it was the last hospital site in Melbourne developed as a
charitable institution. Other sources were searched and extant information was included so that
although there is not as much information as other sites there is sufficient detail by which to
examine the main themes. There was also limited information on the Eye and Ear Hospital
site which remained basically unchanged from the end of the nineteenth century until the
middle of the twentieth century. The hospital was the smallest of the hospital sites in
Melbourne and as it was initially envisaged as predominantly an outpatient facility many of
the features of other hospital sites such as gardens, mortuary, private places in the grounds for
patients were not evident. In many ways it was an atypical site for the period. The decision to
include the *Eye and Ear Hospital* was made as being consistent with the approach of this thesis of including all hospital sites as a method of adding rigour to the analysis. The inclusion of these sites although requiring more time and effort to assemble baseline data supported a more complete overview of hospitals in Melbourne that enriched analysis and findings. Further, the gathering of data which has not previously been included in particular hospital histories and the consolidation of material in a methodical manner has provided a rich resource for further work on hospital history of Melbourne.

Lack of material in assessing the lived experience of the grounds is a difficult problem in historical research dealing with ephemeral events of more than a hundred years ago. Further, although material on staff may be gleaned from hospital records and personal histories to an extent, information on patients is rarer. In this case, newspapers, hospital records, annual reports and importantly personal memoirs were used to assemble material which was then juxtaposed with the grounds as presented in images to construct a history of the lived experience.

Finally, there is the issue of changing or adding to official maps to include omissions. In the case of M.M.B.W. maps for example, not all elements of the grounds were included. Garden beds, trees and shrubberies which photographs showed were present were not indicated. To add these to the maps was problematic because although I had information it was incomplete and there would still be some areas of the map left blank. This of course, did not mean that there was nothing there, only that information was not extant. Also, it was difficult to ascertain with complete accuracy if date of photographs matched the time when maps were drawn. For this reason, to maintain the integrity of the maps as a data source, they are re-produced as drawn and complementary information on the grounds has been provided by photographs and from written accounts.

2. Visual material in research

This thesis used a wide range of visual material including maps, newspaper images, archival photographs and postcards from a range of sources. When using this type of material, three issues which needed to be addressed were firstly, distortion of visual items as a result of
reproduction techniques, secondly, interpretation of images and finally, inclusion of visual material.

1. The distortion of images is relevant to the reproduction of maps and plans and was a difficulty in reproducing and at times re-drawing plans for this thesis. The Melbourne and Metropolitan Board of Works (MMBW) Detail maps and Stephenson and Turner’s architectural drawings were a rich source of information on hospital sites providing details such as location of flower beds and paths, as well as indicating pipe lines and sewerage connections. To reproduce this amount of detail by a simple reproduction of the map however was counter productive. Firstly, details of the sewerage system and building construction was not relevant to this thesis and its presence in the map detracted from the pertinent information of paths, roads and flower beds. Secondly, the images of the maps were often unclear and were either too dark or too light to convey good quality information. The solution adopted in this thesis was to redraw all the maps using Computer Aided Drawing software (CAD). This allowed for the production of maps which were clear and assisted with analysis of site elements. In drawing from scanned images, however, there has been some distortion of image and it was therefore necessary to make a judgment on the best fit for linework. Further, all maps and plans used in this thesis were based on imperial scale (acres, roods and perches, yards, feet and inches), whilst Australia has used metric scales since 1966. For uniformity, all scales were converted to metric by scaling plans into CAD software. Acres have been converted to hectares but both acres and hectares are given. Thus while some distortion might have occurred in the scanning process and some unnecessary detail omitted, the minor inaccuracies are outweighed by the benefit of clarity.

2. The second issue in working with visual material is that of the use and interpretation of images. Issues of objectivity and intent have been discussed by Gillian Rose and Marc Treib in relation to intentions of the photographer and interpretations of visual images. In relation to what the image is trying to convey, Rose advocates that critical

---

attention needs to be paid to the composition of the image, what is the focal point, what is intended to be seen and what intended to be hidden, what is the effect of particular colours and lighting time of day? This is relevant to the distinction made in this thesis between formal images used in promotion of the institution and informal images of personal significance.

Similarly, Treib refers to the work of historian John Berger in arguing that photographs are not an objective view of the world but ‘reflect the bias of both the culture and the photographer.’

In considering cultural meanings given to images of landscapes Treib refers to the ‘invariable’ image of places. He gives as an example Versaille, where images invariably feature the central axis. The image of Versaille is instantly recognizable but misleading in that it does not reveal the complexity and ambiguities of the whole site. This is true also for images of Melbourne hospitals, many of which were made into postcards that give an instantly recognizable view, usually of the front façade. This phenomenon has interest as a cultural image and for details of physical characteristics however, it is also misleading in that it does not reveal sections of the site that may not fit the cultural images of the hospital for that time.

A photograph that is used for publicity purposes may not present the hospital grounds in the same way as a photograph taken as record of personal reminiscence. The image of the hospital site in an Annual Report for instance, is an important signifier of the way in which hospital management wish to project the institution. The usual photograph of the Alfred Hospital that is used for annual reports and tourist postcards showed the front façade taken from an angle that enhanced the idea of the hospital as an imposing institution. The image of the Alfred Hospital grounds in a personal memoir however gave a different interpretation of the hospital site. This was evident in Alfred Hospital Reminiscences (1927-1947) which is comprised of personal account by nurses of their experiences of the hospital. In this publication, images of nurses using the grounds are less formal and more personal than official photographs used for promotional purposes in annual reports and newspaper accounts for the same period. The less

---


32 Ibid.
formal images provide documentary evidence of the grounds not usually included in official representations and in consequence enriches our understanding of the site.

Similarly, are the obvious staged shots used for other promotional purposes, such as the photograph of the arrival of a patient at *St Vincent’s Hospital*, in which staff stand stiffly at attention and a well-dressed man in bowler hat with his arm in a sling, conveys respectability (Figure 3.3). In contrast, the photograph of the same ambulance bay in the 1940s, not intended for public release from St Vincent’s archive gives a more prosaic impression of this part of the hospital (Figure 3.4). For this reason, it is important to acknowledge source, intent and type of image if it is to strengthen rather than confuse interpretations of the site. For this reason, the source and photographer associated with the image is identified in this thesis as
part of the interpretation and analysis to identify whether a formal presentation or informal event.

Figure 3.4 St Vincent’s Hospital ambulance bay in the 1940s. This photograph not intended for public release gives a more prosaic impression of the hospital. St Vincent’s Hospital Archive.

3. Inclusion of visual material is the third issue relevant to this thesis. Use and inclusion of archival images has been discussed by Lorimer and Philo in relation to changing significance over time and quality of images in which visual material of poor quality is often omitted in institutional histories. In this thesis the inclusion of poor quality visual material needs to be addressed as an issue that has implications for the integrity of evidence. This type of material can be problematic as it may be difficult to discern what is being illustrated and its poor quality can detract from the orderliness and production values of the thesis. St Vincent’s Hospital Archive provides a good example of images of poor quality due to the age of the

material or poor camera technique which resulted in blurring. These images nevertheless provide important evidence that forms a basis for a different interpretation of the grounds and the hospital than is presented in published histories. Indistinct images of a man mowing the front lawn, a patient peering around a pillar, a telephone box on the verandah, lean-to structures attached to permanent buildings or blurred view of the rear of the grounds give insights into the hospital that differ from the usual professional images. While every effort has been made to include clear images, where indistinct images provided important evidence that could not be illustrated otherwise, they have been included.

Another issue is the use of a single image to support a number of different aspects of the narrative when there is limited material available. In this thesis this occurred in the analysis of the transition of the hospital from residential site to medical complex. First, the hospital grounds were analyzed in relation to physical characteristics of residential sites for the period of the study. This is undertaken in Chapters 4 and 5 with the use and images of maps of hospital sites in Melbourne. Chapter 6 then investigated the lived experience of the hospital site as it moved from domestic site to medical complex. In some cases, images from previous chapters are used and some of the same points about physical characteristics made in order to support the narrative of hospital site as a place of personal and public activity. This was required in order to support differing arguments. Further it would weaken the narrative to refer to images from previous chapters rather than presenting them again.

The final issue is related to the quantities of material within the text. The methodological basis of this thesis is the use of material evidence of hospital sites to support arguments about changing ideas of health and landscape. This has meant the inclusion of a large number of images across all sites so that arguments are specific and particular rather than general. Visual material therefore, has been included in the text and is considered to be integral to the thesis argument rather than merely illustrative of the main themes.

3.6 Summary

This chapter has outlined the methodological approaches used for this thesis. Methodologies including case studies, content analyses and ‘thick description’ were discussed and their contribution to the examination of the thesis themes addressed (Figure 3.1). Multiple
sources of data and sources were described and the importance of the hospital site as primary material was emphasized. The relationship between research themes and data to be used in analysis were outlined in Tables 3.1 and 3.2. The analytical tool of content analysis was reviewed and described. The final section considered three methodological challenges in dealing with archival material, incomplete data and visual images and a description was given of the ways in which these challenges were recognized and addressed to strengthen the integrity of the data that informed the main themes.
CHAPTER FOUR
MELBOURNE HOSPITAL SITES AND GROUNDS 1848-1918

4.1 Introduction

The period from establishment of Melbourne’s first hospital in 1848 to circa World War I is recognized as distinct period in the identity of the hospital as a charitable institution in the western world.¹ The hospitals were founded by prominent citizens for charitable cases, that is the sick poor, and their external appearance resembled that of a large house and garden (See Chapter Two). Generally hospitals were built on the pavilion plan and the grounds were laid out with garden beds, trees, shrubberies and paths. Adrian Forty in referring to the pavilion plan describes it as ‘unmistakable as a hospital building.’² Adams has pointed out however in elevation, section and plan nineteenth century hospitals shared similarities with other charitable institutions such as orphanages and workhouses.³ This similarity has been ascribed to the use of ‘institutional design as a mechanism in the production of reformed and healthy individuals’.⁴ In this analysis, the sites, grounds and buildings of the charitable institution were important in shaping behaviour of its inmates and reassuring the public of its

purpose. This argues that cultural ideas were more influential to the appearance of the hospital site and grounds rather than medical theories.\(^5\)

This chapter examines the influence of ideas of salubrity on both the location and appearance of hospital grounds in Melbourne, which it is argued, has not been sufficiently recognized in studies of hospitals of this period. Salubrity was medically endorsed as an efficacious treatment for treating disease in the nineteenth century in which access to fresh breezes and sunlight combined with distance from sources of pollution were identified as important to health. Medical texts of the period assessed hospital sites according to these criteria with scientific formulae for calculating distances between pavilion wards and amount of land required to maximize fresh air and sunlight for patients.\(^6\) Location of the hospital was considered an important element of the fitness of the hospital to its purpose. ‘Cheer’ provided by access to gardens, views and beautiful surroundings as prescribed by Florence Nightingale and other hospital experts, were also included in the treatment provided by salubrity. To examine the contribution of salubrity, location and appearance of hospital sites and grounds in Melbourne are analyzed. To what extent did salubrity influence the location and appearance of the grounds in Melbourne? If salubrity was considered an important treatment as argued in this chapter, did the introduction of new treatments such as x-ray and surgery after 1900 alter their appearance and purpose for patient treatment?

The hospital’s domestic setting, the layout and character of its grounds, are also examined as attributes that conveyed civic pride and moral rectitude important to its identity. This focuses on cultural ideas of hospital grounds and the hospital’s identity as a charitable institution. If hospital grounds resembled other charitable institutions can a medical purpose be ascribed to their grounds or were they linked more generally to nineteenth cultural ideas of landscape?

These questions are addressed by firstly providing an overview of Melbourne, the bureaucracy of its hospitals from 1848-1918 and documenting the legislative changes that reduced the hospitals charitable institution status. This is done to deal with the argument that charitable institutions were domestic and residential in appearance as an outcome of their philanthropic and paternalistic intent. The changing status of the hospital then needs to be considered as an influence on its appearance. The next section examines hospital sites and grounds in Melbourne, their geography, topography, what they looked like, what was said about them and what ideas of philanthropy and health they represented. The location of each hospital is discussed in relation to its identity as a charitable institution and ideas of salubrity. The appearance of hospital grounds at 1900 is documented as representing the period before the establishment of new medical technologies such as x-ray, pathology and effective surgery. Changes in hospital grounds from 1900 to 1918 are then examined to assess the impact of new medical technologies on the appearance and identity of the hospital.

This chapter shows that after the introduction of buildings associated with new medical treatments after 1900, the hospital grounds continued where possible, to reflect a landscape aesthetic associated with the earlier period of the hospital as a charitable institution. This reflected not only the impact of World War I and associated economic restraint but a continued belief in salubrity. It is also evident however, that this response that was not uniform across all sites. Factors that influenced the appearance of hospital grounds were the size and topography of the site, its location and importantly the type of patient that was treated there. This last point provides important insights into attitudes to landscape and health for the period before World War I.

It is also shown that the appearance of hospital grounds was based on both medical and cultural ideas of appropriate landscape. This is evident in the similarity of hospitals to other charitable institutions in the appearance and layout of their grounds which indicates cultural influences. The presence of covered ways and balconies on hospital sites only and not on other charitable institutions however, points to a medical purpose for the grounds. This is supported by the ways in which hospital balconies in particular were justified in medical and popular publications by reference to the health benefits of views, sunshine and fresh air.
4.2 Historical overview of Melbourne

Melbourne was established in the south-east of Australia by the British government in 1839 as the chief port city for the Port Phillip District of the colony of Sydney (Figure 4.1). Built adjacent to the freshwater section of the Yarra River on a basalt plain at an elevation of 31 metres, latitude 37.81° S and longitude of 144.97°, its climate is temperate with a mean average temperature range of 10.2 to 19.8°C. The layout of the city was based on the prevailing British planning code of ‘the grid’, a series of straight roads at right angles, the width of which was based on miasma theory of disease transmission, which equated wide streets with health. The landform of the city was comprised of two elevated areas either side of Elizabeth Street which ran along a shallow valley south into the Yarra River and was known to flood at regular intervals. The western section of the city fell away to low-lying swamp. These landscape factors determined the location of Melbourne’s hospitals as discussed later in the chapter (Figure 4.2).

Figure 4.1 Map of Australia showing the location of Melbourne in the south east of the country. This location at Melbourne has a temperate climate with a mean average temperature range of 10.2 to 19.8 °C and an elevation of 31 metres, latitude 37.81° S and longitude of 144.97°. Modifications: author.

---

Melbourne’s first government representative, Charles Joseph Latrobe (Superintendent and Lieutenant-Governor (1838-1854)) was an educated man who had a great belief in the importance of the city as a civilizing influence and strong ideas on the value of outdoor space for the public good. He was well-educated and well-travelled with a number of travel books to his name by the time he arrived in the colony. Son of evangelical parents, able to claim friendship with Irving Washington and with his interest in botany, geology and natural history, La Trobe was an example of the nineteenth century belief in the environment as an agent in individual and social reform. He granted land for public parks and a Botanic Garden and

---

10 See Wright, R. (1989). *The bureaucrats' domain: space and the public interest in Victoria, 1836-84*. Melbourne: Oxford University Press, 32-40, for a description of La Trobe’s attitude towards the ‘public good’ and the impact this had on reserved crown land in Melbourne.

11 The first book published in 1829 when he was 28 entitled *The Alpenstock: or Sketches of Swiss Scenery and Manners* and his second, *The Pedestrian: A Summer's Ramble in the Tyrol*, in 1832 hints at the importance La Trobe placed on landscape as a means of elevating the mind and improving the soul. Other books included a book of poetry *The Solace of Song* (1839) and *The Rambler in North America: 1832-1833* (London, 1835) was followed by *The Rambler in Mexico: 1834* (London, 1836).

encouraged institutions that represented civic virtue such as the *Melbourne Hospital* and Public Library.  

La Trobe’s belief in the value of public gardens and parks was consistent with nineteenth century attitudes to landscape as a positive influence on health and wellbeing, particularly for the lower classes.  

Between 1852 and 1854, the population of Melbourne swelled from 77,000 to 343,000 as a result of the discovery of gold.  

The prosperity from gold revenue laid the foundation for a building reconstruction that replaced many of the colonial buildings with grand multi-storey buildings.  

The period of the 1880s was a boom decade for the city in which the population grew to approximately 500,000, second only to London in the British empire in terms of size.  

The city’s obvious wealth and prosperity earned it the sobriquet of Marvellous Melbourne and it was compared to other eminent cities such as Chicago and Paris (Figure 4.3).  

---

**Figure 4.3** Town Hall, Melbourne at intersection of Collins and Swanston Streets. This image of Melbourne streetscape circa 1900 was reproduced in a popular souvenir album that showcased Melbourne in terms of its buildings, parks and street. Melbourne prided itself on its sophistication and standing as a city of the world. SLVPC.

---

17 Ibid., 80-84.  
The 1890s, a period of economic downturn, resulted in the collapse of many businesses and cuts in government funding for civic works. The legacy of the boom times however, remained in its grand buildings, streetscapes and reputation as a financial and business centre. In 1901 when Australia, gained independence from Britain, the Exhibition Buildings in Melbourne housed the first sitting of the Commonwealth Parliament and for a time, Melbourne acted as the capital of Australia (Figure 4.4).

Figure 4.4 Engraving of Exhibition Buildings in the Carlton Gardens, Melbourne circa Federation in 1901. The Carlton Gardens were one of the parks that had been granted during the administration of Lieutenant-governor Latrobe in the mid-nineteenth century as part of his vision of civilizing the city. The grounds were in the landscape style popular in England, with lawns, wide paths, statuary and avenues of trees conveying order, gentility and good taste for the benefit of its citizens. SLVPC.

As a former colonial city of the British Empire, Melbourne was influenced by English precedent in its legislature, institutions and attitudes. It took pride in its association with the ‘Mother Country,’ as England was referred to by many Australians, and fostered strong links with the British government. The desire for Melbourne to be associated with established countries, particularly England, is apparent in many of the publications of the period.

Melbourne was described in souvenir albums in its capacity to ‘rival[s] older capitals of Europe’, its ‘government buildings’ able ‘to excel any of those of any city of the same size in the world’\textsuperscript{20}, and is an ‘antipodal London’, more ‘London-like in many features than any other city of the world.’\textsuperscript{21}

### 4.3 Hospital development in Melbourne 1848-1918

Melbourne hospitals as a result of the strong colonial ties between Australia and England were modeled to a large extent on the English voluntary hospital system.\textsuperscript{22} This meant that hospitals in Melbourne were established as charitable institutions for the poor, supported by voluntary contributions and governed by committees elected by subscribers.\textsuperscript{23}

In the period 1848 to 1899, nine hospitals were established in Melbourne under the responsibility of the government’s Charities Board. These hospitals were for the ‘sick poor’, drawn from the indigent classes of Melbourne who could not afford to pay for medical treatment. The depression of the 1890s influenced the establishment of the last two hospitals, \textit{St Vincent’s} and \textit{Queen Victoria}, which were unable to obtain the large government land grants and assistance for building works that had been bestowed on earlier hospitals. For the next fifty years (1900-1950), while there were a consolidation and expansion of existing sites no new hospitals were established from the efforts of private citizens. The government however, gradually increased its interest and involvement in day to day management and funding of charity hospitals in the period up to World War I (Figure 4.5).\textsuperscript{24}

---

Figure 4.5 Medical sites in Melbourne 1860-1950. After 1900 no new public hospitals were established in Melbourne. Table compiled from Hospitals and Charitable Commission Reports 1860-1950: author.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Year Established</th>
<th>Type of Site</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melbourne Hospital</td>
<td>1840</td>
<td>Brick Cottage in CBD c.1841. Two-storey building in Bourke Street c.1841-1848.</td>
<td>General</td>
</tr>
<tr>
<td>Melbourne Lying-in Hospital</td>
<td>1856</td>
<td>Nine roomed stone house</td>
<td>Women</td>
</tr>
<tr>
<td>Eye and Ear Hospital</td>
<td>1863</td>
<td>Two storey terrace buildings, East Melbourne. 1863-1865 1865-1881 various sites in Spring and Russell Streets.</td>
<td>Eye and Ear</td>
</tr>
<tr>
<td>Homeopathic Hospital</td>
<td>1869</td>
<td>Residence in Collins St. east. 1869-1876. Three storey terrace Spring Street 1876-1885.</td>
<td>General</td>
</tr>
<tr>
<td>Alfred’s Hospital</td>
<td>1870</td>
<td>Purpose-built two storey pavilion layout</td>
<td>General</td>
</tr>
<tr>
<td>Children’s Hospital</td>
<td>1871</td>
<td>2 storey terrace. Exhibition Street 1871-1874 (6 pts). 3 storey terrace. Spring Street 1874-1877 (15 patients).</td>
<td>Children</td>
</tr>
<tr>
<td>Austin Hospital for Incurables</td>
<td>1882</td>
<td>Purpose-built one storey building</td>
<td>Incurables</td>
</tr>
<tr>
<td>St Vincent’s</td>
<td></td>
<td>Two storey terrace with cottage at rear.</td>
<td>General</td>
</tr>
<tr>
<td>Queen Victoria</td>
<td>1899</td>
<td>Governess Institute, Lt. Lonsdale Street.</td>
<td>Women and children</td>
</tr>
</tbody>
</table>

Table 4.1 List of hospitals in Melbourne 1850-1950 and the sites on which they were first established. Only the Alfred and Austin hospitals were on purpose-built sites and did not start from a domestic residence. Compiled: author.  

The majority of hospitals established as charitable institutions started as converted domestic residences until support from government and public donation could finance a purpose-built hospital, often on land granted from the state (Table 4.1). The exceptions to this were the Alfred and Austin Hospital for Incurables which were constructed at foundation as purpose-built hospital buildings on permanent sites in times of relative prosperity for Melbourne.\footnote{The Children’s and St. Vincent’s hospitals purchased their sites independent of government funding.} Hospitals at this time, before the widespread introduction of surgery, x-ray and pathology provided shelter, food and an environment away from the damp and unhealthy dwellings of the patients’ homes. The domestic house was sufficient to meet these requirements and the establishment of these early hospitals in such places underscored the strong association between the hospital and domestic residence at this time.

Although public charities appealed to the population for funding, the biggest contributor to hospitals in Victoria was the Treasury Department of the Victorian Government.\footnote{See Royal Commission Report into Municipalities and Charitable Institutions. 1862: Victorian Parliamentary Papers, 1862. Government Printer, Melbourne, 49 showing government contributions of 75 per cent.} Other than funding from government, hospitals received income from four main sources, namely annual subscriptions, private donations, bequests and after 1873, the Hospital Sunday Fund. The Hospital Sunday Fund was an idea imported from England in which one day of the year was allocated for the collection of money for hospitals, principally from church congregations. Fund-raising committees organized major events such as public music programs and amusements which were strongly supported by the popular press and

---

became a major charitable event in the social year. Hospital Sunday was also an occasion when the hospitals were open to the public as part of the fund-raising efforts (Figure 4.6).

Although, the hospitals were dependent on government funding, the public were widely involved in fund-raising events through the Hospital Auxiliaries and Subscription Lists. Subscription lists were another feature taken from the English hospital system whereby individuals subscribed to the hospitals for the privilege of nominating patients and in the case of the Melbourne Hospital, electing staff. Similarly, the Ladies Auxiliaries were instituted by the hospitals as a means of organizing fund raising through a system of volunteer boards. The

---

28 See for instance Anon. (October 31st, 1879). Hospital Sunday Choral Service at the Town Hall. The illustrated Australian News and VPRS 609/P0000/5. Austin Hospital Reports 1891-1923 in the Public Records Office of Victoria which has a large range of newspaper clippings reporting on Hospital Sunday.

29 Vagabond. (1877). Three Weeks in the Alfred Hospital In Vagabond Papers. Sketches of Melbourne Life in Light and Shade. 2nd Series. Melbourne, Sydney and Adelaide: George Robertson describes the crowds visiting the Alfred site on Hospital Sunday.
Ladies Auxiliaries, usually led by well known society figures were prominent in the women’s pages of newspapers and hospital records promoting events and reporting on monies raised.30

![Figure 4.7](attachment:image.png)

**Figure 4.7** 1870 List of Charitable Institutions in Victoria. Hospitals were included with other charitable organizations and were not considered a separate category until the 1880s. Report of the Royal Commission of the Charitable Institutions 1870, viii. Asterisks added by author to indicate hospitals in Melbourne.

In 1864, legislation was introduced that required all charities to be registered, including hospitals, as a way of limiting and regulating the appeals to the public purse.31 This placed some demands on the election procedures for committees of management, but essentially the government made no changes in the provision of services and the charitable institutions continued as independent bureaucracies.32 Until the 1880s hospitals were not differentiated from other charitable institutions in government reports such as orphanages, benevolent

---

30 All hospital annual reports included a section for the Ladies Auxillary to report on the year’s activities. See Kennedy, R. (1985). *Charity warfare: the Charity Organisation Society in colonial Melbourne*. Melbourne: Hyland House for more detailed explanation of the role of the charitable system of funding hospitals at this time.

31 This had been one of the recommendations of a Royal Commission into public charities in 1862. This had, had been convened to regulate what was seen as an unsustainable number of requests for public money and concern regarding the bona fides of those receiving funding.

asylums and institutes for the blind which illustrated the generic charitable purposes of hospitals at this time (Figure 4.7).

In 1880 however, as a result of continued concerns regarding the cost of government funding to charitable institutions, an Inspector of Public Charities, H.F. Neal was appointed to conduct an annual inspection and to report on efficacy.\(^{33}\) Charities were classified according to their function from this time with hospitals, benevolent homes and orphanages afforded separate categories. Hospital funding was then dependent on the inspector’s report and the amount of money raised by hospital committees. This attempt to rationalize the charities funding on a systematic basis exemplified a move towards the hospitals becoming part of a network within government control rather than operating as individual entities.\(^{34}\) The relationship between government and hospitals however remained principally financial, and hospital boards remained responsible for medical practices and standards.\(^{35}\)

The 1890s were a period of change in the government’s attitude to hospital funding, driven by the new Munro government and severe economic depression experienced in Victoria.\(^{36}\) This ushered in a period of reduced government funding for hospitals and a new emphasis on accountability for hospital spending.\(^{37}\) As described by Richard Kennedy in his study of charitable organizations of this period, the government considered that hospitals encouraged moral weakness in the lower classes and wasted government funding on elderly and chronically ill patients who should be cared for by relatives.\(^{38}\) By 1900 Government were using grant provisions to control hospitals and threatened to withdraw grants unless particular policies were followed.\(^{39}\) By 1910, the Charities Report referred to hospital funding in relation to measures of efficiency, accurate reporting of statistics and the introduction of a central

\(^{35}\) Walker, op. cit., 31-32.
\(^{37}\) Ibid.
\(^{39}\) Inglis, K.S., op. cit., 166.
controlling authority for hospitals as increasingly, the government moved towards systemic and centralized control as a way to protect its use of public monies for hospitals.\(^{40}\)

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>1890</th>
<th>1910</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Daily</td>
</tr>
<tr>
<td></td>
<td>Number of</td>
<td>average of</td>
</tr>
<tr>
<td></td>
<td>In-Patients</td>
<td>occupied</td>
</tr>
<tr>
<td>Melbourne Hospital</td>
<td>3233</td>
<td>292.2</td>
</tr>
<tr>
<td>Women’s Hospital</td>
<td>1162</td>
<td>50</td>
</tr>
<tr>
<td>Alfred Hospital</td>
<td>1612</td>
<td>147.2</td>
</tr>
<tr>
<td>Children’s Hospital</td>
<td>880</td>
<td>72.6</td>
</tr>
<tr>
<td>Homeopathic Hospital</td>
<td>651</td>
<td>43.8</td>
</tr>
<tr>
<td>Eye and Ear Hospital</td>
<td>373</td>
<td>36.6</td>
</tr>
<tr>
<td>Austin Hospital</td>
<td>143</td>
<td>77.5</td>
</tr>
<tr>
<td>St Vincent’s Hospital</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Queen Victoria Hospital</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

**Table 4.2** Total In-patient and bed numbers for Melbourne hospitals 1890 and 1910. The number of patients and beds increased rapidly between 1890 and 1910 in Melbourne. The increase in patients however was greater than the increase in beds indicating that the introduction of surgery led to a higher turnover of patients. This demonstrates one of the impacts of new medical practices. Compiled from government reports: author.\(^{41}\)

Despite the financial drain of the hospitals on the government treasury, the government actively discouraged the introduction of paying patients to public hospitals.\(^{42}\) The 1901 Charitable Report for instance referred to a paying ward in a public hospital as an ‘anomaly in an institution in receipt of Government assistance, and contributed to by the public in the name of charity.’\(^{43}\) In 1910 the government reiterated its view that it did not support paying patients in public hospitals, although this had become a widespread practice by this time.\(^{44}\)

Contributions’ from charity patients were encouraged however, viewed by the Government as


\(^{41}\) Charitable Institutions, op. cit. (1890); Charitable Institutions, op. cit., (1910).

\(^{42}\) Ibid., 5.


\(^{44}\) Charitable Institutions, op. cit., (1910), 5.
a way of fostering independence and moral fibre in the destitute classes rather than as payment for services.\textsuperscript{45}

After 1900 pressures on hospitals to meet budget deficits, combined with new surgical procedures which improved patient outcomes, resulted in hospital sites concentrating more on surgical rather than traditional charity patients.\textsuperscript{46} The surgical patient differed from the charitable patient in two key ways. Firstly, surgical patients tended to be working poor rather than indigent and were charged a reasonable contribution. Secondly, surgical patients were in hospital for a lesser period than charitable patients. A typical stay for a surgical patient for instance was 20 days whilst other patients, namely elderly and chronically ill could occupy beds for a far longer period awaiting death or alternative and scarce accommodation.\textsuperscript{47} This change in emphasis was reflected in average bed stay rates for the \textit{Melbourne} and \textit{Alfred} hospitals, the two major general hospitals undertaking surgery. For example, the average stay of a \textit{Melbourne Hospital} patient of 26.95 days in 1890 was reduced to 18.5 days by 1910, whilst the \textit{Alfred Hospital} average stay dropped from 66.3 days to 23.5 days for the same period.\textsuperscript{48} At the same time that patient turnover was increasing, the number of beds available on each site was expanding, meaning that sites became more complex as more patients were treated requiring more staff and associated buildings to meet demand (Table 4.2).

Concurrent with the increasing number of patients and increasing specialization of medical treatment was an increasing demand for nursing staff (Table 4.3). This resulted in the building of more nursing accommodation within the grounds and associated recreational facilities such as tennis courts, which again contributed to increased building density on site (Table 4.3).

\textsuperscript{45} Walker, \textit{op. cit.}, (1998), 32.
\textsuperscript{46} Ibid., 33.
\textsuperscript{47} Ibid.
Table 4.3 Numbers of nursing staff at Melbourne hospitals significantly increased between 1890 and 1910. Compiled from government reports: author.\(^{49}\)

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>1890</th>
<th>1910</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melbourne Hospital</td>
<td>67</td>
<td>100</td>
</tr>
<tr>
<td>Women’s Hospital</td>
<td>4</td>
<td>65</td>
</tr>
<tr>
<td>Alfred Hospital</td>
<td>17</td>
<td>53</td>
</tr>
<tr>
<td>Children’s Hospital</td>
<td>19</td>
<td>56</td>
</tr>
<tr>
<td>Homeopathic Hospital</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>Eye and Ear Hospital</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Austin Hospital</td>
<td>10</td>
<td>46</td>
</tr>
</tbody>
</table>

Figure 4.8 Number of patients on individual hospital sites in Melbourne 1880-1950. From 1910-1920 the rate of increase in patient numbers declined in Melbourne hospitals as a result of economic and social changes associated with World War I. The changes in hospital grounds that had begun as a result of new surgical techniques and increased in patient numbers also slowed. The exception to this was the Melbourne Hospital which had finished a building expansion program prior to World War I in 1913. Compiled from Charitable Reports: author.

The period around World War I marked a hiatus in development of Melbourne hospitals as lack of staff due to war shortages, secondment of hospital personnel to armed services duty and the financial priority given to the war effort by government restricted

\(^{49}\) Charitable Institutions, op. cit. (1890); Charitable Institutions, op. cit., (1910).
building and expansion programs.\textsuperscript{50} As is evident in Figure 4.8, in contrast to the years 1900-1909 in which most hospitals experienced a large increase in patient numbers there was little increase in patient numbers from 1910 to 1919. The exception to this was the Melbourne Hospital which had undertaken a major re-building program completed in 1913 before the severe financial and manpower constraints of World War I had taken effect.

4.4 Hospital sites 1848-1900

Location of charitable institutions

The location of hospital sites before 1900 reflected the identity of the hospital as a charitable institution and the importance placed on salubrity as an important aspect of patient treatment. Hospitals were located predominantly in central Melbourne in order to be close to the urban poor who were the main users of the hospitals. (Figure 4.9).\textsuperscript{51} The Australian Medical Journal for instance, writing in relation to a new hospital site in 1869, listed the ‘proximity to destitute class’ as one of its criteria. The hospitals inner-urban location ensured this was met with the city abutted by slums of Fitzroy, Collingwood, Carlton and Prahran.

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>SITE EST.</th>
<th>ACREAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin Hospital for incurables</td>
<td>1882</td>
<td>14.5 (5.87 ha)</td>
</tr>
<tr>
<td>Alfred Hospital</td>
<td>1869</td>
<td>14 (5.67 ha)</td>
</tr>
<tr>
<td>Melbourne Hospital</td>
<td>1848</td>
<td>4 ¾ (1.92 ha)</td>
</tr>
<tr>
<td>Melbourne Lying-in Hospital</td>
<td>1858</td>
<td>2 ½ (1.01 ha)</td>
</tr>
<tr>
<td>Melbourne Hospital for sick children</td>
<td>1877</td>
<td>1 (0.40 ha)</td>
</tr>
<tr>
<td>Homeopathic Hospital</td>
<td>1882</td>
<td>1 (0.40 ha)</td>
</tr>
<tr>
<td>St Vincent’s Hospital</td>
<td>1894</td>
<td>1 (0.40 ha)</td>
</tr>
<tr>
<td>Queen Victoria Hospital for women and children</td>
<td>1899</td>
<td>0.55 (0.22 ha)</td>
</tr>
<tr>
<td>Eye and Ear Hospital</td>
<td>1882</td>
<td>0.2 (0.08 ha)</td>
</tr>
</tbody>
</table>

\textit{Table 4.4 Size of hospital sites in Melbourne at the time of establishment of Charitable Institutions.} Compiled from Report of the Inspector for the Year Ended 30th June, 1910. No. 61, Table III: author.


\textsuperscript{51} Anon. (April, 1869). The New Hospital. \textit{Australian Medical Journal}, 112-115.
Figure 4.9 1892 Land and Survey map of Melbourne showing location of hospitals, convalescent cottages and asylums circa 1900. The majority of hospitals were close to the city and its urban poor. SLVMC. Modifications: author.
Other criteria for Melbourne hospital sites associated with its charitable status included proximity to the University of Melbourne medical school which had been established in 1862 in Carlton.\textsuperscript{52} The evolution of new medical techniques in the early 1800s based on physical examination and observation relied on the availability of patients to observe and for practice of surgical techniques and other procedures. The charity hospital was an invaluable resource for medical students to develop these skills. In turn the medical school provided a source of cheap labour for hospitals.\textsuperscript{53} This reliance on public hospitals for the training of doctors led to repeated calls for hospitals to be close to medical schools from the 1860s to the twentieth century in Melbourne.\textsuperscript{54}

Exceptions to the clustering of charity hospitals in proximity to the Central Business District were the \textit{Austin Hospital for Incurables} and the \textit{Convalescent Cottage} of the \textit{Children’s Hospital}. The \textit{Austin} was located in a semi-rural setting on the extreme fringes of suburbia. As a place that admitted poor patients with terminal illness such as cancer, the \textit{Austin} viewed its inmates as beyond medical care, so association with a medical school was not considered relevant. The rationale for its location can be found in newspaper and \textit{Austin Hospital} publications which referred to the transcendental properties of its site and location as a treatment for the dying.\textsuperscript{55} The \textit{Children’s Cottage} in a seaside location in the middle class suburb of Brighton, also distant from the medical school, was intended to provide a refuge from the city slums.\textsuperscript{56} Both these sites were not associated with medical treatment so much as providing a comfortable shelter for patients away from the environment of the city that was considered to exacerbate their physical conditions.

\begin{flushright}
\footnotesize
\end{flushright}
Figure 4.10 1880 McCarron and Bird map of Melbourne and suburbs showing the relationship between the ‘healthy’ areas of the city and hospitals. All the shaded areas are public parks established by La Trobe as superintendent of Port Phillip District 1839-1851, then Lieutenant-Governor of Victoria, 1851-1854. The private hospitals as with the public hospitals were almost exclusively in the salubrious, eastern section of the city. SLVMP. Modifications: author.
The location of the hospitals also revealed the importance of salubrity considered by medical experts as a mandatory attribute of hospitals in the nineteenth century. Inner-urban hospitals were located in close proximity to parks, gardens and recreation reserves in order to maximize access to fresh air and sunshine and provide beautiful surroundings for its patients (Figure 4.10). The Children’s, Alfred and Homeopathic were adjacent to major parks whilst three hospitals were also associated with open land - the Women’s opposite the extensive gardens of Melbourne University and Eye and Ear and St Vincent’s either side of health reserves included in the city as a way of dealing with miasmas (Figures 4.11 and 4.12). The health reserve of Victoria Parade between Eye and Ear and St Vincent’s hospitals, planted with trees and shrubs and containing elements such as tennis courts and bowling greens, formed a major buffer between the closely packed slums of Fitzroy and the city.57

---

*Figure 4.11* View of the Children’s Hospital from the Exhibition Gardens. Location of the hospital near the park gave patients on the balconies views of the garden and the hospital the benefit of fresh air and sunshine away from dense urban housing. Royal Children’s Hospital Archive.

57 See 1899 MMBW Detail Plan No. 1028 for details of health reserves in proximity to Eye and Ear and St. Vincent’s hospitals.
Figure 4.12 Health reserve between St Vincent’s and Eye and Ear hospitals to relieve the congestion and foetid air of the city, can be seen in the middle background. MMBW plans from 1899 show tennis courts and bowling greens. St Vincent’s Hospital can be seen above the trees of the Carlton Gardens, with the boiler stack behind. The balconies with views to the gardens demonstrated the importance of nineteenth century ideas of salubrity to the hospital and gave patients the experience of sunshine, fresh air and the benefit of views to parks and gardens. Walking Melbourne.

Further examples of the importance attached to salubrity for hospital sites can be found in the controversy surrounding the location of the Melbourne Hospital. This site was originally flanked by public reserves when selected by LaTrobe and was specifically stipulated by him ‘for the use of the Hospital inmates, as a garden or place of recreation’ (Figure 4.13). As the city grew around the hospital site and open grounds were lost to buildings, its location was judged as ‘offensive and contaminated’, victim to the ‘sickening and deadening effluvia’ of its city location. Specific attention was drawn to Florence Nightingale’s stipulation that the recreation grounds of a hospital should not be sacrificed to accommodate extra buildings, as had been the case for the Melbourne Hospital. Further, the Australian Medical Journal had

---

58 1016/P0000/13. (28th February, 1853). Draft letter from Lieutenant Governor La Trobe to Secretary of Melbourne Hospital and Surveyor-General. Melbourne, PROV.
59 Anon. (October 23rd, 1866). The New Hospital. Shall we have a New Hospital or go on adding to the Old One? Melbourne, 1.
60 Ibid.
no objection to the *Children's Hospital* sharing a site with *Melbourne Hospital* ‘if that establishment were elsewhere than in the heart of a crowded city.’\(^\text{61}\)

![Figure 4.13 1860s Land and Survey map shows the ‘Recreation Grounds’ either side of the hospital and also gives an indication of the placing of the hospital close to the museum and Public Library and Museum which at the time had a comparatively large amount of open space surrounding the building, including a garden. This is in contrary to the small, cramped allotments in other parts of the city. SLVMC.](image)

Prescription for suitable sites reflected medical preoccupation with fresh breezes which were believed to dispel miasmas, widely thought to cause diseases.\(^\text{62}\) Topography was another aspect of hospital sites that was widely commented upon by experts. Terms such as ‘medical

\(^{61}\) Editorial, *op. cit.*, (June, 1861), 36.

\(^{62}\) See Chapter 2 for a discussion of the nineteenth century medical belief in the importance of fresh air in dispelling unhealthy air that caused diseases.
geography’ used to describe suitable land for hospitals indicated the medical credibility given to topography for hospital sites:

….no more salubrious position can be found in the whole medical topography of Melbourne, or better adapted for the purpose, than some of the elevated spots of Prahran.63

The concern for elevated topography is evident in the location of hospitals in the city on high ground, either side of the north-south creek bed that sporadically flowed down Elizabeth Street (Figure 4.14). Four hospitals, Eye and Ear, St Vincent’s, Children’s and Women’s, were located on the highest contour surrounding the immediate Central Business District (C.B.D.). Public buildings such as the General Post Office and commercial buildings such as banks and shops not concerned with the problems of miasma and the need for healthful breezes, occupied the low lying areas of Melbourne around Elizabeth Street.

![Map of Melbourne showing hospital locations](image)

**Figure 4.14** Excerpt of 1901 MMBW contour map of Melbourne showing majority of hospitals on higher ground, east of Elizabeth Street. The eastern end of the city was associated with salubrity from an early stage in its history. Most of the hospitals were located on one of the highest contours overlooking the C.B.D. MMBW Contour Plan of Melbourne and Suburbs, 40 Chains to I inch. Re-drawn with modifications: author.

---

The majority of hospitals were located in the eastern parts of the city, culminating in the eastern hill precinct where *St Vincent’s* and the *Eye and Ear* hospitals were sited. This geographic clustering reflected the perceived salubrity of the eastern compared to the western part of the city which had become associated with noxious industries such as abattoirs, tallow making and pollution of the western swamp. The east end of the city on the other hand, was inhabited by professional and business classes and grand civic buildings such as Parliament. The only hospital located west of Elizabeth Street was the *Queen Victoria Hospital*, which was established in 1899 as ideas of hospital sites and healthful breezes were waning. Its location was also influenced by the proximity to St David’s Welsh Church which had provided the first premises for the fledgling hospital in its hall in 1896 and whose minister was married to one of the hospital’s founders – Dr. Constance Stone. Association between the salubrious eastern precinct and hospitals is further reinforced by the location of private hospitals. These were almost exclusively in the eastern city as had been the temporary sites for all hospitals in Melbourne before permanent sites were established (Figure 4.10).

Location of the outer-urban sites was also linked to ideas of salubrity. The *Convalescent Cottage* of the *Children’s Hospital* for example was commended for its proximity to a landscape that provided fresh sea air for patients. The Inspector of Charities described the site as one that provides ‘the change of air and scene [that] are of incalculable benefit to the children.’ Children felt the benefit of the ozone from the sea and could ‘be wheeled to the beach, whose breezes so soon give them strength and energy’, a therapeutic experience of landscape not possible in the city (Figure 4.15).

---

67 The first two city blocks surrounding Parliamentary buildings on the extreme east of the C.B.D. were the first sites of the *Children’s, Homeopathic, Eye and Ear* and *Lying-in hospitals*.
69 Ibid., 24.
The significance of a salubrious landscape is further articulated in Grace Carmichael’s personal account of nursing at the Children’s Hospital at the end of the nineteenth century:

I often think how delicious must be the first sight of the blue sea to those childish eyes, so weary of bare ward walls of the hospital. What visions of sunny hours on the broad sands must come to them as the fresh strength of the breeze meets their wasted faces, sheer from the tossing sea, where the white wings flit between shore and horizon. The convalescent retreat is most valuable in the effectual treatment of children’s ailments, more especially in fever cases. The rapidity with which patients became transformed from tottering wraiths into plump, rosy, scampering children is magical.70

---

Similarly, the location of the Austin Hospital in Heidelberg, an area renowned for its picturesque qualities and associated with the Australian school of impressionist painters, reflected the importance of salubrity, particularly scenic beauty for incurable patients.\(^71\) The institutional history of the Austin Hospital by E.W. Gault and Alan Lucas describes the site as highly suitable for its purpose and give a typical appraisal of its qualities which invariably refer to its picturesque location:

This magnificent site commanded a fine view of Yarra Valley as far as the distant Dandenong, Warburton and Healesville ranges. Here was a place where incurable patients could die in pleasant surroundings.\(^72\)

### 4.5 Hospital grounds 1848-1900

Close attention to the hospital grounds reveal common characteristics that can be attributed to the hospital’s identity as a charitable institution and also to ideas of salubrity. The survey undertaken of hospital grounds of 1900 reveals four characteristics that were common to all hospitals. These were buildings set back from the street, boundary fence, front garden, balconies and verandahs. These elements were similar across sites regardless of size of the land, function of the hospital or number of patients. Table 4.5 summarizes these main elements based on analysis of hospital grounds in Melbourne in Figures 4.16-4.35.

Arguably these elements reflected the association of the hospital with a residential site which was the prevalent hospital form before World War I. The sweeping drives, shrubberies, well-kept lawns were not only symbols of the well-ordered home. They also reflected society’s belief in the influence of middle-class values to mitigate the detrimental effects of poverty and associated disorder and disease. Buildings set back from the street not only reduced contact with the contagions of the city streets but also distanced the hospital from the city itself to create a refuge for patients. This mirrored hospital sites in the northern hemisphere and indicates a common approach to hospitals at this time.


Table 4.5 Site and ground characteristics of hospitals in Melbourne in 1900 which were related to ideas of salubrity. This table demonstrates that there were similarities between the grounds of hospitals and the grounds of other charitable institutions that are typical of charitable institutions in general. The presence of verandahs, covered ways and balconies on hospital grounds distinguished these sites as having a medical purpose. Table compiled from site plans, images in Figures 4.16-4.35 and Queen Victoria Annual Report, 1911, 28. author.
Melbourne Hospital grounds

Figure 4.16 1896 MMBW Detail Plan of Melbourne Hospital showing lawn, garden beds, fernery, ambulatory paths, covered ways and verandahs. Re-drawn from 1896 MMBW Detail Plan No.1018: Author.

Figure 4.17 1870-80s Melbourne Hospital with extensive gardens and buildings set back from the street on highest part of site when built in 1848. SLVPC.
Women’s Hospital Grounds

Figure 4.18 1896 MMBW Detail Plan of Women’s Hospital. Site elements as shown on plan. The buildings were connected by covered ways and provided with wide verandahs attached to patient buildings. Photographs of the period show mature trees and extensive planting throughout the grounds (See Figure 4.39). Re-drawn from 1897 MMBW Detail Plan No. 1171: Author.

Figure 4.19 1897 Women’s Hospital (Melbourne Lying-in Hospital) Swanston Street showing boundary fence, buildings set back from the street and garden setting. Weekly Times 31st July, 1897.
Alfred Hospital Grounds

Figure 4.20 1896 MMBW Detail Plan of Alfred Hospital showing site elements of garden beds, circular drive, path system, grass areas, buildings set back from the street, verandahs and covered ways. The eastern section of the site was largely trees and unkempt grass. Re-drawn from 1896 MMBW Detail Plan No. 906: Author

Figure 4.21 c.1900 Entrance of Alfred Hospital looking towards main gates from Administrative buildings showing, conifer, shrubberies and ornamental trees on either side of the circular drive. Covered way connects the buildings at the entrance to the main hospital. Alfred Hospital Archive.
Children’s Hospital Grounds

Figure 4.22 1896 MMBW Detail Plan of Children’s Hospital showing garden beds, lawns, paths, verandahs and perimeter fence. The original hospital building was a former residence surrounded by extensive gardens. A fernery is retained on the western boundary from its former identity as a large house with land and reinforces the domesticity of the hospital site. Re-drawn from 1896 MMBW Detail Plan No. 1184; Author

Figure 4.23 Children’s Hospital grounds in 1890s. The front garden of the original home that served as part of the hospital from 1877 until its demolition in 1911 with balconies, perimeter fence and garden setting. The hospital retained many features of the former residence including orchard, fernery and shrubberies. Yule, 70.
Homeopathic Hospital Grounds

Figure 4.24 1896 MMBW Plan of the Homeopathic Hospital showing garden areas, grass, verandahs and circular drive. SLVMC Re-drawn from 1895 MMBW Detail Plan No. 595: Author.

Figure 4.25 1906 postcard of Homeopathic Hospital showing boundary fence, verandahs and garden setting. People can be seen on the upper balcony of the hospital which had uninterrupted views of the King’s Domain, a major park in Melbourne adjacent to the Botanic Gardens. SLVPC.
Eye and Ear Hospital Grounds

Figure 4.26 1899 MMBW Detail Plan of Eye and Ear Hospital showing garden areas, verandahs and paving at back of hospital. Re-drawn from 1899 MMBW Detail Plan no. 1028: Author

Figure 4.27 Eye and Ear Hospital in Victoria Parade, East Melbourne. One of the most prestigious parts of Melbourne at the time of building in 1882, the hospital was opposite the wide reservation in the middle of Victoria Parade provided for fresh air and recreation for city residents. SLVPC.
Austin Hospital Grounds

Figure 4.28 Aerial view of Austin Hospital looking west showing roads, lawn and garden areas. 1920 Austin Hospital AR.

Figure 4.29 1900 General Wards of the Austin Hospital with verandahs and garden beds. Patients can be seen on the verandah with a view of the garden. Alfred Hospital Archives.
St Vincent’s Hospital Grounds

Figure 4.30 Garden beds and lawn areas were part of the original hospital of St Vincent’s Hospital which initially occupied residential terraces and cottage at the rear of these buildings. Re-drawn from 1898 MMBW Detail Plan no. 1206: Author.

Figure 4.31 The domestic terrace buildings facing Victoria Parade which were some of the first buildings of St Vincent’s Hospital with front garden and verandahs associated with the domestic residences. The cottage at the back had a typical domestic garden with shrubs and trees. St Vincent’s Hospital Archive.
Queen Victoria Hospital Grounds

**Figure 4.32** MMBW Detail Plan of Queen Victoria Hospital showing verandah at the back of the converted domestic residence. Re-drawn from 1895 MMBW Detail Plan No. 1017: Author.

**Figure 4.33** Queen Victoria Hospital established in domestic site of former Governess’ Institute Building retained its garden until World War I. Queen Victoria AR 1912.
Although the grounds of Melbourne hospitals shared similar characteristics, this did not necessarily mean that this was a distinctive form particular to hospitals. Hospital grounds in many respects were also similar to other charitable institutions in Melbourne such as the Benevolent Asylum, deaf and Dumb Institute and Asylum and School of the Blind. A member of the public for example, not conversant with theories of hospital building would find it difficult to distinguish a hospital site from any other charitable institution, based on its external appearance. *Melbourne Hospital* in Figures 4.16 and 4.17 for instance, is indistinguishable from the grounds of the charitable institutions in Figures 4.34 and 4.35. Site characteristics common to all charitable institutions including hospitals and associated with the garden of a large residential home were shrubberies, garden beds, trees, lawns, perimeter fences, buildings set back from the street, circular drives and paths. This suggests that these elements had a cultural significance in accordance with ideas of civic pride and moral good associated with a charitable institution and its reference to traditional family residence, rather than a particular meaning for hospitals.

The elements of hospital sites not shared with other charitable institutions sites were balconies and covered ways. Both these were present on hospital sites because of medical ideas of salubrity, as described by the *Australian Medical Journal* in 1869 as ‘ventilation, light and cheerfulness’. Meaning for these attributes was associated with the medical purpose of the site in providing elements that promoted the principles of salubrity.

---

74 See Anon. (November 5th, 1905). *St Vincent's Hospital, Melbourne. Souvenir of the Opening Ceremony.* Melbourne, 17 for a description of the colour scheme used in the hospital to relieve the monotony for patients.
Figure 4.34 1895 The three major charitable institutions in Melbourne shared site characteristics such as circular drives, garden beds, path system and lawn with hospital grounds. There were however, no verandahs or covered ways. Deaf and Dumb Asylum 1897 MMBW Detail Plan No 907; Asylum and School for the Blind 1896 MMBW Detail Plan No 906; Benevolent Asylum 1895 MMBW Detail Plan No. 750. University of Melbourne Map Collection. Complied: author.
Figure 4.35 The grounds of other charitable institution in Melbourne were similar to that of hospitals in having shrubberies, paths, trees and lawn typical of the grounds of a large residential site. Deaf and Dumb Institute 1889, SLVPC; Asylum and School for the Blind 1906, SLVPC; Melbourne Benevolent Asylum, c. 1880, Nettleton. National Library of Australia. Compiled: Author.
It is the way the hospital grounds are spoken about however that suggests that there was a medical purpose to hospital grounds related to patient treatment. Balconies and covered ways not only provided patients with fresh air and sunshine but an opportunity to be in contact with nature and be provided with views, considered necessary attributes of hospital treatment. Use made of verandahs by patients and staff circa 1900, as in the case of the Melbourne and Children’s hospitals, reflected their importance to hospital treatment whilst publications indicated its inclusion as a normal part of the hospital site (Figures 4.36 and 4.37). In 1895 and again in 1906 for example, the Melbourne Guide Book commended the width of the verandahs at the Homeopathic Hospital whilst patients using its balcony and enjoying the views featured in the Illustrated Australian News in 1889 (Figure 4.38).  

It was also popularly considered that the Alfred Hospital’s verandahs ‘contribute[d]s greatly towards the speedy recovery of the patients in 1879.’

Mary Grant Bruce in her account of the Children’s Hospital captures the belief in the verandah’s salubrious advantages in which contact with nature and views of the garden form a part at the beginning of the twentieth century:

On sunny balconies cots are packed thickly. The smuts from the city chimney lodge on the white bed-linen and the pale faces, but what are smuts when you can be in the open-air?—seeing the blackbirds happy in the trees and catching glimpses of children in the streets.

Figure 4.36 Balcony of Children’s Hospital with nurses and children. The verandahs were widely used in hospitals and were seen as an important part of hospital treatment before World War I. Royal Children’s Hospital Archive


76 The Guide to Melbourne and suburbs, op. cit., (1879), 47.

77 Bruce, M. G. (28 June, 1909). The Least of These Little Ones. Woman, 472-473.
Figure 4.37 Circa 1900 Patients on the balconies of Melbourne Hospital. These verandahs gave patients close contact with garden areas that adjoined these buildings and exposure to fresh air and sunshine. Sherson, 173.

Figure 4.38 Illustrations of patients using balconies in the popular press indicated the importance of this type of treatment to the hospital’s identity as a place of appropriate standards and practices as a medical institution. This drawing appeared in a feature on the Homeopathic Hospital. ‘Illustrated Australian News’, 1st August. SLVPC.
Covered ways were another feature that differentiated hospital grounds from other charitable institutions as part of the idea of separation of buildings considered necessary to treat disease. Connecting separate buildings, covered ways provided protection for staff and for patients undertaking exercise in the fresh air (Figures 4.39-4.41). Professor Allen for example, who took a study tour of international hospitals in 1890 for the Victorian government, approved of the covered ways at *Eppendorf Hospital* in Germany, which he noted were not glazed despite the extreme cold.78

---

Figure 4.41 Covered way on Alfred Hospital grounds between patient pavilions built in 1905. The covered way indicated the continued importance of salubrity even as new medical procedures and practices were impacting on other parts of the grounds. Alfred Hospital Archive. Hembrow Collection.

The hospitals as well as resembling a domestic residence were in fact home to a large number of staff and long-term patients. In the nineteenth century hospitals were expected where possible to provide its own food for staff and patients which contributed to the association of the hospital with a large house and its grounds. Hospitals kept chickens and other livestock for this purpose.79 The Alfred and Austin hospitals had large vegetable gardens

---

79 For instance, the 1896 MMBW plan for the Alfred Hospital indicates a fowl yard behind the kitchen, whilst matrons Reports from the Austin and Inspector of Charities Reports for the Homeopathic refer to chickens and geese. See Chapter Six for more detail.
which in the case of the Austin were also worked by patients. Nurses who lived on the site also needed to be accommodated. Before 1900 however, nurses were not generally allotted a separate residence and were usually housed in parts of the main hospital. The nurses at the Alfred for instance lived in the Administration Block whilst at the Homeopathic Hospital the inadequate accommodation for nurses in various parts of the hospital was well documented.

In cases where purpose-built accommodation was built for nurses, it followed the traditional architecture and garden setting of a domestic residence as in the case of the Bowen Home at the Austin and the part of the Genevieve Wing at the Women’s (Figures 4.42 and 4.43). These two examples were built in the latter quarter of the nineteenth century and presaged the prominence of the nurses’ home that occurred after 1900. The domestic form and setting however was not unique to the nurses’ home which reflected a general association of residences with hospitals at this time.

Figure 4.42 Bowen Home for nurses and maids built in 1897 at the Austin Hospital was domestic in its form and garden setting. Gault, 64.

---


4.6 Hospital grounds 1900-1918

After 1900 the changes in treatment approaches influenced the hospital site in two ways. Firstly, hospitals built operating theatres and surgical wings to house patients to meet the demand for surgery and to reduce debt. This increased the density of buildings on site as the sites themselves did not gain more land (Table 4.6).\textsuperscript{82} This had different implications for sites depending on their size and capacity to absorb the extra buildings within their existing site configurations and garden layouts. Secondly, the higher turnover of patients together with the increase in outpatient services linked to surgical aftercare meant that hospital sites became busier and less a retreat from the external world. In 1906 for example, the number of outpatients increased to over 20,000 at the Melbourne Hospital for the first time, directly as a result of the opening of the new operating theatre.\textsuperscript{83}

\begin{flushright}
\textsuperscript{82} Walker, C., \textit{op cit.}, (1998), 33.
\textsuperscript{83} Ibid.
\end{flushright}
Melbourne Hospital Sites and Grounds 1848-1918

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>Pathology Building</th>
<th>X-ray building</th>
<th>Theatre building</th>
<th>Out – patients building</th>
<th>Patient buildings</th>
<th>Nurses’ Home</th>
<th>Tennis Court</th>
<th>Boiler Stack</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melbourne</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Women’s</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Alfred</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Children’s</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x*</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Homeopathic</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Eye and Ear</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Austin</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>St Vincent’s</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Queen Victoria</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.6 New buildings built on Melbourne Hospital sites between 1900 and 1914. The persistence of verandahs and pavilion buildings indicated the continued significance of salubrity after 1900. The first tennis court was established on the Alfred site in 1900. Compiled from Annual Reports and hospital plans: author.
*Built in 1899.

Figure 4.44 The Alfred Hospital’s first tennis court was built in 1900 and emphasized the growing importance of nurses to the hospital. Alfred Hospital Archive.
The emerging importance of nurses was apparent in the number of nurses’ homes built and the first appearance of staff tennis courts at the Alfred, Melbourne and Austin hospitals (Figures 4.44). All hospitals constructed purpose-built nurses’ homes during this period. On sites with sufficient room these followed the usual pattern of recalling the solidity and respectability of a domestic residence or as Annmarie Adams has called it the ‘big house.’(Figures 4.45-4.47 and 4.50). This was the case at the Women’s, Homeopathic, Austin, Alfred, Eye and Ear and Children’s hospitals. The grounds of the Alfred nurses’ home were later noted for their prize dahlias whilst the immediate surroundings of the Marian Drummond Home were described as featuring:

…extensive plantings of mature trees towards the south east section of the site. Many trees are set in lawn, and date from the early history of the site. They include Himalayan Cedar (Cedrus deodara), Monterey Cypress (Cupressus macrocarpa), Desert Ash (Fraxinus oxycarpa), Brush Box (Lophostemon confertus), Pinoak (Quercus palustris) and Common Oak (Quercus robur). Also of note is a large Cotton Palm (Washingtonia robusta) and extensive Privet (Ligustrum ovalifolium) hedges near the south eastern entry area.84

Figure 4.45 Night nurses residence after it was newly built in 1909 at the Alfred Hospital. This was later surrounded by a domestic garden. Alfred Hospital Archive.

Figure 4.46 The Residency built at the Women’s Hospital in 1908 reflected the attributes of a domestic residence that were usually associated with accommodation for doctors and nurses in Melbourne before World War I. Nattrass (1972), 22.

Significant departures from the traditional association between the nurses home and middle-class residence and grounds were evident at the Melbourne and St Vincent’s hospitals.
Instead of a traditional family residence, the nurses here were provided with a multi-storey block built on the street without a garden but with flat roofs for nurses to use (Figures 4.48 and 4.49). In the case of *St Vincent’s* it could be argued that lack of room forced this decision upon them. In the case of the *Melbourne* site however, large parts of the hospital were re-built at the same time with traditional patient buildings set back from the street and surrounded by garden. The variation for the nurse’ building suggests that association of nurses with the traditional and conservative values of domesticity were changing.

*Figure 4.48* View of the nurses’ home of the Melbourne Hospital built in 1912. This was the first purpose-built nurses’ home in Melbourne not in the style of a middle-class domestic residence. Nurses could use the flat roof for recreation. SLVPC.

*Figure 4.49* 1914 three story nurses’ home at St Vincent’s was built at the same time as the Melbourne Hospital nurses’ home and shared the same characteristics of being built on the street and not reflecting a middle-class domestic residence. The ground floor was used for outpatients. The flat roof was available for nurses to use. St Vincent’s Hospital Archives
The boiler stack became a dominant feature of hospital sites and sky-lines (Figure 4.50). Although hospitals had laundry and furnaces, larger more powerful boilers with chimney stacks appeared as sterilization for aseptic surgery and dressings became accepted medical practice. *St Vincent’s* in its souvenir pamphlet for the opening of its new building in 1905 for instance, highlighted the new 80 ft chimney stack and ‘35 horsepower Multitubular Boiler’ as the latest technology from overseas for its new modern hospital buildings. 85 While *Melbourne Hospital* in its 1902 Annual Report commented:

A further considerable outlay has had to be incurred by the pressing necessity which arose for a new boiler. The boiler which served for kitchen and laundry purposes had been in use for over 25 years and was quite inadequate to the work required. The new boiler, in addition to adequately meeting all requirements for kitchen and laundry also provides for the heating of the Operating Theatre, and for effective and modern means of sterilization of Surgical Dressings.86

---

85 Anon. (November 5th, 1905). *St Vincent's Hospital, Melbourne. Souvenir of the Opening Ceremony.* Melbourne, 21.
86 *Melbourne Hospital. Year ending 30th June, 1901.* Melbourne: Melbourne Hospital, 5.
While such innovations resulted in new buildings and installations in the grounds, salubrity remained important. When *St Vincent’s Hospital* opened it’s new building in 1905, new garden areas were included and the souvenir pamphlet commented on views, elevation, fresh air and distance from the centre of the city (Figures 4.51 and 4.52):

It is one of the desiderata of a modern Hospital that there should be perfect drainage, air circulation, the site elevated, open to every wind that blows, and to the full glare of the sun. As St Vincent’s stands upon the very highest point of Melbourne, and is sufficiently removed from the Centre of the City to be free from surrounding high buildings, yet easily accessible by the various tram routes and only one mile from the G.P.O, it will be seen that the site is an ideal ones for the purpose in every aspect.  

---

**Figure 4.51** c.1910 Garden area of St Vincent’s Hospital adjacent to the verandah of the 1905 patient building. The grounds demonstrated a strong link between ideas of salubrity and the purpose of the hospital. St Vincent’s Archive.

**Figure 4.52** 1905. New buildings of St Vincent’s Hospital were designed with balconies and Promenade Roof and were surrounded by ornamental garden beds. The hospital faced the health reserves of Victoria Parade which contributed to the salubrity of the hospital Folding souvenir of Melbourne.

---

Anon. (November 5th, 1905). *St Vincent's Hospital, Melbourne. Souvenir of the Opening Ceremony.* Melbourne, 9.
Other hospitals continued to value a garden aesthetic and to build balconies, verandahs and pavilion buildings until 1922 (see Chapter Five).\textsuperscript{88} The \textit{Melbourne Hospital}, for instance, in 1913 after its architect J.J. Clark returned from an international study tour, reproduced the pavilion plan, including balconies, flat roofs and patient buildings set back from the street (Figure 4.53).\textsuperscript{89} The \textit{Alfred} also maintained large ornamental garden areas despite the extension of the outpatients and casualty departments at its entrance and access areas for cars (Figure 4.54).

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{image.png}
\caption{Melbourne Hospital site after its reconstruction in 1913 maintained elements of salubrity such as patient buildings set back from the street, garden areas and flat roofs which were intended to be used by patients and staff. University of Melbourne Archive.}
\end{figure}

\textsuperscript{88} The Alfred Hospital built the Edward Wilson Ward in 1922 which was the last pavilion hospital building built in Melbourne. See Chapter 5.

Figure 4.54 The front entrance of the Alfred Hospital around the period of World War I maintained its garden aesthetic despite renovations to the front entrance and the need to provide car parking on site. Alfred Hospital Archives.

Figure 4.55 Balcony of Queen Victoria Hospital was widened in 1910 to allow patients greater access to fresh air and sunshine. Queen Victoria Hospital 1913 Queen Victoria Hospital AR.
St Vincent’s and Queen Victoria included verandahs, balconies and flat roofs for patient and staff use. St Vincent’s promoted its ‘…Balconies on every floor, 8 ft wide and the full height of the storeys’ whilst the Queen Victoria Hospital widened and lengthened its verandah in 1910 for patient use (Figures 4.55). St Vincent’s flat roof, the “Promenade Roof” was widely promoted as providing patients an ‘uninterrupted view of the whole of Greater Melbourne.’ The Women’s and Children’s hospitals under pressure to provide more hospital beds introduced patient buildings close to the street in 1912, and 1903 and 1913 respectively. In both cases however, open balconies were also included giving fresh air and sunshine to patients (Figure 4.56).

Figure 4.56 1912 Postcard of Druid’s Wing of the Women’s Hospital built near the street in 1912, maintained balconies and small garden area as buffers to the street. SLVPC.

The grounds of the Austin Hospital also incorporated new buildings, including boiler stack and nurses home, but its identity continued to be linked with beautiful surroundings.

---

92 Women’s Hospital Annual Report. Year ending 30th June, 1913. Melbourne: Women’s Hospital, Gardiner, L., op cit. 78.
considered an important part of its treatment. Newspaper article continued to equate the grounds not only with fresh air and sunshine but solace and consolation for those unable to be cured. In 1916, a newspaper article described the grounds and the ‘sloping path by the hawthorn hedge..red with “haws”… garden, ablaze with late autumn flowers – roses and dahlias and cosmos… the lawn with the statue of Berenice. …’. Patients on balconies ‘command a beautiful outlook’, use tents on the lawn for recreation, point out flowers in the garden, describe ‘how beautiful the mists are at dawn’. Such emphasis on the salubrity of the grounds by newspapers paralleled with the appreciation by patients shows the importance of the site and grounds in the care of the incurable patients at this time (Figure 4.57).

Figure 4.57 Austin Hospital c.1900. The hospital was on an elevated site with extensive gardens and views across to picturesque rural countryside. These attributes of the hospital were routinely mentioned in connection with patient treatment. National Library of Australia.

4.7 Purpose and meaning of hospital grounds 1848-1918

The importance of hospital grounds for the purpose of salubrity and as a means of expressing civic pride and charitable endeavour dominated the period from 1848-1918. This

---

93 ATB. (October 7th, 1916). The Austin Hospital. The Argus.
was evident despite economic difficulties, increasing bed numbers and changing medical practice.

**Salubrity as medical science**

Analysis of hospital sites in Melbourne from 1848 to World War I reveals that the idea of salubrity was a scientific tenet of treatment for this period, where ventilation, light, views and a garden aesthetic were considered part of medical treatment. Although hospital sites shared salubrious characteristics with other charitable institutional sites of the period, the presence of covered ways and verandahs and importantly, the way hospital sites were spoken about and used, revealed a medical purpose for hospital grounds.

The mechanism by which salubrity was thought to cure patients was linked to antiseptic qualities of fresh air and sunshine but as importantly, to the effect of beautiful surroundings on the mind. Jennings Carmichael, a nurse from the *Children’s Hospital* identified ‘cheerfulness’ as one of the most important attributes for a nurse that engendered hope and prevented a ‘depressing moral atmosphere’ that was detrimental to the patient.⁹⁴ This was a widely held medical belief of this period as the official journal of the British Medical Association, the *Australian Medical Journal* makes clear:

…The bare unsuggestive walls of the hospital wards are in the last degree depressing to those who are compelled from day to day to look upon nothing but unpractical whitewash….Nobody of any intelligence pretends to deny how much a cheerful condition of mind promotes the health of the body, and helps to overcome disease…⁹⁵

Ideas of the site and salubrity went beyond elevation and access to breezes. Attributes that were believed to contribute to psychological well-being was also considered. For this reason, views and beautiful surroundings were important as they were linked to psychological benefit for patients. For example, *The Argus* newspaper’s report on the opening of the *Women’s Hospital* cited at length the desirable attributes of the hospital in terms of views, ornamental gardens and proximity to the university gardens:

---

One of the chief recommendations of the hospital is the beauty and salubrity of its situation. As it stands opposite to the University Gardens no building can encroach upon it in front, and from the windows above a splendid prospect extends uninterruptedly towards Ballarat and Mount Buninyong. An additional half acre on either side of the original ground having been granted by the present government, the detached character of the building, which adds much to its value, is effectually preserved; and when the ground is planted, which we understand is proposed to be done, the site will not be unworthy of its more imposing neighbour opposite, the University. 96

Other publications also associated scenic attributes with best qualities associated for a hospital. The location of the Children’s Hospital facing Carlton Gardens was described as ‘admirable’ and ‘views of extraordinary extent and beauty may be obtained’ from the upper windows of the Homeopathic Hospital. 97 The description of Alfred Hospital also emphasized aesthetic factors such as views, the setting of the buildings back from the street, garden areas and extensive tree planting:

…the situation is healthy and pleasant, extensive views all round being visible from the windows and balconies, and doubtless this fact combined with the quietness reigning around contributes greatly towards the speedy recovery of the patients. 98

The inclusion of salubrity as part of hospital treatment was related to a cultural belief in the power of nature to restore and heal, as is evident in the many references to gardens and nature in descriptions of hospitals in popular publications. 99 The illustration of the Children’s Hospital in the Illustrated Australian News for example, depicted a sick child sheltering on the verandah amongst garden and pot plants with a solicitous nurse (See Figure 4.58). The garden, well-ordered plants, fresh air and sunshine were used to promote the hospital to the public because they were seen as a legitimate treatment for illness. The association between garden and the hospital still persisted in 1906, when popular tourist guides continued to mention the

99 See Chapter One.
‘good orchard enclosed in high brick walls’ although this had long been demolished by previous building programs.\textsuperscript{100}

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{convalescent.jpg}
\caption{Caption ‘Convalescent A sketch at the Children’s Hospital’. Illustrated Australian News, 1881 6\textsuperscript{th} April. These types of illustrations which promoted the hospital and its treatment in terms of fresh air and gardens, underscored its identity as a place associated with these elements. SLVPC.}
\end{figure}

The grounds of the \textit{Melbourne Hospital} in another example, are described in the 1879 tourist publication, \textit{The Guide to Melbourne and suburbs}, as ‘a large shrubbery and garden with neatly-kept walks [are] reserved for the use of convalescing patients, to whom fresh air and gentle out-door exercise are desiderata, and in the 1888 publication \textit{Victoria and Its Metropolis: Past and Present}:\textsuperscript{101}

The front of it is still a green spot in the heart of the city, fresh with sward and leafy trees, but behind these what a cluster gathers of those dark-red buildings, all gables and angles… Here in the breezy quadrangles we see the convalescents, whose wounds are healing after the ordeal of the surgeon’s knife; or whose emaciated features are beginning to gather a little flesh after that critical struggle which the clinical folks up there have lately waged with death, gaining perhaps but the barest victories. Out here they are renewing again the joys of living – for the air is balmy in this bright spring morning, and the

\textsuperscript{100} The Melbourne guide book, op. cit., (1906), 56.
\textsuperscript{101} The Guide to Melbourne and suburbs, op. cit., (1879), 19.
buddling trees are pleasant to look on, and the ceaseless twitter of sparrows in their branches and up on the eaves must be a perfect dream to those who have been long-a-bed, counting the same cracks in the wall, and recording the monotonous hours as they sounded from the Post Office tower. Now they are happy out in the open air, with nothing in the world to do but gather an appetite for the next meal.  

The images accompanying this text represent the garden as a park-like setting with trees and seats with little indication of its location in the middle of the city (Figure 4.59). Elsewhere in the publication other hospitals are described as if part of a large semi-urban setting, populated by civic buildings, parks and gardens, removed from the pollution and moral threat of the city. The Alfred Hospital is placed in the context of the ‘breezy extent of Albert Park’, the Homeopathic Hospital as one of many important buildings on St Kilda Road

---

102 Sutherland. *Victoria, op. cit.*, (1888), 556-557.
which cannot be ‘easily seen, so thick are their arboreal surroundings’, whilst the ‘picturesque structures’ of the *Women’s Hospital* were associated with the abundant foliage of the Melbourne University grounds across the road.\(^{103}\)

The linking of hospital sites to natural elements such as parks, orchards, birds, trees to the exclusion of the city in popular publications, exemplifies the anxieties about the role of industrialization in the moral and physical decline of the population. As discussed in Chapter One, the industrial city was widely held to be responsible not only for illness and disease but the erosion of moral values, as people were separated from nature and forced to live in the polluted and overcrowded built environment of the city.\(^{104}\) In this context, salubrity, particularly the experience of the garden and park landscape addressed the ills of the city and restored patients to a relationship with nature that was considered therapeutic.

This belief was particularly prevalent for the treatment of children and incurable patients who were envisioned to be victims of physical and moral contact with the crowded and unnatural city. The location of the *Convalescent Cottage* and the way it was spoken about makes apparent that the site was valued not only for its fresh sea air but for its distance from the factories and foul air of Melbourne.\(^{105}\) Lyndsay Gardiner in his history of the *Children’s Hospital*, attributes the establishment of a separate children’s convalescent site to a desire to remove the children from ‘the evil moral influences’ to which they were exposed in inner urban hospitals and to provide a healthful environment away from the ‘squalid or at best penurious conditions from which they came’.\(^{106}\) Mary Grant Bruce in 1909 in another example, writes of the *Convalescent Cottage* ‘close to the clean, wind-swept shore… [which] to many slum children has spelt a glimpse of paradise’.\(^{107}\)

The landscape of the *Children’s Cottage* was perceived to provide an experience of the natural world that would in some way compensate for illness. Slum children were viewed as

\(^{103}\) Sutherland, *Victoria*, *op. cit.*, (1888), 556-557, 573.


\(^{107}\) Quoted in Gardiner, L. *op. cit.*, (1970), 61.
disconnected from nature and missing an essential experience of childhood in the city. The landscape not only provided a physical cure through fresh air and sunshine but also a moral cure for a missing childhood. This is articulated by Jennings Carmichael in her account of the Children’s Hospital. She describes at length the beauties of the natural world her patients had been deprived of in the city ‘without any knowledge of the colour and the shapes of nature, imprisoned amid the glamour and dirt and disease of an overcrowded city’ and links this with a stunted appreciation of beauty that she considered damaging to the child. The landscape of the Convalescent Cottage on the other hand connected the deprived child with the nature that was lamented as a missing element of the typical patient’s experience.

**Figure 4.60** Austin Hospital for Incurables as depicted in 1888 McCarron and Bird promotional publication of Melbourne, emphasized the rural aesthetic of the site and patient use of the grounds. Sutherland (1888), 570.

In the case of incurable patients, the Austin Hospital site was linked through description of its setting and visual image with the landscape of a rural idyll, which in turn was a solace for those sick poor who were without hope of cure. The Argus newspaper in 1886 referred to its rural location and its distance from the ‘outer world’, with a view from the steep entrance path of ‘a wide expanse of hill and dale… and the hillside flecked with farm and

---

hamlet’ (Figure 4.60). Similarly, in 1916 the site was described by reporter ‘ATB’, as redeemed as a ‘place of hopeless sorrow’ by its beautiful surroundings with ‘folds of dreamy blue hills’ and beautiful mists at dawn, as ‘they roll along the valley like a sea.’ In keeping with the idea of the transcendental power of the surrounding landscape, Heidelberg, the location of the Austin Hospital, is described in Victoria and its metropolis: past and present in similar romantic language emphasizing the comparative freshness of its location to the ‘squalor and destitution’ of the city:

Let us cross the Yarra by the long wooden bridge which leads to Heidelberg, and see that pretty suburb, lying in picturesque seclusion in its little hollow; its old-fashioned church, its quaint old inn, its orchards daintily white with blossoming fruit trees, will make a pleasant impression on our visitor. A visit to the Austin Hospital for Incurables should be managed if he does not feel the prospect too depressing of seeing so many sad hearts waiting the hour of doom, expectant of the mortal grasp of that somber monarch to whom we must succumb. Yet, as we view from afar the building with its wholesome and cheerful surroundings, we shall doubtless offer our tribute of gratitude to the kind-hearted lady who made it possible for the poor, when mortally stricken, to die out here in brightness and comfort rather than in lanes with no surroundings but squalor and destitution.

Despite the new medical treatments and associated building after 1900, salubrity was still articulated in medical circles as important to hospitals. International hospital experts such as William Milburn, whilst acknowledging that the discoveries of Louis Pasteur had shifted the focus of disease transmission from air-borne particles to that of direct contact, still included salubrity in his assessment of hospitals. Speaking before the Royal Institute of British Architects in 1913 for instance, Milburn notes that the modern hospital treatment after Pasteur was now based on scientific principles which included ‘fresh air, sunlight, environmental diet, and rest.’ He comments favourably on sites for new hospitals in

110 ATB. (October 7th, 1916). The Austin Hospital. The Argus.
111 Sutherland, J., op. cit., (1888), 569.
112 Ibid.
114 Ibid., 283.
Germany, ‘which are usually most excellent in all respects, being generally in the suburbs or adjoining large open spaces, whilst the attention given to the lay-out of the grounds is most remarkable.’\footnote{Ibid., 290.} Further:

There are numerous other suggestions in design, construction, heating, and ventilation, which one can obtain from a study of Continental and American hospitals, but I will not say more at present time than to suggest that we might emulate the Germans in the provision of grounds and gardens. The value of environment as an important factor in the treatment of disease is, I believe, well recognized, and when one has seen the lay-out of the grounds and gardens in such hospitals as those of Berlin and Cologne, one cannot help but contrast them favourably with the majority of our own institutions.\footnote{Milburn, W., op. cit., (1913), 301.}

These sentiments were echoed by Dr. John N.E. Brown, Superintendent of Detroit General Hospital and Secretary of the American Hospital Association, who also extolled the virtues of German Hospitals because of the ‘extensive grounds….beautiful parks; trees and gardens surrounded the pavilions.’\footnote{Brown, J. N. E. (April 1913). A comparison between German and American Hospital Construction. The Brickbuilder, 22(4), 73.} He goes on to describe the patients using the grounds, sitting under trees, ‘remote from the dust and din of traffic.’\footnote{Ibid.} American architect, Edward Stevens had similar comments to make of continental hospitals in his 1918 book on recommendations for American hospitals, highlighting the green lawns, the widespread use of garden seating and expressing approval for seeing patients ‘enjoying the green grass and flowers, and chatting with one another.’\footnote{Stevens, E. F. (1918). The American hospital of the twentieth century: a treatise on the development of medical institutions, both in Europe and in America since the beginning of the present century. New York: Architectural Record Publishing Company, 228.} Despite the introduction of new medical treatments ideas of salubrity and the garden in particular, as important in patient treatment continued as orthodox medical opinion before World War I.
Hospital grounds as charitable institutions

Hospitals as charitable institutions consistently presented a well-ordered facade to the public as a way of legitimizing their credibility as sites worthy of public donation and pride. The public took pride in charitable sites and looked to their physical appearance as verification of public monies well spent and proof of the enlightened generosity of its citizens. By 1899 The Standard Guide to Melbourne for example, still referred to charitable institutions and ‘the noble response to the repeated claims for assistance’. Hospitals continued to be routinely included in tourist publications as emblems of civic pride into the twentieth century. As a harbinger of the changes in hospital funding that occurred after World War I however, the publication also proposed that new ways of financially supporting these institutions needed to be investigated as well as public donation.

The 1894 Tramway guide to Melbourne and suburbs for instance, recommends that charitable institutions be visited to ‘learn how well public money is expended and how much good is done with it.’ The site characteristics of the charitable institutions parallel those identified by David and Beverlie Sloane as typical of domestic residences, representing ideas of order and control. The form of the garden, in particular manifested the idea of institutional respectability.

Order and beauty of surroundings was offered as a method of projecting values of order and control on charitable inhabitants. Patients from environments considered dangerous physically and morally by middle and upper class supporters of hospitals, were to be positively influenced by traditional domestic values as represented by the garden. The grounds in this paternalistic sense could be read as a civilizing influence in which the ordered garden

---

120 Smith, op. cit., (1899), 48.
122 Ibid.
aesthetic, together with the buildings recalled a domestic site and the moral influence of the family in promoting civic virtues of order, rectitude and work.

The shaping of behaviour through association with a domestic aesthetic was considered not only possible but a desirable purpose for the hospital. Hospital sites demonstrated this as did publications at the time as exemplified by St Vincent’s Hospital at the opening of its new buildings in 1905:

And we may further look to these buildings to have an educational effect, for these have the authority of Ruskin, the great apostle of art – “To build to last, and build to be beautiful’ The influence of environment on life and character is subtle, real, and strong, and we look to the cleanliness, cheerfulness, and brightness of the Hospital following the patient, and stimulating him to take on grace, to improve his too often dreary home…”

In her history of the Homeopathic Hospital, Jacqueline Templeton describes the necessity to instruct patients on appropriate behaviour in hospital surroundings. These rules ‘forbade patients to play at gambling games, to swear, to use abusive language, to deface the walls, to damage the furniture, to smoke without leave or to mix with the opposite sex.’

The clear implication is that patients were unused to the genteel environment provided by the hospital and were given clear guidelines as to how to moderate their behaviour. The Homeopathic Hospital was considered a grand building at the time of construction with ‘[D]eep verandahs with magnificent cast-iron lacework’ which overlooked ‘the particularly fine grounds landscaped by the Director of the Botanic Gardens and planted with pines, cypresses, oaks, poplars and pittosporums.’ The form of the hospital grounds was the means by which cues were provided for behaviour of the patients who came from far more humble residences than the hospital itself. The grounds suggested that as residents of a fine stately home behave in a civilized stately manner so to the patients who occupied this stately hospital were similarly expected to behave in a civilized manner.

The hospital grounds were also places that demonstrated as well as represented philanthropy and patronage. The community strongly identified with charitable hospitals which were associated with social networks and the undertaking of philanthropic work by private citizens, an important social obligation in the Victorian era. Ladies Auxiliaries were examples of the personal interest in hospitals, whilst the community’s sense of ownership was evident in subscription and gifts-in-kind lists in annual reports and the reporting of fundraising activities in the popular press. Citizens took a personal interest in the appearance of the hospital with donations of garden material and changes in the ornamental grounds reported in newspapers and annual reports. In 1862 for example, the Women’s Hospital Annual Report noted the donation of plants and shrubs to the hospital by Professor Von Mueller, Director of the Botanic Gardens and Redmond Barry, both prominent citizens of Melbourne. Further examples include the Report of the Monthly Meeting of the Homeopathic Hospital in The Argus newspaper which records the intention of ‘laying out and planting of the grounds surrounding the institution’. The Alfred Hospital, routinely listed donations of trees, shrubs, seeds, bulbs, plant and rose cuttings in annual reports before World War I. Hospital grounds provided a personal connection to the hospital that was predicated on the charitable nature of the institution.

Conclusion

Hospital sites and grounds in Melbourne between 1848 and 1918 evolved as a result of medical beliefs in salubrity and cultural and paternalistic attitudes to landscape as an antidote to disease and moral decline. Ideas of civic virtue were also influential. These factors determined their location and physical appearance and were tied to a wider cultural belief in

128 For instance see obituary of Mrs David Syme, well-known society figure married to a prominent businessman who was strongly associated with the Austin Hospital. Anon. (August 31st, 1915). Death of Mrs. David Syme. The Age.
131 Women’s Hospital Annual Report. Year ending 30th June, 1862. Melbourne: Women's Hospital.
133 The Alfred Hospital routinely listed donations of plants and garden material in its annual reports. See for instance Alfred Hospital Annual Report, 1875, 4, 1884, 14, 1910, 16, 1912, 5.
the capacity of landscape to provide moral, psychological and physical benefit. The association of charitable institutions with respectable middle-class residences influenced the hospitals appearance as is evident in the similarities of hospital grounds with other charitable institutions such as the Benevolent Asylum. Purpose-built nurses’ homes were relatively rare before 1900 but in cases where they were built they too resembled traditional domestic house and grounds Hospital grounds differed from other charitable institutions however in having covered ways and verandahs specifically built for patient use and treatment.

After 1900, hospitals grounds changed as a result of the new medical treatments that introduced increased patient populations and associated buildings. Continued use and building of verandahs and covered ways together with maintenance of gardens however, indicate that ideas of salubrity were important despite the new medical technologies and practices. At the Children’s and Women’s hospitals, patient buildings were built close to the street, albeit with small gardens as buffers and open balconies. The fact that this happened on smaller sites indicates that this was driven by expediency rather than preference. The most significant change after 1900 was the building of two multi-storey nurses’ homes without a garden setting in the style of office blocks rather than as a traditional home set in gardens. This was the first indication of a breaking with the traditional association between the residential landscape and the hospital usually associated with nurses.

Although the period after 1900 introduced some changes, the hospitals where possible maintained a residential aesthetic with gardens and external grounds for patient use. This was particularly true for The Austin and Alfred sites which maintained a strong link with a residential garden and grounds. As large sites these were able to build new buildings and maintain garden beds, trees and shrubberies. This again indicates the persistence of ideas of salubrity and the hospital as refuge despite new medical treatments.
CHAPTER FIVE
MELBOURNE HOSPITAL SITES AND GROUNDS 1919-1948

5.1 Introduction

This chapter argues that changes to hospital grounds after World War I indicated changed purposes for hospital landscapes. The adoption of modernist architecture was one factor that influenced hospital sites but this oversimplifies the process by which one idea of landscape gains ascendancy over another. Other ideas such as the impact of reduced bed stays, economic pressures and lack of land similarly do not fully explain these changes. Instead it is argued that whilst these had an influence, other cultural factors determined the appearance of the grounds. These had to do with the changing identity of the hospital and a new understanding of the role of hospital landscapes in treatment.

Heliotherapy as a post-World War I version of salubrity, with its ‘scientific’ rationale of efficacy is implicated in changed attitudes to hospital landscape. Although, salubrity is generally considered to have waned in influence, it is argued in this chapter that instead, its emphasis had changed. It is this change in emphasis that reveals a changed attitude to the role of landscape in human health and a changed identity of the hospital. Salubrity as a treatment approach that involved fresh air and sunshine remained part of orthodox medical treatment. The third component of salubrity however, namely exposure to beautiful surroundings lost importance. This is in contrast to the period before World War I and particularly before 1900, when the garden and its surroundings were promoted as an important element of the hospital,
important in patient treatment. The hospital had moved from a residential house and grounds to a place of scientific purpose in which treatments that were ‘scientific’ were now acceptable. This to some extent explains the continued emphasis on sunshine, now medicalized as heliotherapy, but the neglect of psychological benefits of garden surroundings not scientifically proven beneficial for patients. Under this rationale, balconies and flat roofs were retained for heliotherapy treatment but gardens and outdoor grounds for exercise and the lifting of morale became redundant. This was not true for all sites. Variations between attitudes to salubrity are shown to be related to type of patient, hospital and site which again indicates the role of scientific purpose in determining hospital landscapes at this time.

This chapter also examines the argument of Annmarie Adams that the exterior aspects of hospitals and old-fashioned gardens disguised technological advances happening within the buildings that were viewed with fear and mistrust by patients as ‘too sterile or too scary’. Although Adams argues that this was a design intent of hospital architects in the interwar period in North America, the evidence of this chapter suggests that this was not the case in Melbourne. In contrast, The Alfred Hospital as early as 1921, purposefully adopted a modernist aesthetic for its grounds despite its nineteenth century pavilion buildings. The grounds identified the Alfred as a modern hospital, and were promoted in these terms. Instead of the hospital presenting a reassuring domestic aesthetic to reassure patients of its merit, it removed trees, shrubberies and ornamental garden beds to confirm its competence. Providing refuge and psychological benefit to the patient through a traditional nineteenth century garden aesthetic were losing currency.

Context for the development of these arguments is provided by an overview of hospital bureaucracies from individual boards to a single government department which formally signaled the end of the hospital as charitable institution. The impact of changes in medical treatments and patient and staff populations on hospital sites is included as part of the analysis. This is followed by a discussion of the way in which modernism was viewed and promoted in relation to hospitals in Melbourne and the impact of this is also evaluated. Then hospitals sites

and grounds are examined in detail to see what happened during the period from 1918 to 1948. Finally, this evidence is used to discuss changing attitudes to hospital landscapes and the impact of modernism.

5.2 From Charity Board to Hospital and Charities Commission

The government intention to take over the administration of hospitals from individual hospital boards gained momentum after World War I. St Vincent’s Hospital Annual Report in 1919 presaged the changes:

The present popular movement is towards making hospitals official institutions, financed wholly by the State Treasury, and managed wholly under official supervision.²

Any interference of government in the management of the hospital however, other than providing financial funds was deeply resented by doctors and incumbent hospital managers.³ The idea of the Labour government to ‘provide free medicine and surgery for the masses’ and nationalize the hospitals was seen as an attack on the professional practice of doctors and detrimental to the purpose of hospitals for the ‘sick poor’.⁴

Change was driven by the government’s conviction that organizing hospitals under one government board would control spending and provide more efficient and streamlined services for patients. The Hospitals and Charities Act of 1922 and 1928 formalized the consolidation of hospital bureaucracies with the creation of Charities Board of Victoria.⁵ These changes met with strong objections from individual hospital boards who among other criticisms objected to the proposal that a new Director of Charities, a government bureaucrat, would attend all hospital board meetings.⁶ Public interest and donation it was argued, would be withdrawn from hospitals which would be seen no longer as charities but a government department. The changes however, continued and the 1948 Hospitals and Charities Act, illustrated the

---

² St Vincent's Hospital Annual Report. Year ending 30th June, 1919. Melbourne: St Vincent's Hospital.
increasing dominance of government bureaucracy at state level. The 1948 legislation replaced the 1922 Charities Board of government officers and hospital representatives with a three man committee of government bureaucrats, thus officially marking the conversion of hospitals from charity organizations to government departments.\(^7\)

The new Hospitals and Charities Commission had overall responsibility for hospitals across the state with aims which included standardization of nursing staff qualifications, promotion of Administrative Training Scheme, allocation of hospitals for nursing training, establishment of a central Bureau to rationalize patient admission throughout the hospital system and the introduction of a collective buying system for standard equipment.\(^8\) All these functions which had been the responsibility of individual hospitals before World War I and had allowed for individual preference and practices were now systemized and centralized. Importantly, hospitals now had to apply for building approval to the Commission who had powers to build and expand hospitals.\(^9\) Although bureaucrats approached ‘[S]suitable organizations….to acquire properties and establish homes with financial aid granted by the Government on the recommendation of the Commission’, the era in which hospitals were created by the efforts of a small group of prominent citizens was past.\(^10\)

Under this new system, the commission report listed nine new hospitals and extensive building programs on existing sites in 1950-51.\(^11\) These new sites represented the first hospitals established in Melbourne since \textit{Queen Victoria Hospital} in 1899.\(^12\) Bureaucratically, the hospital had moved from a personal and idiosyncratic administration in which individual boards wielded strong influence over patient admission, nursing training, hospital building schemes and staff standards to a centralized system aimed at standardization and uniformity across hospital sites.

\(^11\) Ibid.
\(^12\) Ibid., Table 8.
5.3 Patients, nurses and medical treatments

The traditional users of the public system, that is the ‘sick poor’, the objects of charity, had also changed with the shift in attitudes to hospitals that legitimized the sites for middle class patients in the 1920s. Pressure to provide private hospital accommodation had been gaining momentum since the beginning of the century as increasingly hospitals were seen by the middle classes as preferable places for treatment compared with the family home or small private hospital. In 1901, only two Victorians in 100 were in-patients in public hospitals, in 1913, there were three in 100, and 1921 nearly five and in 1931, nearly six.\(^{13}\) So although prior to World War I, the Victorian Government had constantly reiterated that the purpose of charity hospitals was for charity patients, by the 1920s, the government had embraced the concept of private patients on public hospital sites.\(^{14}\)

Such growth in public hospital admissions outpaced the growth of Victoria’s population and indicated the increasing acceptance of hospital treatment to broader groups in the community.\(^{15}\) The government wished to maintain a clear distinction between public and private patients however, and provided funding for construction of private wings or buildings for private patients on the understanding that the hospital staffed and funded all running costs.\(^{16}\) This meant that private patients were to be accommodated in buildings separate from public patients termed ‘intermediate’ or ‘community hospitals’. This was to have implications for the grounds of public hospital which now had to accommodate a separate building for intermediate patients alongside the buildings for public patients. By 1944 under this change of emphasis, there were five intermediate hospitals on public hospital sites: St Vincent’s Maternity Hospital, Jessie MacPherson Intermediate Hospital (Queen Victoria Hospital), Hamilton House and Margaret Coles Wing (Alfred Hospital) and Heidelberg House (Austin).\(^{17}\)

---


\(^{15}\) Inglis, K. S., *op. cit.*, (1958).


\(^{17}\) Ibid., 6435/P0000/60.
The accelerating rate of change to medical and hospital practices that had begun at the end of the nineteenth century was also a hallmark of this period. By the 1940s, these changes were widely recognized and summarized in *The Medical Journal of Australia* as follows:

> It goes without saying that during the last fifty years hospitals everywhere have found themselves increasing in complexity. The older subdivision into medical, surgical and maternity sections is no longer sufficient. Specialty after specialty has demanded its own wards and equipment; the kitchen is evolving into a scientific dietary department under a trained dietician; the nurses’ quarters have become almost a residential college, with preliminary training schools, lecture rooms and permanent tutors; the medical records department has become an elaborate statistical bureaus; routine laboratory work now requires a staff of trained scientists and technicians.18

One of new medical treatments that influenced hospital site development after World War I was heliotherapy. *The Medical Journal of Australia* featured an article on heliotherapy or sun treatment in 1924 based on the work of Dr. Rollier at Leysin, Switzerland in which therapeutic benefits of the sun are explained in relation to cure of ‘surgical tuberculosis and ricketts’.19 The article described open balconies, solariums, sun baths and the importance of physical exercise while exposed to the sun, including the example of nude skiing, with images of dramatic improvement of patient’s conditions who had undertaken the cure. Heliotherapy was similarly accepted in Victorian hospitals as a scientific cure for tuberculosis, rickets, polio, wound septicemia and general undernourishment and hospitals integrated this treatment within hospital sites.20

The return of soldiers from World War I led to an increased incidence of Venereal Disease which also impacted on hospital sites. Treatment of syphilis had improved with the introduction of mercury and then salvarsan and other arsenical drugs since 1900, although

---

gonorrhea remained a problem in treatment options until the introduction of antibiotics.\textsuperscript{21} With this potential way of restricting the spread of sexually transmitted diseases, public health authorities introduced the \textit{Venereal Diseases Act} in 1917 which required hospitals to provide ‘effective provisions for all persons suffering from Venereal Diseases.’\textsuperscript{22} The Public Health Department provided funding for a number of buildings on public hospital sites to treat the disease, which led to the \textit{Melbourne, Alfred, Children’s} and \textit{Queen Victoria} hospitals introducing new buildings.\textsuperscript{23}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure5_1.png}
\caption{Numbers of beds and nurses in Melbourne metropolitan hospitals from 1890 to 1950. The sharp increase in both nurses and beds after World War I reflected the increasing professionalization of hospital treatment and wider access of hospital treatment to broader sections of the community. The bed numbers included both public and private patients on public hospital sites. Graph based on statistics provided in Charitable Reports in Victorian Parliamentary Papers in 1890, 1900, 1910, 1920, 1930, 1940 and 1950. Compiled: author}
\end{figure}

The numbers of beds and nursing staff on individual hospitals sites also increased significantly across this period. Figure 5.1 makes evident the sharp increase of both hospital

\begin{flushright}
\textsuperscript{21} Yule, P., \textit{op. cit.}, (1999), 139.
\textsuperscript{22} Anon. (December 29th, 1917). Treatment of Venereal Disease. \textit{Medical Journal of Australia}, 55.
\end{flushright}
beds and nursing staff on hospital sites after World War I. This is particularly significant since the increase in nurses and beds was accommodated on existing sites which put pressure on land and garden areas. The number of people and buildings resulted in congestion and complexity on hospital sites which now not only catered for more people but a greater variety of services and treatments.

![Graph](image)

**Figure 5.2** The numbers of paid staff on Melbourne hospital sites after World War I increased as the complexity and variety of medical treatments required more people. Types of staff had expanded and diversified beyond that of nursing and doctors. Graph based on statistics provided in Charitable Reports in Victorian Parliamentary Papers in 1900, 1910, 1920, 1930, 1940 and 1950. Compiled: author.

The hospital as a workplace became increasingly professionalized with the formalization of nursing training induced by initiatives such as the *Nurses’ Act* of 1923 which established training standards and registration of nurses. By 1941, nurses’ wages, hours of work, recreation facilities and general conditions had steadily improved to support the status of nursing in order to attract ‘suitable girls’. Increasingly, hospital sites supported more and

---


25 Arden, *op. cit.*, (November 8th, 1941), 535.
more staff from diverse disciplines who in turn required work spaces and accommodation (Figure 5.2). New professions to the hospital included dieticians, almoners and physiotherapists. Professional medical administrators also emerged at this time, usually as medical doctors trained in the new discipline of medical administration to manage the increasingly complex organization of the hospital. An added factor in the complexity of the hospital sites was the increase in outpatient services after World War I which necessitated increased and new facilities for outpatients (Figure 5.3). The combined of all these changes to hospital grounds was a fundamental shift in the nature of the hospital as a place removed from the outside world to a public facility open to the general public.

![Out-patient Attendances 1890 -1950](image)

**Figure 5.3** Outpatient attendances of Melbourne hospitals 1890-1950 showing a sharp increase in outpatients on hospital sites in the years after World War I. Graph based on statistics provided in Charitable Reports in Victorian Parliamentary Papers in 1890, 1900, 1910, 1920, 1930, 1940 and 1950. Compiled: author.

Average bed stays remained relatively stable for inner-urban hospitals with a decrease in hospitals stays of six days in the fifty year period from 1900 to 1950, form 21 to 15 days (Figure 5.4). Arguments that hospital grounds became less important after World War I as hospital stays rapidly decreased is not supported by these figures. The outer urban site of the

26 Almoner was the original name for social worker in hospitals in Melbourne; Anon. (June 21, 1941). Hospitals and their Executive Officers. *The Medical Journal of Australia*, 2(25), 761.
Austin Hospital with its long-term patients also experienced a decline during this period, falling from 124 days in 1900 to 37 days by 1950.\textsuperscript{27}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{average_bed_stay_melbourne_hospitals_1890-1950.png}
\caption{Average length of bed stays in Melbourne remained relatively stable after a sharp decline around 1900. Figures compiled from Charitable Reports, 1890, 1900, 1910, 1920, 1930, 1940 and 1950: author.}
\end{figure}

By the end of World War II, hospitals in Melbourne had evolved from places of free medical treatment for the ‘sick poor’ to institutions that balanced the needs of public patients with those of private patients. The private patient system was viewed by both government and hospital boards as a commercial opportunity which injected extra funds into the hospital, whilst at the same time meeting middle class demand for hospital services. Social attitudes had also changed so that hospital treatment for the general population was seen as a logical use of new scientific medical treatments. These views are encapsulated in comments by influential American hospital expert Dr. Malcolm T. MacEachern during his visit appraising Victorian hospitals at the request of the Victorian Government in 1926/27.

At present the Victorian public hospitals are limited in their service to the supposedly necessitous type of patients. Patients who can afford to pay more than the per diem charge are expected to go to one of the numerous private hospitals in the State, where they may have the privilege of the selection of their own accommodation and doctor, but invariably are deprived of the scientific equipment and facilities and trained personnel so necessary in diagnosis and treatment. Can we today, in the light of the modern science of medicine, conceive of any hospital being run without competent personnel, adequate physical plant and equipment, and organized medical staff, case records, laboratory, and X-ray service? It is not doing justice to the patient, whose life frequently hangs in the balance, with very little required to turn the tide one way or the other, to be subjected to these conditions.\(^{28}\) (original bold type).

This was a change from the identity of the hospital before World War 1 when the patients were viewed as objects of charity and the hospital site as an extension of that charity reflected benevolence and philanthropy. Instead, hospital sites after World War I were identified with the ‘modern science of medicine’ and the emphasis became focused on medical interventions inside the buildings such as surgery and radiology.\(^{29}\) The grounds were viewed as a place in which to fit ‘scientific equipment and facilities’ and ‘adequate physical plant equipment’ rather than a place for the purposes of patient nurture and cure.\(^{30}\)

### 5.4 Hospital sites and modernism

After World War I Victorian health officials increasingly looked to America for models of hospital development, rather than to England which had been the previous dominant influence.\(^{31}\) America with its model of public, private and intermediate beds was seen as more relevant to the Australian situation by government bureaucrats and architects.\(^{32}\) In 1926 for instance, Inspector of Charities, R.J. Love and Professor R.J.A. Berry of the University of Melbourne undertook a tour of Canadian and American hospitals to study hospital

---


\(^{29}\) Ibid.

\(^{30}\) Ibid.

\(^{31}\) Inglis, K.S., *op. cit.*, (1958), 180. England at this time was mainly concerned with reformation of its poor law infirmaries, a system which had not been implemented in Australia.

\(^{32}\) Ibid., 180-181.
This led to proposals based on the American medical complex, such as the removal of the *Eye and Ear Hospital* to join with other specialist departments in forming an extensive comprehensive medical centre on the *Royal Melbourne* site.\textsuperscript{34}

The visit of Dr. Malcolm T. MacEachern in 1926 is a further indication of the influence of the American concept of hospital design in Victoria. Dr. MacEachern visited all metropolitan and selected regional hospitals in the state in order to give advice to the Victorian Government on future hospital management and construction.\textsuperscript{35} Interviews, remarks, lectures and his final report tabled in the Victorian Parliament were widely reported in the popular press and medical literature, and his lectures were attended by hospital administrators, architects and doctors.\textsuperscript{36} MacEachern articulated the key indicators of post- World War I hospital development as including: the professional hospital administrator, standardization of administrative procedures, medical records and ancillary services such as dietician, social worker, physiotherapist, professionally trained nurses, scientific medicine including analysis and research which included pathology, radiology, metabolic investigations and inclusion of private patients on public hospital sites.

The efficient and functional modern hospital promoted by MacEachern and built in Melbourne was International modernist in design and was clearly identified as such. International modernism in hospital design was promoted as a metaphor for scientific, technical and medical progress in Australia. This is evident in a prominent advertisement in the publication *The Australian Modern Hospital*, which itself was based on the influential American publication *The Modern Hospital* (Figure 5.5). ‘Australia’s Leading Hospitals’ as identified in the *The Australian Modern Hospital* were International modernist hospitals, with


\textsuperscript{34} See Gardiner, L. (1968). *The eye and ear: the Royal Victorian Eye and Ear Hospital centenary history*. Melbourne: Robertson and Mullens, 10-12, for a description of this proposal.


multi-storey buildings expansive lawn areas, minimal ornamental planting and direct access from the street.  

Australian architects travelled extensively at this time to view hospitals design and constructions with America as a prominent model and source for ideas.  

Architectural firms such as Stephenson and Meldrum (Jessie MacPherson Community Hospital, St Vincent’s) and then Stephenson and Turner (Royal Melbourne Hospital, Frankston Orthopaedic Hospital),

---

Irwin Leighton (*Prince Henry's Hospital*) and Yuncken, Freeman Brothers, Griffiths and Simpson (*Heidelberg House - Austin Hospital*), embraced the modernist hospital architecture in their designs.

![Image](image-url)

**Figure 5.6** Illustration of the proposed Children’s Hospital designed by Stephenson and Turner presented in ‘The Australian Modern Hospital’ as an example of a modern hospital. The grounds of the hospital were mainly grass with minimal planting. The aesthetic was functional and streamlined to complement the modernist building. Stephenson, A. G., 21.

A.G. Stephenson partner in Stephenson and Turner, writing in *The Australian Modern Hospital* in 1949, acknowledged the influence of American hospital design on Australian hospitals after 1917, and names particular American architectural firms he credited with influencing modernist hospital architecture in Australia.\(^{39}\) Dr. MacEachern, the international study tour by the Victorian government delegation and the influential American ‘world-famous journal *The Modern Hospital*’ are noted as important in the development of hospital design in Australia. Stephenson names Melbourne as the place of origin of the ‘Australian modern hospital’ and supports his case with full page images of modernist hospitals in Melbourne such the *Royal Melbourne, Children’s Orthopaedic* and proposed *Royal Children’s* hospitals (Figure 5.6).\(^{40}\)

---


\(^{40}\) Ibid., 26.
Although this article was largely self-serving as Stephenson focused almost exclusively on hospitals developed by his own Melbourne based firm, it serves to illustrate the significant links between Melbourne and America in relation to hospital design.\(^{41}\) The article describes streamlined services efficiently delivered by the building design that included: boiler plant, stores department, kitchen, nurses’ home, lecture theatres, research department, doctor’s quarters, operating suite, outpatients’ department, X-ray department, pathological laboratory, mortuary, telephone, switch room, central records department, lifts, stairs, corridors, ward service rooms and a host of other necessities and equipment such as sterilizing equipment, refrigeration, food conveyers call and paging systems and piping of oxygen and anaesthetics.\(^{42}\)

In contrast with expert writing of the early twentieth century which specifically mentioned grounds and gardens as important elements in patient care, the site or outdoor areas are not mentioned.\(^{43}\) In modern hospitals the grounds had become irrelevant to the identity of the hospital and patient requirements. In 1949 in England, as another example of the elision of the grounds from the identity of modern hospitals, the Nuffield Provincial Hospitals Trust charged with hospital design after World War II in Britain made the following recommendation in for the outward appearance of the hospital site:\(^{44}\)

\begin{quote}
It is often and rightly urged that the hospital architect should give particular thought to the difficult problem of investing the building with a reassuring appearance. Unfortunately this aim is not often attained, and many modern hospitals are monumental in scale and awe-inspiring in character….Generally, whenever it is possible to provide for views through, under, or between the various blocks comprising the hospital, a lighter or less menacing character will be attained.\(^{45}\)
\end{quote}

Ideas of beautiful views, gardens for patients and contact with nature had become secondary to buildings.

\(^{42}\) Ibid., 27.
The Charities Board adopted modernist hospital design as the pattern of progressive hospital site development. The 1948 Annual Report of the Charities Board for instance referred to its policy of adopting International modernism for hospitals in Victoria from the late 1930s. The report, which promoted the virtues of uniformity in hospital construction, included the publication of an architect’s drawing of the proposed hospital in regional Traralgon which exemplified all the attributes of International modernism (Figure 5.7). Under the title ‘An Illustration of Forward Planning by the Board’, the picture represented the new type of hospital that ‘typifies a number of 200-bed hospitals planned to be constructed elsewhere in metropolitan and country locations.’ Again it bore the hallmarks of modernist site elements of expanse of lawn, no boundary fence, minimalist planting and prominent road system and was indistinguishable from other modernist hospital sites.

---

The Charities Board in Melbourne associated modern hospitals with medical technology rather than the comforts of home. In this shift of emphasis, any resemblance to a residential residence was eschewed as is evident in the promotion of a new hospital at Mildura, a regional city of Victoria, in the Hospitals and Charities 1948 annual report (Figure 5.8). In this publication, the former hospital, a single story residential building with patients on its verandahs looking into the garden is superceded by a three story office block without verandahs and balconies. The new site has an ornamental garden but there is no indication of
patient use or that its purpose is more than cosmetic. Function is determined by the central path that leads directly to the main entrance and associated area for bicycles. In contrast to the former hospital that has staff and patients using the grounds, the photograph of the new hospital shows only the building.

**Figure 5.9** (Left) Cover of 1948 Annual Report for Queen Victoria Hospital depicting a baby in the new technology of a humicrib. Underneath the apparatus is written: ‘Another Australian Saved’. 1948 Queen Victoria AR.

**Figure 5.10** Diagram of Royal Melbourne Hospital services in 1946/47 Annual Report. The specialist services that had developed since World War I such as x-ray, physiotherapy and laboratory tests are shown as part of a modern hospital within an integrated system under one roof. The emphasis is on the modern hospital as an efficient machine. 1946/47 Royal Melbourne Hospital AR.

Hospitals also linked their identity as an institution to ideas of medical science and technology rather than to a domestic place of refuge and salubrity. Emphasis on technology, scientific treatments and the hospital as an efficient machine are evident in the Annual Reports of the *Queen Victoria* and *Royal Melbourne Hospitals* after World War II (Figures 5.9 and 5.10). The caption underneath the humicrib, a machine for keeping premature babies warm, on the front cover of the *Queen Victoria Annual* report reads ‘Another Australian Saved’ (Figure 5.9). Technology and cure are offered as an inducement for public good-will, rather than views and garden surroundings that had been the case before World War I. The association
between the hospital and civic pride is similarly reinterpreted and increasingly the modernist form of the new Royal Melbourne Hospital is used to promote the image of Melbourne as a place of civic virtue. A 1956 postcard for instance, included the Royal Melbourne Hospital site beside other icons, its modernist appearance proclaiming its civic worth beside pre-war sites (Figure 5.11). The explicit message is that the city could take pride in the site of the Royal Melbourne which represented modern medicine and modernist design.

![Figure 5.11 1956 The postcard of Melbourne represents the Royal Melbourne Hospital as a site of modern medicine and modernist design in which the city can take pride. SLVPC.](image)

5.5 Physical characteristics of Melbourne hospital grounds 1918-1948

The period between World War I and 1948 was a transitional stage for hospital sites and grounds as the government built new buildings on existing sites, whilst at the same time unable to finance or satisfactorily cope with the implications of demolishing nineteenth and early twentieth century infrastructure (Table 5.1).

Differences between grounds were determined by factors such as size of the site, type of hospital and/or the existence of long-term plans for new sites or major re-building programs. As is shown in Table 5.1, immediately after World War I to 1930, hospital buildings were constructed on all sites except at Melbourne Hospital, which after its reconstruction in 1913 remained unchanged until after World War II. The Eye and Ear
Hospital and Children Hospital sites remained unaltered after new buildings in early 1930s. The most common buildings to be built were nurses’ homes and staff facilities. Five of which were built between 1918 and 1925, and in-patient ward blocks. This indicates the changes in medical treatments which from this time relied on specialized staff across a range of disciplines such as physiotherapy, and hospital administration. Increased numbers of nurses were also a feature of this period (Figure 5.1).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Melbourne</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women’s</td>
<td>Nurses’ home</td>
<td>Operating Theatre Gillot Wing (Patients)</td>
<td>Pathology Laundry Services Tennis court</td>
<td>Kumm Wing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s</td>
<td>Nurse’s Home</td>
<td>Outpatients Tennis Court</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alfred</td>
<td>VD Clinic Staff Dining EWW Wing Nurse’s Home</td>
<td>Casualty Outpatients Pathology</td>
<td>Hamilton Russell House (Private)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Austin</td>
<td>Nurses’ home Radiology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye and Ear</td>
<td>New wing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeopathic</td>
<td>Outpatients Tennis Court</td>
<td></td>
<td>Hospital re-built</td>
<td></td>
<td>Hospital re-built</td>
<td></td>
</tr>
<tr>
<td>St Vincent’s</td>
<td></td>
<td>Healy Wing Pathology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queen Victoria</td>
<td>Lady Mitchell Wing (midwifery and nurses’ accommodation)</td>
<td>Lady Forster Wing (Patients)</td>
<td>Mabel Brookes Wing Jessie MacPherson Wing</td>
<td></td>
<td>Moved to former Melbourne Hospital site</td>
<td></td>
</tr>
</tbody>
</table>

Table 5.1 Buildings constructed on Melbourne hospital sites between 1918 and 1948. Table collated from hospital plans, annual reports and institutional histories: author.47

Nurses’ homes were located where possible at a distance from hospital buildings and their associated smells and noise, which it was felt would be tiring and depressing for nurses.48 For similar reasons, tennis courts were also provided as a method of encouraging healthy exercise for nurses who were felt to be particularly at risk of poor health due to the demanding nature of their work and irregular hours of shift work. 49 Tennis courts were also strongly

47 Specific references for information in this table is provided in chapter text.
48 Between 1919 -1925, four hospital sites built substantial nurses homes.
linked to the residential function of the hospital, in which nurses living on site could use the courts between shifts and on days which they did not work. Tennis courts for staff were established on all sites of sufficient size, namely the Homeopathic, Children’s and Women’s in 1928, 1929 and 1938 respectively, years after the Melbourne, Alfred and Austin hospitals had installed them prior to World War I.50

The 1929 economic depression, rising costs and increased demand on hospital beds placed the hospitals under increased financial pressure during the 1930s and 1940s in Melbourne.51 Construction on existing hospital sites, particularly during the period 1930-1935 was restricted. Major constructions in this period were intermediate and community hospital buildings and a number of patient and service buildings site (Table 5.1). The inclusion of buildings for paying patients not only added extra buildings to the site but influenced its layout. Intermediate hospitals had separate entrances and were oriented away from public hospital buildings to create a separate zone for private patients and an association with the ‘sick poor’ and connotations of charity and poverty.

By the end of the 1930s more money was being spent on hospital construction with the Alfred, Austin, Women’s, Melbourne hospitals and Homeopathic (Prince Henry’s Hospital) benefiting with new buildings. Melbourne Hospital, which had changed its name to Royal Melbourne Hospital in 1935, moved to a new site in 1944 and Prince Henry’s, the former Homeopathic Hospital, underwent a protracted re-construction between 1937 and 1952.52

For the purposes of analysis, hospital sites during this period are divided into three types of grounds. Firstly, sites that remained basically unchanged from World War I for which the term ‘museum sites’ is used. These are Melbourne Hospital, Children’s Hospital and Eye and Ear Hospital. Second is the group of hospitals resembling what medical historians David and Beverlie Sloane have characterized as ‘chaotic sites’, in which buildings were added to existing nineteenth century configurations predominantly within site boundaries. This, the largest category consists of Women’s Hospital, Alfred Hospital, Homeopathic Hospital, Austin

50 See relevant sections of chapter for specific references.
Hospital St Vincent’s Hospital and Queen Victoria Hospital.\textsuperscript{53} Finally, modernist sites are represented by the Royal Melbourne Hospital, the first hospital site developed in Melbourne since the opening of Queen Victoria Hospital in 1899.

Museum sites

Melbourne Hospital

\textbf{Figure 5.12} 1946 plan of Melbourne Hospital showing buildings since 1895. The new buildings were part of the 1913 re-construction and there had been little change since then. The nurses’ building is on the corner of Swanston and Little Lonsdale street. Plan redrawn and annotated from 1895 MMBW plan and Lewis, N (1983): author.

The major re-building of the Melbourne Hospital site that took place from 1912 to 1916 introduced a number of site elements that were new to Melbourne hospital sites, namely six storey patient blocks instead of the usual two, buildings on the street line and flat roofs (Figure 5.12).\textsuperscript{54} The firm of J.J. and E.J. Clark designed the new buildings based on ‘latest developments in hospital construction’ after a study tour of Europe and America in 1908 and had noted the North American practice of buildings on the street line and multi-storey blocks instead of low storey pavilions spread over the site.\textsuperscript{55} This influenced the design of the reconstructed Melbourne Hospital with Clark arguing that although there was less room

\textsuperscript{55} Lewis, op. cit, (1983), 39.
around the buildings than had previously been considered mandatory, there was sufficient room for aeration.\textsuperscript{56} Clark still carefully considered the need for ventilation but the benefits of consolidation of services and the relatively constricted site made the solution of multi-storey blocks attractive. Accordingly, Clark designed a series of six storey pavilions, 80 feet apart, ‘running north and south, which is sufficient distance with the sun so much nearer the vertical than in North America.’\textsuperscript{57}

![Figure 5.13](image)

\textit{Figure 5.13} Section of 1913 plan of elevation of patient Block F showing flat roof and wire fence on roof. This building was east of the Administration block on Lonsdale Street and indicates the continued importance of salubrity c. World War I. J.J. and E.J. Clark Drawing Melbourne Hospital. University of Melbourne Archives.

Patient buildings were not located on the boundary line, set back 50 feet from Lonsdale Street whilst patient blocks nearer Little Lonsdale ‘are set much further apart.’\textsuperscript{58} Concerns for adequate ventilation for the nurses’ home, were not as pressing as for patient buildings, and in consequence the nurses’ was built on the boundary line with its own entrance on Lonsdale Street. Flat roofs were included as a means of providing extra ventilation and sunlight (Figure 5.13). A tennis court and garden areas were reinstated after re-building (Figures 5.14 and 5.15).

\textsuperscript{57} Ibid.
\textsuperscript{58} Ibid.
Tennis court and garden areas were re-instated after re-building of the Melbourne Hospital in 1913 which retained these features after World War II, although with a marked decline in the quality of these features. Sherson, 222.

Melbourne Hospital site remained unchanged after World War I except for minor building works. Balconies, gardens, tennis court and covered ways remained on site. Patients in beds can be seen on the balconies which were provided with sunshades but not glazed. The nurses’ home is on the perimeter of the site at the back of the hospital on the street. SLVPC.
The re-built hospital was a nineteenth century layout of pavilion buildings with balconies. The familiar configuration concealed to some extent the novelty of changes such as flat roofs and greater number of storeys, but also indicated that this was a variation on hospital design rather than a new approach. The site remained essentially unchanged until the hospital moved in 1944 with gardens, covered ways and tennis court remaining on the site although, lack of money led to a deterioration in the aesthetic qualities of these features (Figure 5.16). The nurses’ home was similarly unchanged. In 1913, it had set a trend for nurses’ homes on sites of limited size in being located on the street-line, by 1948 it was outdated and compared poorly to the elaborate nurses’ homes of the Alfred and Austin hospitals.

Patients continued to use balconies during the 1940s. Alan Gregory in his history of the Royal Melbourne Hospital cites the use of balconies for patient care in terms of a response to overcrowding.\(^59\) At the Melbourne Hospital overcrowding was a well-known deficiency of the site. This however, does not preclude the element of fresh air and sunshine as a consideration

in the use of balconies. Arguably, if bed capacity was the only consideration, glazing of balconies would have been put forward as a solution. A newspaper article in 1928 that described the effect of a tempestuous storm on the balcony on patients who had to be moved into ‘the already overcrowded wards’, does not advocate glazing the balconies.\textsuperscript{60} Instead, The Argus article uses this incident to justify new buildings on the site. In fact, the verandahs were not glazed until after Queen Victoria Hospital had moved to the site in the late 1940s.\textsuperscript{61}

**Children’s Hospital**

\begin{center}
\includegraphics[width=\textwidth]{figure.png}
\end{center}

*Figure 5.17 1948 Children’s Hospital site remained generally unchanged from the end of the 1920s until the hospital moved in the early 1960s. The site retained elements such as clipped shrubs, trees, balconies and covered ways. The tennis court (1925) is in the middle of the site and the Splint Workshop (1936), the last minor building added to the site in 1936 is in the south-east corner. Redrawn and key added from 1951 and 1956 Stephenson and Turner Site plans: author.*

\textsuperscript{60} Anon. (Tuesday, 25th September 1928). Melbourne Hospital Extensions. *The Argus*, 11.

\textsuperscript{61} 1950s postcards of the Queen Victoria site on Swanston Street show glazed balconies.
The *Children’s Hospital* site remained essentially unchanged after the extension to the outpatient’s building in 1928, until it moved site in the early 1960s (Figure 5.17).\(^{62}\) The Splint Workshop was added in 1936 but this was a relatively minor structure, built behind two cottages that had been converted to nurses’ accommodation and did not impact significantly on the hospital site.\(^{63}\)

Two floors were added to the original outpatient buildings in 1926 to accommodate an infant’s ward (Wards 12 and 14) (Figure 5.18). This extension included a flat roof which was a used as an outdoor ward for babies for heliotherapy treatment (Ward 15) (Figure 5.19). Doctors returning from World War I to the *Children’s Hospital* had been converted to the benefits of heliotherapy as a result of their experiences overseas and aggressively instituted the practice on the Carlton site.\(^{64}\) The hospital committee however, had decided that this was not appropriate for the Carlton site after reports of children ‘in a nude state [were] having sun

\(^{62}\) Yule, *op. cit.*, (1999), 105.
\(^{63}\) 1956 *Block Plan of Children’s Hospital*. Stephenson and Turner Plan Collection, SLVMC.
baths on the lawns, balconies and verandahs’ reached then from shocked visitors. In consequence, a heliotherapy ward was opened at *Convalescent Cottage* in Brighton. Open balconies and flat roofs continued to be used for clothed patients at the Carlton site until 1950 (Figure 5.20).

![Image](image.png)

**Figure 5.19** 1938 *Children’s Hospital*. Flat roof of babies ward (Ward 15) facing Drummond Street. The flat roof was routinely used for heliotherapy treatment. Yule, 260.

---

![Image](image.png)

**Figure 5.20** c.1938 Balconies of the Edward Wilson Surgical Ward which gave patients a view of the Carlton Gardens and activities in Rathdown Street, Carlton. Balconies were still an important element in patient treatment after World War I. Yule, 256.

---

65 Ibid., Yule, P.,178.
66 Ibid., 178, 183.
The area of the grounds available for patient use remained unchanged from 1936 to 1948 but the domestic aesthetic of flower beds and ornamental areas was replaced with clipped shrubs and lawn areas (Figure 5.21). In 1936 when the Splint Workshop was built, the area was planted with lawn only, without ornamental shrubbery or garden beds as had been the practice before World War 1 (Figure 5.22). The result was a more austere site that lacked places of retreat for patients and staff and the familiar garden aesthetic of a residential site (Figure 5.23).

Figure 5.21 1950 Internal courtyard of the Children’s Hospital indicating that the grounds had lost much of the domestic character derived from ornamental flower beds and shrubberies of the pre- World War 1 era and was more functional and severe. Royal Children’s Hospital Archive.

Figure 5.22 The lawn in front of the 1936 Splint Workshop was functional rather than beautiful and indicates that the grounds as a respite for staff and patients was losing importance by the 1930s. SLVPC.

67 See also 1956 Block Plan of Children’s Hospital which indicates existing trees and garden beds on the hospital site. Stephenson and Turner Plan Collection, SLVMC.
Figure 5.23 1940s Staff member standing in front of tennis court and back of outpatient building. The Children’s Hospital site in the 1940s lacked the warmth and familiar domestic character of the pre-World War I grounds. Royal Children’s Hospital Archive.

Eye and Ear Hospital

Figure 5.24 c.1950 Eye and Ear Hospital site. Although the hospital had land it was unable to build due to financial constraints. By this time, nurses were living in domestic accommodation across the road from the hospital. The hospital site remained unchanged from 1930 until 1960 when a major re-development was undertaken. Donovan, 120.
Figure 5.25 1935 This image of the Eye and Ear Hospital looking east was taken in 1935, shows a view of the hospital that remained unchanged from 1930 to 1960. The reserve in the middle of Victoria Parade was given over to electric tams in 1926 which removed the ornamental gardens and impacted on the salubrity of the hospital. SLVPC.

The Eye and Ear Hospital, despite a number of proposals for a new site continued in its nineteenth century form until 1960, when a multistory block was added (Figures 5.24 and 5.25). The site of 0.2 acres at the time of its establishment in 1882 had neither the land nor the funds to make any changes and although it had acquired land on the south of the site in 1935 it was unable to build. The hospital façade and grounds remained unchanged for thirty years. A major change in the salubrity of the vicinity of the Eye and Ear Hospital occurred in the 1920s when the ornamental reserve that ran down Victoria Parade was given over to the Tramways Board for the installation of electric trams. Although this was hotly contested as a ‘rank folly to allow any public body to spoil the beautiful, health-giving reserves’ and as detracting from the beauty of the area with ‘ugly poles and spider web of overhead wires', in 1926 permission was given to introduce tramlines to the reserve.70

69 Ibid., 14.
Chaotic sites

Women’s Hospital

The Women’s Hospital with its relatively small site of 2½ acres (1.01 ha) had constructed a number of buildings around the time of World War I which impacted on its garden and open land (Figure 5.26). The Edward Wilson Wing for example, removed a large ornamental garden of trees, shrubs and lawn on Cardigan Street and closed in the open-ended courtyard behind the original buildings (Figures 5.27 and 5.28).

Figure 5.26 Site plan of Women’s Hospital showing the significant amount of building since 1937. Two tennis courts were also added in 1937. The buildings from the late 1930s were in the International modernist style. Adapted from MMBW plans and plans in Nattrass (1978): author.
Figure 5.27 The building of the Edward Wilson Wing next to the 1888 Genevieve Wing and over the garden area on Cardigan Street shown in this photograph, substantially reduced the domestic garden aesthetic of this part of the grounds. The garden area had previously connected with the open-ended courtyard creating a large open area of land around the hospital. James Fox (1899) SLVPC.

Figure 5.28 A third storey was added to the Edward Wilson Wing in 1924 and as can be seen in this photograph, the balconies continued to be used for providing fresh air and sunshine for patients. Nattrass (1972).
The grounds before the late 1930s however, still exemplified a garden aesthetic. A third storey added to the Edward Wilson Wing in 1924 included balconies used for providing fresh air and sunshine to babies in the 1930s and a garden area remained in front of the building (Figure 5.28). In contrast, the building of the nurses’ home on the perimeter of the site and on the street boundary indicated that salubrity whilst still associated with patient care was seen as less important for a non-medical building (Figure 5.30). By the late 1930s, much of the planting and ornamental garden areas had been reduced and the courtyard which had contained Moreton bay figs, shrubs connected with the domestic front garden on Cardigan Street was now a simple lawn area and tree and surrounded by buildings (Figure 5.31).

---

Figure 5.30 Five storey nurses’ home at the Women’s Hospital built on the street in 1925 as an unadorned office block without garden or traditional domestic features. This replicated characteristics of the nurses’ homes built at the Melbourne (1913) and St Vincent’s (1914) hospitals. McCalman, 219.

Figure 5.31 Garden area behind the staff wing of the Genevieve building that formed a private retreat for staff. This area with tree and lawn was retained despite the building of Edward Wilson Wing (1916), nurses’ home (1927) and operating theatre (1927), although the garden area was diminished in size and number of garden elements. The building of the Kumm Wing in 1941 however, severely impacted on the garden aesthetic. (See Figure 5.32) McCalman, 135.
From 1927 to 1937 site characteristics remained relatively stable whilst little significant building was undertaken. By the end of the thirties however, the remnant garden elements and open land were lost to a number of large scale buildings built in a modernist style. The Kumm Wing for instance was built over lawn and trees at the back of the Genevieve Ward (Figures 5.31-5.32). Adding to the sense of disorder was the practice of partial demolition of existing buildings with new buildings abutted as shown in Figure 5.32. This and the inclusion of makeshift structures such as the staff dining room and tennis courts, removed the last connection between the hospital courtyard and a nineteenth century garden aesthetic.73

The pattern of increased building density and its subsequent impact on the aesthetic qualities of the site was repeated with the construction of the pathology building, also known as the King George V Jubilee Maternal and Child Welfare Centre (1939), Services Building,

Central Laundry and Boiler Building and stack (1937) (Figure 5.33). The services building and new boiler stack in particular, exemplified the changed purpose to the hospital which now focused on function, technology and scientific medicine rather than salubrity (Figure 5.34).

*Figure 5.33* c.1940 Swanston Street frontage of Women’s Hospital showing (King George V Jubilee Maternal and Child Welfare Centre) designed by Stephenson and Turner in front of Services Block, Central Laundry and Boiler Stack (1937). These buildings on the north end of the site removed the remnants of the original garden entrance that had been part of the site since the 1850s. The services building and new boiler stack in particular, exemplified the changed attitude to the hospital which now focused on function, technology and scientific medicine rather than salubrity. SLVPC.

*Figure 5.34* The building of the services block and boiler room in 1937 reduced the ornamental garden area associated with the nurses’ home, to a functional laneway for cars and people which made no pretence to a picturesque aesthetic. McCalman, 309.

---

74 Cunningham, E. S. (1940). *History of Women’s Hospital, Melbourne 1856-1940*. Melbourne: Royal Women’s Hospital, 12.
Alfred Hospital

Figure 5.35 Alfred Hospital site at 14 acres had the largest inner-urban hospital land. This feature of the original site influenced subsequent site development which was not as cluttered as other inner urban sites. By 1940s however, as medical belief in fresh air and sunshine began to wane, the hospital abandoned its commitment to providing air and sunshine around the buildings. The nurses’ home is on the corner of Punt and Commercial roads. 1948 Stephenson and Turner site plan redrawn: author.

Of all Melbourne’s inner urban hospital sites, the Alfred Hospital site retained the closest links with nineteenth century ideas of salubrity. At 14 acres (5.67 ha) it was the largest of inner-urban hospital sites and consequently remained less cluttered. (Figure 5.35). It is evident however, in the account of the improvements made to the grounds in the 1920s that the idea of a garden setting reminiscent of a domestic home had been replaced by a preference for sweeping lawns and uncluttered views of the buildings. The 1921 Annual Report noted the clearing of trees in the grounds under the heading ‘Innovations’:

We cannot conclude under this heading without reference to the great improvement that has been made in the appearance of the extensive grounds surrounding the hospital buildings. Old trees have been removed and a lawn scheme introduced, the general effect being to greatly enhance the architectural beauty of the institution.

---

75 Charitable Institutions, op. cit., (1910).
76 Anon. (December 1933). "I Like This Old Place". The Alfred, 13.
77 Alfred Hospital Annual Report. Year ending 30th June, 1921. Melbourne: Alfred Hospital, 12.
Similarly in the 1922 Annual Report, elements such as the elm avenue which in previous reports had been promoted as a feature of the hospital grounds was now presented as an opportunity for expansion (Figure 5.36). The Hospital’s architect, Kingsley A. Henderson further illustrated the preference for lawns to garden beds and shrubberies by reference to the removal of trees and vegetable garden as an example of progress (Figure 5.37). Whereas before World War I, it was considered appropriate that the hospital was benefited by ornamental garden beds and trees for reasons of salubrity, this had now changed. The grounds were primarily a means by which to showcase the building, and the cleared grounds were a symbol of the progress and modernization which were part of the ‘remarkable advance’ the hospital site had undergone since World War I. Significantly the hospital’s head gardener continued to plant dahlias, a popular ornamental flower, only near the nurses’ home. The nurses’ garden which ran the length of the nurses’ home facing Punt Road was his ‘special pride’ and retained its domestic aesthetic.

**Figure 5.36** The 1922 Annual Report promoted sections of the ground which previously had been identified as contributing to the beauty of the surroundings and important in the identity of the hospital, as sites for building expansion. The caption reads: ‘Elm Avenue in Hospital Grounds, indicating possibilities for Building Expansion.’ 1922 Austin Hospital AR.

78 Alfred Hospital. Fifty-second Annual Report. Year ending 30th June, 1922. Melbourne: Alfred Hospital
80 Ibid.
82 Anon. (December 1933). "I Like This Old Place". *The Alfred*, 14.
Figure 5.37 The two images used in 1924 by architect Kingsley A. Henderson to illustrate the many improvements made to the grounds in recent years. The upper image taken in 1912 is of the vegetable garden and treed area east of the main hospital building which was replaced by the Edward Wilson Wing and expanded nurses’ home in the early 1920s. The lower image shows the treed area in the upper image made into lawn and tennis court. Tent and vehicle are part of the annual carnival held in the grounds. The Alfred, June 1924, 20.

Figure 5.38 1926 aerial of the Alfred Hospital site showing that many of the ornamental garden bed, shrubberies and trees had been removed as part of modernization of the hospital in the 1920s. The Alfred’, 33.
Figure 5.39 1924 Previous images of the front grounds of the Alfred Hospital featured a large conifer, Moreton Bay figs, garden seats, shrubbery and ornamental fountain, all of which had been removed for building expansion and car park. This image was included in the 1924 Annual Report as evidence of improvement and progress associated with the hospital. 1924 Alfred Hospital AR.

Figure 5.40 1960 view of the front courtyard of The Alfred showing the changes made to the grounds from 1920 to 1930 which resulted in loss of garden areas and large central conifer that had contributed to the domestic character of the institution. Mitchell, 145.
Modernization of the grounds included the construction of new Casualty and outpatients buildings, kiosk and car park on Commercial Road which removed rockeries, Moreton Bay figs, garden beds and large conifer that had dominated the front entrance before World War I (Figures 5.39 and 5.40).

![Image](image_url)

**Figure 5.41** The new Edward Wilson Wing with open balconies and solariums on the north façade and covered way on the extreme right connecting it with the existing hospital buildings. Unlike pre- World War I pavilions this was not surrounded by an ornamental garden. Alfred Hospital Archive.

As a response to medical beliefs of heliotherapy the *Alfred Hospital* continued to build and renovate the site with pavilion buildings and the additions of balconies, solariums and covered ways, a re-modelling, claimed to be ’based on the most modern English and American lines’ (Figure 5.41). What is evident however, is that ornamental garden elements were not included in the new additions. Heliotherapy treatment was based primarily on access to sunshine and fresh air with ideas of beautiful surroundings less important. In this way it differed from pre- World War I medical ideas of the benefits of salubrity which had included pleasant surroundings as well as sunshine and fresh air.

The *Alfred Hospital* used the scientific authority of heliotherapy to promote the hospital as both a place of cure and moral good, in ways that replicated earlier twentieth

---

century ideas of the hospital site but with a different type of grounds to support its argument. The hospital magazine *The Alfred* provided a number of examples of this:

..The Advantages of being able to use this great gift is greater than we can comprehend. The strength, the mental uplift and the renewed spirits of the sick patient from the sunbath are common occurrences. The freedom from a monotonous view of the same dull walls day after day is in itself a wonderful mental tonic, but when reinforced by the sparkle of the bright sunlight on the grass and the view of a cheery world outside, the full effect is nothing short of a miracle. Even the onlookers, and those who are not themselves ill, but whose work brings them in contact with the sick, can derive benefit from the picture. The sight of some two dozen happy children who, though afflicted with sickness and pain, seem able to forget everything but their happiness, invariably causes the passer-by to pause and to experience a rather unique thrill at one of the most wonderful of Nature's gifts to mankind.  

Photographs included in *The Alfred*’s publications show children in rows of beds on the front lawn of the hospital in full view of the public (Figures 5.42 and 5.43). What is significant in these images is the disconnection of the patients from an ornamental garden aesthetic of shrubberies, garden beds and trees that had dominated the pre-World War I grounds. The purpose of the *Alfred* grounds had moved from that of beautiful views and refuge from the city, to that of display and scientific doses of sunlight. Despite the romantic description of the ‘sparkle of sunlight on the grass’, the children have no shelter from the street and have an interrupted view of the car park and road leading into the hospital which had replaced the ornamental garden area and mature trees.

---

Figure 5.42 Picture accompanying article outlining the physical and moral benefits of sunshine in ‘The Alfred’, the house magazine of the hospital. The beds were in full view of the street and faced the entrance and car park rather than a garden. ‘The Alfred’ March/June 1929, 22.

Figure 5.43 Picture of children’s cots outside the children’s ward at the main entrance of the hospital with onlooker on path stopping to enjoy the spectacle as described in the hospital magazine. The children faced the roadway and car park at the entrance to the hospital. ‘The Alfred’, December 1933, 7.

Although, the association of heliotherapy and the hospital site was most often talked about and promoted in relation to children, adults also were taken onto the lawns in close proximity to the main entrance and roadway (Figure 5.44). As with the children however, the experience of the grounds was one of scientific application of principles of fresh air and sunshine rather than an understanding of landscape as capable of healing both physically and psychologically.
Figure 5.44 1940s patients in beds on lawns outside Administration Block and modernized covered ways that ran from the front casualty buildings. These patients as with the children were visible from the road leading into the hospital. Henderson, 150a.

The building of Intermediate hospitals, that is Hamilton Russell House (1931) and Margaret Coles (1941), introduced the public and patients to the eastern vicinity of the site which had previously been restricted to hospital personnel. A separate road system constructed for Hamilton Russell House was built over the nurses’ tennis court which was re-located to the front of the hospital on Commercial Road. (Figures 5.45-5.47). These changes further eroded the purpose of the hospital grounds as a secluded retreat from the outside world and as a place of privacy for patient and staff use.

The grounds surrounding the private hospital, Hamilton Russell House, reinforced the ‘big house’ aesthetic of its architecture, with circular drive, separate entrance and tree-lined avenue. These features differentiated it from the functional grounds of the public hospital and

emphasized the separation of private paying patients from public patients who still associated with charity. Ideas of the comforts of a substantial home to reassure and encourage middle class use of the hospital is also evident here.

Figure 5.45 Hamilton Russell House built in 1931 on the Alfred site. Its road system, orientation and stately residential style made a clear distinction between the public and private sections of the hospital. The avenue of trees to the left were incorporated into the new road system and reinforced the idea of the ‘big house.’ Alfred Hospital Archive.

Figure 5.46 c.1925 The tennis court was re-located to the front of the hospital grounds on Commercial Road as a result of the building of Hamilton Russell House. The covered way lead from nurses’ home to patient buildings. The trees and garden areas that occupied this part of the site prior to World War I were lost to the extension of the nurses’ home and the preference for lawn areas for hospital grounds which greatly reduced the privacy and salubrity of the site. Paterson, 90.
Figure 5.47 1933 Aerial of Alfred Hospital site with dotted line indicating the new road system for Hamilton Russell House to provide separate access for private patients. A large section of the avenue of elms that lead to the main buildings of the hospital were removed. Alfred Hospital Archive. Adaption: author.

By the 1940s The Alfred had begun its radical re-building program that was intended to supercede the nineteenth century buildings.\textsuperscript{86} The hospital architect, K.A. Henderson had undertaken a world study tour of hospitals in 1935-36. From this trip he had returned converted to the modernist hospital form current in America, citing the Los Angeles County General Hospital as the ‘last word in hospitals of the present day’ (Figure 5.48).\textsuperscript{87} Henderson designed an 8 storey tower ‘Centre Block’, as the first stage of the re-building program, the first building built above 3 floors on the hospital site.\textsuperscript{88} Centre Block abutted the nineteenth century pavilion building in a manner that would have been considered negligent design for a hospital site before World War I as it reduced air circulation and access to sunshine (Figures 5.49 and 5.50). The practice of part demolition of existing buildings was followed at The Alfred contributing to the ‘chaotic site’ character noted in the Women’s Hospital site.\textsuperscript{89}

\textsuperscript{87} Ibid., 20.
\textsuperscript{88} See Stephenson and Turner Collection, A and K Henderson, Alfred Hospital Site 86/9 Sheets 8, 15, 14. Flat roof and 8th Floor. State Library of Victoria.
\textsuperscript{89} Alfred Hospital Annual Report. Year ending 30th June, 1939. Melbourne: Alfred Hospital.
Figure 5.48 The Los Angeles County General Hospital that the Alfred’s hospital architect, Henderson described as the ‘last word in hospitals of the present day.’ A photograph of the hospital was included with the article. Google Images.

Figure 5.49 The 8 storey Central Block of the Alfred Hospital dominated the site built in 1941 behind the nineteenth century administration building. A large oak was removed to accommodate the building. SLVPC.
Figure 5.50 1941-50 8 storey block (1941) abutted earlier nineteenth century buildings, including covered ways which had been enclosed. The new building which accommodated patient wards in the upper storeys, was the first public patient building on the site to eschew balconies and covered ways. Alfred Hospital Archive.

Priority had shifted from provision of salubrity to that of provision of efficient service delivery considered to save time and money. A 1954 aerial photograph of the site demonstrates the impact of the new approach on the grounds compounded by proliferation of buildings at a larger scale than had been built before World War I (Figure 5.51).

Figure 5.51 1954 aerial of the Alfred Hospital site. Garden beds and trees that had been evident on pre- World War I site had been replaced by lawns, buildings and car parks. The large chimney stack towered over the grounds creating an industrial rather than garden aesthetic to the grounds. Mitchell, Plate 86.
Homeopathic Hospital (Prince Henry’s)

**Figure 5.52** 1946 Prince Henry’s site looking south with new central block amidst earlier site elements from nineteenth and early twentieth century. Remnants of the former 1880s patient building and 1910 nurses’ home are on southern border with the new pathology building built in 1937 on south-east corner. The nineteenth century ornamental garden and front fence have been removed. The new chimney stack is directly behind new building. SLVPC. Annotations: author.

**Figure 5.53** Homeopathic Hospital site c.1920 before the introduction of electric trams down the middle of St Kilda Road which reduced the ornamental areas of the road and introduced ‘ugly poles and spider web of wires’, thus impacting on the salubrity of the area. SLVPC.
The Homeopathic Hospital (Prince Henry’s) buildings remained unchanged from 1925 to 1937 after the addition of a new outpatients, the Edward Wilson Wing, in 1925 (Figures 5.52 and 5.53). As with St Vincent’s and Eye and Ear hospitals, the hospital site experienced added noise with the introduction of the electric tram in the mid-1920s to St Kilda Road, which had similarly been opposed on the basis of reduced salubrity (Figure 5.53).

Lack of new building was partly the result of financial constraints but was also due to a conservative management board which was reluctant to embrace new medical treatments that required specialist buildings. Management refused to implement treatment approaches such as physiotherapy and pathology or establish a clinical school. Without a clinical school the hospital was chronically short of doctors and could not undertake research and new clinical treatments associated with medical faculty of a university. As homeopathy, the medical foundation of the hospital, waned in influence and popularity with both general public and government bureaucrats, the hospital found it harder and harder to attract funds to update facilities or expand. Jacqueline Templeton in her history of the hospital describes it as an old-fashioned and homely institution during the thirties and forties, administered as a ‘household economy, in a personal, informal way. Matron with a maid and a wardsman went to Victoria Market weekly for vegetables and the secretary collected wages from bank on foot.’

The hospital was renamed Prince Henry’s in 1934 after the Duke of Gloucester partly in response to the Charitable Board’s objection to the use of the word ‘homeopathic’, which it considered an archaic and unscientific method for treating patients. Finally, after a long

91 Anon. (August 12th, 1924). Victoria-parade Trams. The Threatened Destruction of Reserves. The Age, 6 refers to an intention to save St Kida Road from the same fate as Victoria Parade.
92 Ibid., 136-137.
93 Ibid., 172-174, 158-160. In contrast to other sites which had established pathology departments after World War I for instance, the hospital did not have a full-time pathologist until 1947. Clinical schools which had been instituted in other Melbourne hospitals before World War I, appointed hospital medical staff through an electoral college associated with the university, who then trained doctors in the hospital. See Vellar, I., op.cit. (2006), 3-4, for a description of the establishment of the first clinical school in Melbourne by St. Vincent’s Hospital in 1909, which was quickly followed by the Alfred, Melbourne and Women’s hospitals
95 Ibid., 171.
running dispute with the Royal College of Surgeons was settled in 1936 that introduced training of doctors within the hospital, the government funded a major site re-development.\textsuperscript{97}

\textbf{Figure 5.54} \textit{c.1925 Homeopathic Hospital entrance with formal garden including flower beds, lawn, climbing creeper and Cordyline australis, a fashionable garden element of the period before being replaced by lawn in 1934}. Templeton, between 102-103.

\textbf{Figure 5.55} \textit{Front balcony of Homeopathic Hospital in 1930s continued to be used by patients much as it had been before World War I}. Templeton, between 110-111.

\textsuperscript{97} Templeton, J., \textit{op. cit.}, (1969), 111, 159.
\textbf{Figure 5.56} 1938 Prince Henry’s Hospital. The building form retained its nineteenth century character of a charitable institution whilst the grounds had become modernized with lawn and removal of front fence. The 1925 Edward Wilson Outpatient building is the extreme left of the 1880s southern wing. SLVPC.

The grounds retained ornamental beds and elaborate garden aesthetic until the mid thirties when the garden was removed and replaced by lawn (Figures 5.54 and 5.55). Changes in the ornamental garden aesthetic were evident in the 1938 postcard of the site in which the perimeter fence has been removed and lawn has replaced trees and shrubbery (Figure 5.56). This replicated changes in the physical characteristics of the grounds that had occurred at the \textit{Alfred Hospital} in 1921 and indicates the decreasing importance of salubrity to the purposes of the grounds.\footnote{Ibid., 75.} The site characteristics associated with nineteenth century salubrity such as balconies continued to be used, much as they had been before World War I which also suggests that provision of fresh air and sunshine continued as an acceptable hospital practice (Figure 5.55).\footnote{Ibid., 128.} The inclusion of a tennis court on the site in 1928 indicated that in this respect the \textit{Homeopathic Hospital} followed other sites in considering exercise and recreation important for nurses
The new buildings constructed after the resolution of the clinical school dispute were pathology block (1937) and eleven storey administration and patient wing (1941). Balconies and solariums were included for heliotherapy treatment for patients. The nurses’ home which replaced the 1910 domestic residential style building in 1948 was built as a modernist block of flats on a new site behind the hospital (Figure 5.57). The hospital was designed by architectural firm Leighton Irwin, strongly associated with modernist architecture in Melbourne through its founder Leighton Irwin. Prince Henry’s on completion of its buildings in 1952 received recognition as an important modernist building of Melbourne both locally and overseas. Promotion of the hospital emphasized the minimalist modernism of tall sleek buildings with the grounds of lawn and roadways for movement of people (Figure 5.58). It is important to note however, that modernist hospital grounds preceded the modernist buildings.

Figure 5.57 1952 North Wing has been completed but the 1880s buildings remain, adjacent to the 1940 central block, awaiting demolition for the building of the south wing. The solariums at the north end of the building and balconies were for heliotherapy treatment. The nurses’ home is the multi-storey building behind the hospital. SLVPC.

Figure 5.58 c. 1950s postcard of Prince Henry’s Hospital promoted the hospital as a functional and modernist building and the grounds were similarly functional but without purpose for patient treatment. SLVPC.

Hospital construction from the building of the pathology building in 1937 until the completion of the southern wing in 1952, took fifteen years to complete. In the meantime, the site followed the usual pattern of chaotic sites of half completed buildings juxtaposed to half demolished nineteenth century structures (Figure 5.59). For most of this period, the hospital grounds were a building site and any connection to nineteenth century ideas of salubrity and domestic residence were not evident.

Figure 5.59 1951 Completed central administration and patient block with construction of north block underway in 1951. The drawn out building process added to the chaos and lack of salubrity of the site. SLVPC.
Austin Hospital

Figure 5.60 1946 aerial of Austin site looking south-west. David Symes X-ray Block (1925 middle-right), Edward Wilson Night nurses’ home (1925), Administration (1937), Heidelberg House (Community Hospital 1939 middle-centre), 1st Section of 3KZ Children’s Block adjoining existing Children’s Ward (1939) were built in the interwar period. Tennis Court which had been built in 1900 is behind Administration Building with the Marion Davies Nurses Home and Edward Wilson Building facing it across a garden. Austin Hospital AR. Labelling: author.

The Austin Hospital site reproduced the juxtaposition of modernist and nineteenth century buildings that had occurred on inner urban sites. In contrast to the majority of inner urban sites however, its geographical location, specific topographical features and particular patient population led to a site character that linked strongly to the ornamental garden aesthetic of the pre-war period. Undulating topography provided opportunities for views, despite the increased building program after World War I. Further, past practice and association of ornamental hospital grounds with patient treatment continued to place a great deal of emphasis on the ornamental garden setting.

Association of the Austin Hospital site with a garden setting continued to be articulated even as treatments changed and the hospital claimed that it cured patients. The Leader
newspaper acknowledged the hospital’s changed status in 1927, where ‘thanks to the wonders of modern science, 11 per cent. of the patients were discharged from the hospital last year as well and cured.’ Nevertheless, whilst the *Austin* could boast of modern treatments and was happy with references to scientific expertise, the hospital continued to present itself in terms of ‘nature’ that is ornamental garden, views and experience of sun and fresh air as important to patient treatment.

![Figure 5.61](image)

*Figure 5.61* 1930 newspaper article associating patient care with the garden at the Austin Hospital. (9th April, 1930). ‘The Sun News-Pictorial’.

---


105 Prominent American expert, Dr. MacEeachern also emphasized merits of the emergent scientific approach at the Austin characterized the site as ‘a most excellent physical plant which permits of a scientific grouping of cases’ and for ‘[C]arrying on chemical research.’ Quoted in fundraising pamphlet. Turner, W. J. G. (1926). *The Austin Hospital for Incurable and Chronic Diseases*. Heidelberg: The Austin Hospital for Incurable and Chronic Diseases.
Fundraising activities highlighted the outdoor areas of the site. So for instance, the donation of money for new beds in 1930 is recorded by a photograph of patients in wheeled beds in the garden (Figure 5.61). This suggested that the practice of patient beds in the garden was routine but was also an implicit message that the Austin Hospital still identified the garden an authentic place of treatment. Similarly, an appeal to visit the hospital by management was augmented by an invitation to the visit the gardens, to inspect the hospital ‘under the most favorable circumstances’.106 These sentiments are further articulated in a pamphlet issued by the Austin Hospital as part of a fundraising appeal which refers to the Austin as a ‘Palace of Pain’ ‘charmingly situated on a hill-side at Heidelberg, overlooking the Yarra Valley and within full view of FIVE MOUNTAIN RANGES’ (original emphasis).107 Other hospital publications habitually referenced ‘the beautiful surroundings’ of the hospital as part of its identity (Figure 5.62).108 Again, the inclusion of garden and landscape and its implied transcendental qualities are central to the identity of the hospital.

Figure 5.62 Back cover of 1927 Austin Hospital Annual Report continued to promote the hospital in terms of its salubrity after World War I until 1950s. 1927 Austin Hospital AR.

108 Austin Hospital for Chronic Diseases Annual Report for the Year Ended June, 1927. Austin Hospital, Heidelberg.
Further examples include the 1934 Annual Report that aligned the hospital grounds with its treatment approach where location and ability to be a refuge were still important:

The hospital is situated on a hillside immediately opposite the Heidelberg Railway Station from which the Valley unfolds itself with the blue Healesville and Dandenong Ranges in the background. In these beautiful surroundings, where no noisy traffic disturbs the serenity of the place, the patients have a haven of refuge to pass their last days in peace or, in many cases on the road to recovery. 109

As late as 1982, Gault and Lucas’ history of the Austin gave a detailed account of the garden and emphasized the ‘unique’ nature of its site with ‘the beauty of its garden setting, which has long been recognized as making an important contribution to the well-being of patients.’ 110 Note is also taken of the ‘pleasant custom’ of placing ornamental plants in the offices and wards which is still practiced. 111 A detailed description of the grounds and a series of postcards circa 1950, confirms that even in the 1980s, the garden setting remained an important element in the identity of the Austin Hospital both symbolically and literally (Figures 5.63-5.65):

Splendid elms, oaks, poplars and eucalyptus provided shade on the wide, sloping lawn areas below Heidelberg House; the roses at the entrance are of great variety and beauty; the roadway from the entrance gate to the hospital is bordered by a garden bed which is a blaze of colour changing with the seasons; around the administration building and the library there are beds of bright annual; rhododendrons, azaleas, and camellias are found near the nurses’ home, Zeltner Hall and around the thoracic ward; in autumn many of the trees show vivid colours and in spring flowering peach, cherry, apple and plum trees give gay splashes of colour to which magnolia trees add their beauty. Two splendid rows of oak trees line the roadway leading to the Marian Drummond Home. 112

109 Austin Hospital for Cancer and Chronic Diseases Annual Report 1934. Austin Hospital, Heidelberg, 5.
111 Ibid., 176.
112 Ibid., 174.
Figure 5.63 c.1950 Oak Drive leading to the Marian Drummond Nurses’ Home described by Gault and Lucas in 1982. Commentary on The Austin Hospital site continued to articulate ideas about gardens and benefits to patients into the late twentieth century. Rose Series, SLVPC.

Figure 5.64 c.1950 Front park area of the Austin Hospital near the Ladies Auxiliary kiosk. The shade trees, lawn and seating indicate the use made of the grounds. Rose Series. SLVPC
**Figure 5.65** c.1950 View from the hospital grounds into a park setting. The adjoining land was also maintained as part of the hospital grounds in recognition of the importance of views to the patient. Rose Series, SLVPC.

**Figure 5.66** 1939 panorama of Austin Hospital site with Heidelberg House adjacent to Zeltner Hall (1917) and the clock tower of the original 1882 hospital. The hospital included solariums and balconies and had a separate road with circular drive. The topography and expansive site at 17 acres accommodated the new buildings without losing the park aesthetic. Heidelberg House was oriented away from the rest of the hospital and had its own road access. Gault & Lucas, 142.
The Austin site was impacted to some extent by the building of the intermediate hospital, Heidelberg House designed by in 1939 which was placed over the vegetable garden. This had been established in the nineteenth century to provide for the hospital’s needs and therapeutic activity for patients and was re-located near the nurses’ home (Figure 5.66). The site of Heidelberg House on sloping ground that gave views of the distant mountains and away from existing hospital buildings, combined with the construction of separate road system, contributed to the private hospital as a site separate from the rest of the public hospital grounds. The building also included solarium and balconies in keeping with ideas of heliotherapy. A large nursery for cut flowers continued until the building of the new boiler in the early fifties which again indicates the different character of the site compared to the inner urban hospital sites.

Figure 5.67 1920 Aerial of the Austin Hospital site. The Marian Drummond Home is located in the upper left hand corner, apart from the main hospital building, next to the cut flower nursery and facing the children’s ward across the formal garden. The tennis court for nurses is located to the left of the Children’s ward. This spatial arrangement formed a domestic zone of nurses, children and garden. The tennis court is in the centre of the site, to the left of the children’s ward. Austin Hospital Archives.

114 Ibid., 176.
At the other end of the site to Heidelberg House the Marian Drummond Nurses’ Home (1914) was sited separately from the main hospital buildings but associated with the children’s ward located across a formal garden. This spatial arrangement which was in the vicinity of the large cut flower nursery created a domestic zone that reinforced ideas of home, children, garden and nurses (Figures 5.67 and 5.68).

Figure 5.68 1927 Annual Report Austin Hospital for Cancer and Chronic Diseases. Children's Ward and tennis court (right of Children’s Ward) faced the nurses’ home and created a separate zone form the rest of the hospital. Composite image from 1927 Austin Hospital Annual Report: author.

St Vincent’s Hospital

Figure 5.69 1948 Site plan of Vincent’s Hospital. The site had expanded in a piecemeal fashion since 1893 as land and finances became available. Plan re-drawn and modified version of 1896 MMBW Detail Plan, 1987 Lawrence Nield and Partners Master Plan and archival images: author.
St Vincent’s Hospital which had developed from its original site to one acre (0.4 ha) by 1910, then to 3.5 acres (1.42 ha) by 1948, had taken up land for its expansion in a plot by plot acquisition as sites and money became available. This was in contrast to other sites that were able to build on greenfield sites after establishment before 1890. The piecemeal acquisition of land meant that until 1927 when it was demolished, the hospital shared its site with the cyclorama building. This circular building seen in Figure 5.70 was used for public gatherings and entertainments and reduced the privacy and seclusion of the site. The construction of the 1905 building had been followed by the building of two small building in 1910 (Southall-pathology, mortuary, lecture theatre, chapel) and 1911 (Cullen Wing – Residence for RMOs.). In 1913 Austral Hall was acquired further west along Victoria Parade and was used for out-patients, physiotherapy and as a dispensary. In 1914 the Druids Wing was built on a site between Austral Hall and the main hospital for outpatients and

---

118 Egan, B. (1993), 63.
nurses’ accommodation. The costs of these buildings and the restraints of World War I precluded any major building by St Vincent’s for the next twenty years. The grounds during this time although cramped, still reflected ideas of domestic garden and the importance of fresh air and sunshine (Figures 5.71-5.72)

![Image 1](image1.jpg)  
**Figure 5.71** Front entrance on Victoria Parade recalled a domestic residence before building of the Healy Wing with front porch, garden beds and lawn. Seats indicate that the garden was used by people. St Vincent’s Hospital Archive.

![Image 2](image2.jpg)  
**Figure 5.72** View of the St Vincent’s Hospital, facing Regent Street before the building of the Healy Wing in 1934. This garden was adjacent to the patient wing of the 1905 buildings. St. Vincent’s Hospital Archive.

---

120 Ibid., 33.
The building of the Healy Wing in 1934 over the existing garden of the hospital drastically lessened the association of the hospital with a domestic site (Figure 5.73). The new building was without ornamental garden and set back from the street. Its architect, A.G. Stephenson identified the new building at St Vincent’s, the Healy Wing, as one of the new type of hospital buildings in Australia and revolutionary in its design.\textsuperscript{121} The land to the east of the 1905 building which had been the site of ornamental garden beds, lawn and seating became a car park. The front garden on Regent Street was converted to an ambulance bay and roadway for the Casualty Department (Figure 5.74). Financial constraints prevented any new building for another twenty years by which time the site as described by historian Bryan Egan was a ‘strange collection of buildings.’\textsuperscript{122}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure5.73.png}
\caption{1950s. Healy Wing was built over the ornamental garden in front of the hospital in 1934 with Pathology Building at the back. All the ornamental garden areas have been removed and the area turned into an ad hoc car park. This treatment of the grounds was in contrast to the well-tended garden beds and lawns that had existed until the 1930s. Balconies remain open. National Archives of Australia.}
\end{figure}

\textsuperscript{121} Stephenson, A.G., \textit{op. cit.}, (October 1949), 26.
\textsuperscript{122} Egan, B., \textit{op. cit.}, (1993), 63.
Figure 5.74 St Vincent’s Hospital ambulance bay and road entrance for the casualty department in the 1940s. An ornamental garden was removed to build this ambulance bay. Decisions which removed ornamental garden areas were made for pragmatic reasons rather than as part of a strong design aesthetic. St Vincent’s Hospital Archive.

Queen Victoria Hospital

By 1930 the Queen Victoria Hospital grounds had altered considerably from its pre-World War I site. As with St Vincent’s it developed as a result of acquisition of adjoining lots of land over number of years and building was undertaken in a piecemeal fashion. A new midwifery and nurses’ accommodation block, the Lady Mitchell Wing (1923) built over the front garden of the original Governess’ Institute, removed the connection of the hospital with a domestic residence (Figure 5.75). This trend was continued with the construction of the Lady Forster Wing in 1929 for maternity, surgical and medical patients, south of the Lady Mitchell Wing in Mint Place (Figure 5.76). Unlike the Lady Mitchell Wing, which was a remodelling and extension of the original building, the Lady Forster Wing was built on a cleared site. The building was located on the street boundary without front garden or perimeter fence to separate it from the street. Mint Place became part of the hospital grounds with patients and

staff using it to move between buildings. The idea of the hospital as a private site and a refuge from the city streets current before World War I was not apparent on this site.

Figure 5.75 1923 Lady Mitchell Wing was built over the front garden of the original site which removed the association of the hospital with a domestic residence. 1923 Queen Victoria Hospital AR.

Figure 5.76 Lady Forster Wing opened in 1929 next to the Lady Mitchell Wing. Balconies are still evident but the grounds are limited in extent and have little purpose for patient and staff use. 1929 Queen Victoria Hospital AR.
This was replicated in the next and final group of buildings constructed on the site – the Jessie McPherson Community Hospital (1931) and Mabel Brookes Wing which were built facing Williams Street to the north of the existing buildings (1934) (Figures 5.77 and 5.78). The design was one of the first hospital buildings to abandon the standard large wards of 20 or more beds for smaller wards, and in keeping with this break with tradition, the grounds were primarily lawn without ornamental garden beds and separated from the street by a simple low railing fence. Balconies were provided on all four buildings built between 1923 and 1934 in accordance with heliotherapy principles but the grounds themselves were public, limited in extent and provided no places for patient and staff use.

Figure 5.77 The sites of the Jessie McPherson Community Hospital (right) and Mabel Brookes Wing built in 1931 and 1934 respectively facing William Street, represented a radical break with hospital sites up to this period which previously had ornamental gardens and barrier fences as typical elements. This photograph is of the west facades of the buildings. 1934 Queen Victoria Hospital AR.

Figure 5.78 1934 West and north facades of Mabel Brookes Wing on corner of Mint Place and William Street housing a Children’s ward, nurses accommodation, Operating Theatre and Outpatients. The lack of ornamental grounds and building on the street were site elements typical of an office block rather than residential building. Little or no grounds were provided for patient and staff use. 1934 Queen Victoria Hospital AR.

All hospital sites until this period in Melbourne had included a barrier fence and ornamental garden beds as elements of a hospital site. By removing the barrier that separated the hospital site from the street and providing a simple lawn without ornamental planting, former ideas of the hospital as a retreat from the world and its former affinity with a domestic site were challenged. After the radical changes to the site in the early thirties there was no major building undertaken. In 1946 the Queen Victoria Hospital moved to the former Melbourne Hospital site which had become vacant after that hospital had moved to its new location in Parkville.

**Modernist site-Royal Melbourne Hospital**

![Figure 5.79](image-url)

*Figure 5.79 1946 Royal Melbourne Hospital site plan by Stephenson and Turner showing hospital as a central block building surrounded by grass areas. SLVPC.*

After protracted public debate as to the fate of the Melbourne Hospital, the Victorian Government approved the building of a new hospital on a new site in 1938.\(^\text{125}\) The main

building was completed in 1943 and was initially used as a military hospital by the American Armed Forces. In 1944 it was handed back to the Victorian Government and was occupied by the Melbourne Hospital later that year.

Stephenson and Turner, the well-known firm of modernist hospital architects had been awarded the contract for the new hospital. As Stephenson and Meldrum, the firm had previously been responsible for the 1930s buildings of the Queen Victoria and St Vincent’s hospitals as already discussed. The Royal Melbourne Hospital however, differed from these previous hospitals in being built on a greenfield site in which existing buildings did not determine the configuration. This allowed Stephenson and Turner to implement a design which Julie Willis has described as typical of the functional and unadorned International Style architecture.

Figure 5.80 1940s view of Royal Melbourne site indicating its minimalist and functional layout and relationship to the street as a public site. Melbourne University is on the other side of Royal Parade on the extreme right of the photograph. The triangular piece of land that Dr. Schlink advised to become a garden so as ‘to enhance the prestige of the building’ is in the left corner. This land subsequently became the site for the Royal Melbourne Dental Hospital, also designed by Stephenson and Turner. SLVPC.

126 Ibid., 26.
127 Ibid.
The site for the new hospital was in Parkville on the outskirts of the Central Business District (C.B.D.). One of the driving reasons for its location was its proximity to the medical school of the University of Melbourne. The university with the hospital was envisioned as forming the nucleus around which a medical complex would develop. Discussions surrounding the suitability of the site highlighted its size and proximity to the university as important elements of its location. This is in contrast to nineteenth century discussions of a suitable site which had centred on access to prevailing winds, elevation, aspect and distance from the city as criteria for a hospital (See Chapter 4). Commentary on the hospital design reinforced the importance of the site as a public space that displayed buildings. A number of commentators for instance, recommended that no major construction be allowed to lessen the impact of the buildings, so that it could be seen in ‘all its magnificence’. Dr. H. H. Schlink, editor of the *Australian Modern Hospital* similarly advised against any building that would detract from the buildings and ‘[A]part from anything else, this would take away from the

---

130 Graduate. (Thursday, 24th May 1928.). A University Hospital. Some ideals and suggestions. *The Argus*, 17; Anon. (Tuesday 27th August, 1929). Melbourne Hospital. *The Argus* both discuss the merits of the hospital being associated with University of Melbourne.

pleasant picture presented by the hospital tower at one end of Elizabeth Street and the Flinders Street Station tower at the other.’

Both commentators recommended that the triangular site across the road from Royal Melbourne Hospital be reserved for a suitable garden (Figure 5.80). In contrast with the idea of the gardens for benefit of the patients, the idea of this garden was to enhance the prestige of the building. As Dr. Sclinck asserted, the City of Melbourne would be ‘lacking in some aesthetic taste’ to do otherwise. Similarly, the buildings should be placed in adequate parkland not for any patient purpose, but to provide ‘air lungs’ for the hospital structures and allow the buildings to have ‘proper orientation’ and suggested that 300 to 400 acres (121-162 ha) should suffice. The site had limited purposes for patient use, dominated by paths leading directly to buildings, car park, absence of a boundary fence, and lack of garden seating (Figures 5.80 and 5.81).

Figure 5.82 1943 Nurses’ home to the left of the image, reiterated the modernist form and site aesthetics of the patient buildings. SLVPC.

---

132 Anon., op. cit., (Thursday, 19 July 1945).
133 Ibid.
134 Ibid.
The nurses’ home associated with the *Royal Melbourne* site reiterated the modernist form of the adjacent patient buildings (Figure 5.82). The grounds, as with the patient buildings, were minimalist and functional and contributed to the idea that an ideal hospital site epitomized progressive and efficient science (Figure 5.83). A rose garden, a traditional landscape element associated with women was included in the walkway between the nurses’ home and hospital, but its intent was cosmetic rather than useful in creating a domestic garden or place of staff activity and retreat.

*Figure 5.83 1945 Nurses on the lawn area with rose garden that bordered the path from nurses’ home to main hospital. The planting style is minimalist and complementary to the modernist buildings. Sherson, 315.*

The demise of the balconies as a treatment option is evident from the building form. The balconies which were a last minute addition and narrow were not for the benefit of patients but ‘to provide alternative access to wards, to shelter the windows of the wards from the weather, and to enable floor-length windows to be opened.’\(^{135}\) In any case, the balconies were not an adjunct to patient care but a threat, so that ‘patients whose mental state is a danger to themselves had been housed on the 1\(^{st}\) floor North Wing.’\(^{136}\) By 1960 Stephenson and Turner dispensed with balconies altogether in designing the new *Children’s Hospital.*


\(^{136}\) Ibid., 278.
5.6 Hospital grounds and the new salubrity

Covered ways and balconies had been established elements of hospitals since the nineteenth century and continued to be prominent on Melbourne hospital sites after World War I. Initially, these elements were officially linked to salubrity and the ideas fresh air, sunlight and beautiful surroundings as discussed in Chapter 4. After World War I however, salubrity became legitimized as the medical treatment of heliotherapy, its promotion couched in terms of medical science and the physiological benefits of ultra-violet light. Heliotherapy paid less attention to ideas of pleasant surroundings as part of the treatment process. Although hospital publications such as The Alfred extolled the virtues of patient beds in the sun, it is evident in the lack of ornamental garden beds and trees that beautiful surroundings were not part of the treatment.

Hospital sites in Melbourne responded by the inclusion of flat roofs and balconies on existing buildings. The Children’s Hospital specifically included flat roofs in order to provide areas for patient exposure to the sun, whilst other sites such as the Alfred, Queen Victoria and Women’s, included balconies in new buildings and added balconies to existing ones. In general, hospitals continued with open balconies until after World War II.

Differences between inner and outer urban sites however indicate that previous ideas of rural or seaside landscape as restorative persisted for children and incurable patients. The Children’s Hospital in Carlton expanded its existing site at Brighton (Hampton Convalescent Cottage) and developed new sites in rural Victoria to provide its patients with the type of landscape experience considered therapeutic for children. The Children’s Hospital’s outer urban sites of Hampton Convalescent Cottage (previously Brighton Convalescent Cottage), Frankston Orthopedic Hospital, a 20 acre (8.1 ha.) site in the outer sea-side suburb of Frankston (1930) for children with poliomyelitis, Sherbrooke Convalescent Cottage (1935) on 4 acres (1.4 ha) of land in the temperate rainforest region of outer Melbourne (Figures 5.84 and 5.86).

138 Yule, P., op. cit., (1999), 180-182., 188. The firm of Stephenson and Meldrum (later Stephenson and Turner) were commissioned to build the heliotherapy ward at Hampton in 1925 and Frankston Orthopaedic Hospital in
Figure 5.84 Grounds of Hampton Convalescent Cottage encouraged physical exercise as part of its treatment. The grounds contained playground equipment, vegetable patch cows, horses and rabbits. Yule, P., 204.

Figure 5.85 Aerial of Frankston Orthopaedic Hospital showing its relationship to the sea. This was a site characteristic that was favourably commented upon by hospital historian Lyndsay Gardiner and others. Gardiner, L., (1970), 103.

1927. Brighton Convalescent Cottage had moved to the nearby suburb of Hampton after being burnt down early in the twentieth century.
These sites for children provided a contrast to ideas of medical technology, scientific medicine and the modern hospital as efficacious treatment. Heliotherapy was used as the justification for these sites but particularly with Sherbrooke Convalescent Cottage, romantic ideas of saving children from the unhealthy and corrupt city persisted.
Hampton, although near the sea was a suburban site. Its grounds were used for childhood activities with playground, vegetable garden, cows, horses and rabbits included on the site. Its grounds were spoken about in quasi-scientific language investing the heliotherapy treatment undertaken there with almost mythical properties (Figure 5.87):

There are two wards, which the unscientific mind would call simply verandahs…

To the ordinary observer it seems an almost Arcadian existence, this basking in the warm sun, sleepily absorbing health and delight in life. Compared with the sad little mortals in hospitals….these children are delightfully gay. They lie there, some reading, some meditating profoundly, their bodies burned to various artistic shades of brown. The sun seems to have invested them with essential optimism.

**Frankston Orthopaedic Hospital** site chosen for its distance from the city and proximity to the sea combined ideas of heliotherapy with nineteenth century ideas of landscape as important for human well-being. Appreciation of the site was indicated in accounts of the hospital which emphasized views of the sea from the buildings, grassy slopes and long verandahs where the ‘healing rays played over the brown limbs of little patients’. Although, the site was designed around heliotherapy principles by Stephenson and Turner, Peter Yule’s account of Frankston indicates that the grounds were also used for children to connect with nature, with images of pony rides, trips to the beach and playing in the garden.

In the case of Sherbrooke Convalescent Cottage for children ‘suffering from chronic diseases…[who]…if returned to their homes too early…would either die or return to hospital…’, romantic ideas of rural life as morally redeeming for slum children remained current. Lyndsay Gardiner in his 1970 account of Sherbrooke, presents this place as an agrarian and rural paradise focusing on the sister in charge, Sister Millburn, who grew her own

---

139 Yule, P., *op. cit.*, (1999), 175.
140 Anon. (3 August, 1926). *The Age*.
143 Yule, P., *op. cit.*, (1999), 211, 221 and 220.
144 Ibid., 184.
vegetables, bottled her own fruit and encouraged the children to 'help her in these homely tasks' (Figure 5.88).\textsuperscript{145} Further, Sister Millburn 'who had a great love of the Australian bush' felt it her duty 'to introduce the pallid, listless children of Melbourne's industrial suburbs to the beauties and excitements of the natural world around them.'\textsuperscript{146} Significantly, the cottage was 'built in a domestic style of architecture', indicative of the continued belief in middle-class domesticity as an appropriate site for children from disadvantaged backgrounds (Figure 5.89).\textsuperscript{147}

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{figure5.88}
\caption{1951 Sister Milburn with patients experiencing restorative landscape away from the industrial city. The nurses' uniform indicates the medical rationale of this treatment. Yule, P., 189.}
\end{figure}

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{figure5.89}
\caption{Sherbrooke Convalescent Cottage was domestic in its appearance in contrast to the inner-urban hospital sites. SLVPC.}
\end{figure}

\textsuperscript{145} Gardiner, L., \textit{op. cit.}, (1970), 134.
\textsuperscript{146} Ibid.
\textsuperscript{147} Yule, P., \textit{op cit.}, (1999), 188.
The *Austin* clearly continued to articulate the value of landscape that would transcend the experience of incurable illness as important in patient treatment. Although, medical treatments were introduced into the hospital, its status as a place for chronically ill and incurable patients remained until the 1950s. It was not until the late 1940s that an outpatient clinic was instituted at the hospital. As pointed out by Gault and Lucas:

This was the first time since the inception of the hospital that any patients, referred to the Austin usually to die, had improved sufficiently to go home and subsequently attend an outpatient clinic.\(^{148}\)

In these circumstances the landscape offered the treatment and solace that modern medical treatments were unable to provide. Other post-war sites for dying patients revealed a similar focus on a garden setting. *Caritas Christi*, a hospice attached to *St Vincent’s Hospital* opened in 1941 on the fringes of Yarra Bend Reserve, a large urban park of over 300 acres (121 ha). Its site and grounds reiterated nineteenth century ideas of the hospital as a place of refuge and consolation that differed from inner urban sites offering modern medical cures (Figure 5.88).\(^{149}\)

![Caritas Christi Hospice](image)

**Figure 5.90** Caritas Christi Hospice opened in 1941. The idea of the garden as a refuge and consolation for patients is evident in the site and ground characteristics of domestic garden and distant from the city. SLVPC.


5.7 Conclusion - Charitable Institutions to medical complex

Hospitals which had resembled domestic residences and gardens before World War I had changed by 1948. Site plans of hospitals, photographs, annual report, newspaper articles and promotional literature reveal that many of the distinctive features of nineteenth century hospital still existed in 1948 (Table 5.2). These however were remnants from before World War I rather than the result of design intent. There were no new ornamental garden areas or

<table>
<thead>
<tr>
<th>ELEMENTS OF GROUNDS</th>
<th>1900</th>
<th>1948</th>
</tr>
</thead>
<tbody>
<tr>
<td>Garden beds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circular drive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lawn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proximity to Open Space, Gardens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Buildings on street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balconies and Verandahs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered way</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Converted Residential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boundary Fence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPITALS</th>
<th>1900</th>
<th>1948</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melbourne (1944)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alfred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeopathic (Prince Henry’s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye and Ear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Austin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Vincent’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queen Victoria (1946)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Melbourne (1946)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5.2 Table of hospital site characteristics in Melbourne 1900 and 1950. Modernist sites continued with balconies and covered ways which were considered important for fresh air and sunshine before the introduction of anti-biotics. The distinguishing characteristics were lack of boundary fence and reduction in ornamental elements such as flower beds and shrubberies. Compiled from site plans, images of hospitals, and Annual Reports: author.
shrubberies introduced to sites after World War I. Similarly, while circular drives remained a feature of a number of hospitals such as the Alfred and Homeopathic (Prince Henry’s), these became noticeably more functional with associated ornamental features such as central conifer and shrubberies removed. Their prime purpose became efficient movement of cars to and from the site and inevitably as informal car parks. Balconies and covered ways too were still considered important for fresh air and sunshine in treating diseases before the introduction of anti-biotics, although covered ways became less important. In 1932 for example, the Alfred glazed its covered ways with money received from an anonymous donor who had witnessed patients being wheeled between operating theatre and the wards in freezing winds.\textsuperscript{150} The perception of the benefits of fresh air had reduced in significance, in contrast to the early period of pavilion hospitals. Another distinguishing characteristic of 1948 sites was the lack of defining boundary fences which had once symbolized the privacy and residential character of charitable institution hospitals.

The example provided by the Alfred and Prince Henry hospital sites during the 1920s demonstrated that whilst the construction of extra buildings put pressure on existing grounds, this was not the only reason for loss of ornamental beds and shrubberies during this period. Hospital managements and architects who no longer recognized a link between a nineteenth century garden aesthetic and medical treatment were important in the process. The influence of architects and other medical experts on the appearance of hospital grounds however is complex. Significantly expansive lawn areas and open access to the street were characteristic of the modernist site of the Royal Melbourne Hospital. That is to say existing hospital sites such as the Alfred and Homeopathic, in adopting a modernist garden form before the introduction of modernist buildings, were not necessarily driven by modernist architectural practices or by architects but by other cultural factors. It also has to be considered that modernist hospitals grounds could only be promoted as meritorious because the public accepted them as suitable for the purpose of the hospital.

\textsuperscript{150} Anon. (March 1933). Glazing-in of Covered Ways. \textit{The Alfred}, 17.
Other factors also played a part such as decreasing length of stay for patients and the desire to decrease maintenance costs, but were not the prime motivations. At the time the *Alfred* removed its garden areas, shrubberies and trees in 1921, the length of time that patients stayed in hospital had not significantly altered from 1900, only decreasing from 21 to 19 days during this period (Figure 5.4). Arguments that as patients spent less time in hospital, the grounds became inevitably less important is more relevant to the later twentieth century, particularly after the introduction of anti-biotics in 1940. Maintenance issues and a desire to decrease costs may also have had an impact. The *Alfred* however continued to employ full-time gardening staff after the modernization of the grounds which suggests that this was not an important motivation.\(^{151}\) Further it needs to be considered that lawns are not low maintenance but require frequent attention and care. The hospital journal *The Alfred* provided an insight into the effort required to maintain the lawns of the hospital:

\[\ldots\text{seven (2.8 ha) and eight (3.2ha) acres of lawn, which has to be cut once a week in the summer and three times every fortnight in the early spring. Innumerable paths and boundaries make somewhere about nine miles (14.5 k) of edges to be clipped…}\]\(^{152}\)

Furthermore, the removal of trees and replacement with lawns was articulated as an aesthetic improvement, not as economic necessity. For these reasons, the 1920s marked an era when ideas about types of sites that were suitable for hospitals changed. Preference for lawn areas over ornamental garden beds and shrubberies and removal of perimeter fences make this evident.

These findings parallel the work of Annmarie Adams and Adrian Forty who have argued against a simplistic correlation between architectural styles and medical treatments in formulating ideas about hospital development.\(^{153}\) Specifically, Adams has argued that cultural

---

\(^{151}\) Anon. (December 1933). "I Like This Old Place". *The Alfred*, 14 describes the long career of head gardener, Richard Healey who had worked at the hospital since 1915 and had at times six men working on the grounds.

\(^{152}\) Anon. (December 1933). "I Like This Old Place". *The Alfred*, 14.

influences are far more important in hospital form than architectural or medical theories\textsuperscript{154}. This points to a cultural shift in the understanding of hospital landscape and human health. A nineteenth century garden aesthetic was no longer relevant to hospitals that now provided scientific cure rather than benevolent care. This was further reinforced by the example of the \textit{Austin} where it could be argued that the garden and rural landscape remained important because medical science had little to offer in terms of cure. In these circumstance nineteenth century ideas of landscape as offering solace and moral benefit persisted. Similarly, in the case of the \textit{Sherbrooke Convalescent Cottage} the landscape was to restore the childhood that living in the slums had taken away. As with the \textit{Austin}, modern medicine had little to offer in these circumstances.

Not all sites removed garden beds and shrubberies as a design intent. Unlike \textit{Prince Henry’s} and the \textit{Alfred}, the grounds of \textit{St Vincent’s}, the \textit{Women’s} and to a limited extent \textit{Queen Victoria} were not linked to a modernist aesthetic. These sites developed as result of a series of pragmatic decisions that introduced what were considered improved facilities to the hospital. Nevertheless, the downgrading of a garden aesthetic as important to patient treatment is evident in these decisions. The \textit{Queen Victoria} Hospital whilst building over garden areas for pragmatic reasons also implemented a modernist aesthetic on other parts of the site. The new buildings on additional land were modernist in their relationship to the grounds with a predominance of lawn areas and a without a boundary fence.

In keeping with the changes to hospital sites, the rhetoric from the new generation of hospital experts such as MacEachern and implemented by the Charities Board, was focused on modern service delivery and efficiency with little reference to the purpose of the grounds for patients. This represented a change in expert opinion. As discussed in Chapter Four, previously the grounds had been specifically mentioned as important to treatment. Under such changes, the association of inner urban hospitals with domesticity and care became redundant, although it remained important on outer urban sites. This trend was further strengthened by increasing professionalisation of hospital staff and introduction of middle class patients for

\textsuperscript{154} Adams, A. (2007). 'That was Then, This is Now': Hospital Architecture in the Age(s) of Revolution, 1970-2001. In J. Henderson, P. Horden & A. Pastore (Eds.), \textit{The impact of hospitals 300-2000} (pp. 219-234). Oxford, Berne: Peter Lang, 222.
whom the example of moral order provided by a domestic site was of less importance. Further, increasing similarities of social background between patient and medical staff may have impacted on reducing the paternalistic intent associated with hospital surroundings of nineteenth century sites.

This chapter has demonstrated that a specific and comparative examination of hospital sites and grounds confounds the architectural discourse that focuses on buildings only in discussing the chronology of modernism and hospital history. Rather than a straightforward narrative of transition from nineteenth century residential sites to modernist medical complexes, the history revealed a complex cultural process. It also suggests that unlike sites in North America identified by Adams as continuing with a traditional garden aesthetic in the interwar period to ally fears of modern medical treatments, Melbourne embraced modernistic site layouts as a way of promoting their credentials as sites of modern medicine.
CHAPTER SIX

HOSPITAL GROUNDS AS PLACES OF HUMAN ACTIVITY

6.1 Introduction

In 1969 the oldest building of the Alfred died. Supporters of the institution found it hard to contemplate the death agonies of places that they had worked in for so many years – and loved because of, rather than in spite of their eccentricities….and there are many who can still remember the beautiful avenues of elms, the bush atmosphere, and the extensive vegetable gardens; all of which were gradually swallowed up by encroaching buildings.¹

This extract from the doctoral thesis by Ann Mitchell on the history of the Alfred Hospital demonstrates the significance of the hospital’s site and grounds to its staff. It reveals an ambiguous attitude to changes that are generally reported as one of scientific progress and improvement by architects and hospital bureaucrats (See Chapter Five). This raises a wider issue in the history of the built environment of hospitals which generally focus on buildings and overlooks the people who used the site. One of the reasons for this is the difficulty of finding information on patient and staff activities which are usually not formally documented. Buildings on the other hand leave the physical evidence, and if these are demolished plans, architect drawings, photographs and annual reports remain. More generally however, architectural histories are interested in buildings rather than people who use them and in this focus the impact of changes are often overlooked. For hospital landscapes this means that the loss of garden areas and reduced activities in the grounds is seldom considered as part of the history of the built environment of hospitals.

This aspect of hospital history is important to investigate for two reasons. Firstly, it integrates the site and grounds as part of the built environment. Secondly, it reveals the way in

which site and grounds impact on the lived experience of patients and staff. This is important generally as insight into the ways in which the built environment interacts with human purpose and meaning has implications for design of built environments of today. Specifically, however, it reinforces the theme of this thesis, namely that site and grounds and the ways in which they are used are not incidental to buildings and need to be considered as part of the built environment.

This chapter is predicated on the definition of site articulated by Robert Beauregard described in Chapter One, whereby site is a place that is created through the meaning constructed through everyday experience of physical characteristics of space by people. Everyday experience is explored by analysis of photographs of patients and staff using the grounds and the ways in which they were spoken about. Further, the relationship between elements of the grounds, such as balconies and garden areas, and their impact on experience of the hospital is identified and discussed in terms of change over time.

The sites as places of lived experience evolved from resembling that of a residential home to that of an office block as the hospital changed from charitable institution to medical complex. Arguably this could also be seen as a change from a residential to non-residential site. As a way of linking this analysis to the changes in hospitals, the grounds are explored in terms of front garden and backyard, with places both of public display and private retreat typical of a residential site. As the hospital changed to that of a non-residential site, it is argued, the distinctions between front garden and backyard, public and private places disappeared. This meant a change of meaning and purpose for the grounds for patients and staff.

Conceptualizing hospital sites in terms of public and private areas by employing the categorization of front garden and backyard is key to understanding the difference between charitable institutions and medical complexes. Charitable institutions provided privacy and a connection to domesticity for patients and staff as part of their purpose as a refuge and substitute home for both patients and staff. The form of domestic residence with front garden

---

and back yard was a logical manifestation of this purpose. As with other domestic sites, the front garden provided places of display and a barrier between the street and residence, whilst the back yard was connected with more private and personal activities.\(^3\) This type of site had uses and meanings that differed from those of the medical complex where all areas are public. The grounds of medical complexes are not homely places, in the sense of meeting human need for meaningful activity and connection, but rather unhomely spaces.

Hospital sites with an ornamental front garden with trees, shrubberies and backyard private spaces that were used by patients and staff for domestic, recreational and therapeutic activities defines charitable institutions. Medical centres are sites that have largely lost outdoor areas or have grounds that are not intended for patient and staff recreational and restorative purposes. All sections of the medical complex site are public and in modernist landscape terminology ‘readable’, being easily understood at a glance. This particular linking of hospital typology to the use, purpose and configuration of the grounds changes the perception of the hospital as solely defined by building form. By identifying use and configuration of the grounds as another attribute of its identity it includes the site as part of the definition of charitable institution and medical complex. It is recognized that sites do not change abruptly and may contain a mixture of both sets of characteristics. Nevertheless, allowing for the complexity of describing change in the built environment, the distinction between hospital sites as charitable institutions and medical complex can be made within these parameters.

The expansion of buildings across previously open hospital sites after World War I radically altered the experience of the grounds for both staff and patients. Loss of garden areas was an obvious impact, with the related loss of sensory experiences of flowers, sun, views, sitting in the shade of trees or walking around shrubberies. There was the removal of places for retreat and quiet contemplation as and movement and bustle of people and cars replaced the places of refuge.

---

Figure 6.1 1873. Front grounds of Melbourne Hospital with patients using the grounds. Timber picket fence ensured privacy for residents and patients, whilst elements such as shrubberies, garden bower and garden paths provided opportunities for quiet contemplation, social interaction and exercise. Gregory, 44.

Although it is the absence of garden areas which is most commonly lamented by critics of hospital sites, there were and are other more subtle impacts. Patients and particularly staff who lived on site, connected to the hospital through their everyday experience of the grounds prior to World War I. There are numerous reminisces in institutional histories that characterize hospitals as small home-like communities in which everyone knew each other. Hospital grounds as shared places of personal activity connected to domestic aesthetics were important in creating a sense of belonging to what was perceived as a home-like place. Many staff lived on-site which increased this sense of attachment. Photographs have the unmistakable feeling of family snapshots with nurses, patients and doctors posing in informal groups smiling into the camera or undertaking the rituals of afternoon tea in the relative privacy of the hospital

---

grounds.\textsuperscript{5} In such accounts the familiar and domestic nature of the hospital grounds is nostalgically remembered and its loss regretted.

Significantly, it is garden elements associated with the hospital as charitable institution that have been linked to landscape preference and health benefits by environmental landscape theorists such as Stephen Kaplan, Kevin Thwaites and most recently Catharine Ward (Figure 6.1).\textsuperscript{6} Of particular relevance is the work by Thwaites who links the achievement of ‘emotional fulfilment’ or human well-being with spatial settings and characteristics that support social interaction and contemplative responses.\textsuperscript{7} Under this criteria shrubberies, trees, private areas and boundary fences of the hospital residential site introduced complexity and opportunities for contemplation and social interaction. Modernist hospital sites with their minimal planting and limited range of plant material made the site more legible but offered little in the way of the complexity or mystery.\textsuperscript{8} This chapter argues that this loss of privacy and complexity meant not only a loss of places for patient activity and treatment. Importantly, it signified a loss of places that fostered the social connections, contemplation and sensory experiences that gave health benefits to both patients and staff.

As has been seen in previous chapters as hospitals moved from charitable institution to medical complex the process of change varied between sites. The grounds of the Homeopathic Hospital (Prince Henry’s) for example, remained as they had been in the nineteenth century well into the 1920s, whilst the Children’s changed rapidly between 1913 to 1930, with little alteration to its site until it moved in the early 1960s (Chapter 5). For this reason, rather than rely on a particular date, the particular sites and grounds themselves drive the analysis of

\textsuperscript{5} Ibid., 137.
\textsuperscript{7} Thwaites, K., et. al., op. cit., (2005), 543.
change, with approximate time periods used as context, such as the hospital as charitable institution and as medical complex. The focus remains with the interaction between grounds and people and the ways in which activities as the grounds changed, leading to changes in purposes and meanings.

6.2 Front gardens and backyards

During the nineteenth and early twentieth century hospital grounds had front garden and backyards typical of the residential house of the time and the activities that occurred in these separate areas were correspondingly different. Surrounded by perimeter fence, the front gardens provided a grand setting for the hospital, underlining its respectability and charitable purpose. At the Homeopathic Hospital for example, the front garden served a dual purpose of presenting an imposing facade to the public whilst at the same time ensuring privacy for patients from the public street by the complex planting of trees and shrubs and perimeter fence. The backyard was for activities away from the public eye. Typical features were the morgue, laundry, cess pits for dealing with sewage, isolation wards and fowl yards. The back yard was also planted for the benefit of patients but the photograph of maids in the backyard of the Homeopathic Hospital indicates the use of typical backyard building materials of corrugated iron and lattice rather than elaborate wrought iron as at the front of the site (Figures 6.2 and 6.3).

---


The back yard housed the working parts of the hospital, such as laundry, boiler room, fowl house and drains. The morgue was also in the backyard with a separate entrance that

Figure 6.2 The front garden of Homeopathic Hospital in the era of charitable institution provided a grand façade for the hospital as a symbol of its respectability. SLVPC.

Figure 6.3 Maids in the backyard of the Homeopathic Hospital circa 1925. Tree, lattice, corrugated tin fence replicate the elements of a domestic backyard. Templeton, between 37-38.

The back yard housed the working parts of the hospital, such as laundry, boiler room, fowl house and drains. The morgue was also in the backyard with a separate entrance that

---

11 Smith, J. (Ed.), *op. cit.*, (1903).
allowed bodies to be removed from the site without the knowledge of patients. Jacqueline Templeton gives a detailed account of the back of the Homeopathic Hospital before it was connected to the sewerage system at the end of the nineteenth century:

...The state of the unpaved back premises provoked some criticism. Drainage was defective and a cess-pool near the kitchen smelt objectionably; and at the lower end of the yard there was a pond and near it lay a heap of waste and refuse, which was burned periodically, but in 1889 the House Committee complained that the backyard was too dirty – the many old boxes and refuse were ‘causing a bad smell’. Ducks, geese and fowls were kept at the Hospital and housed at the end of the back balcony but allowed to roam at large...
Hospital grounds were not open to the general public before World War I except at visiting times and the gatehouse and perimeter fence were intended to maintain the privacy of the institution. The presence of the gatehouse reinforced the front garden as a private area of the hospital (Figure 6.4). The role of the porter and gatehouse was to control people entering and leaving the site and to maintain the privacy of the grounds:

Here the official Cerberus is in constant attendance to prevent the exit of in-patients without a written order, to regulate the admission of visitors, and stop the introduction of contraband liquors or provisions for the use of the inmates.  

14 Anon. (Saturday April 18th, 1891). A Stroll through the Melbourne Hospital. The Age, 14.
Photographs of backyards of the Queen Victoria and Women’s hospitals further illustrate the significant differences between the ornamental front garden and the backyard (Figures 6.5-6.8). The backyard, less ornamental and more functional than the front garden was unmistakably domestic and indicative of human activity and purpose consistent with its relative privacy. A domestic scale for instance, is apparent in the Women’s Hospital backyard where the narrow path lined by pot plants suggests an area used by few people, whose numbers did not require a wider walking surface (Figure 6.7). The presence of bird cage and pot plants recalls domestic activities that connected the hospital grounds to a backyard purpose. This image was published in the Argus newspaper in 1922 and although strongly associated with domestic backyard, the caption which reads, ‘Portion of the old section of the Women’s Hospital which it is desired to replace with modern hospital buildings’, makes evident that the homely detail and scale of the charitable institution was no longer considered appropriate for a ‘modern’ hospital after World War I.15

Figure 6.9 1915 Backyard of Eye and Ear Hospital resembled a domestic backyard with garden tap, chicken wire, fern and pot plant indicating a general homely setting. The collection of staff and patients including children suggests a family atmosphere in which all available people are rounded up for a group photograph to mark a special occasion. Donovan, 63.

15 Anon. (Saturday September 2, 1922). Portion of the old section of the Women’s Hospital which it is desired to replace with modern hospital buildings. The Argus, 23.
Similarly, the backyard of the *Eye and Ear Hospital* in 1915 is domestic in character with garden tap, chicken wire, fern and pot plants indicative of homely activities (Figure 6.9). The collection of staff and patients including children suggests a family atmosphere in which all available people are rounded up to mark a special occasion by a photograph. In contrast with the severe formality of the front of the building, the photograph reflects the informal relaxed privacy of a backyard away from the public street.

The grounds of charitable institutions recalled home both in having private places and in the domestic and personal activities that were undertaken (Figures 6.10-6.23). More than this however, the configuration of the grounds with balconies, verandahs and gardens between buildings provided places of privacy that allowed the undertaking of activities such as group photographs, posing with friends and domestic activities, such as nursing and bathing babies and hanging out the washing. The separation of buildings across the site, and lack of centralization of services meant that staff undertook domestic and familiar activities in the grounds which would not be possible in centralized towers of hospital sites in Melbourne. For both staff and patients who witnessed these activities, the routines of home were visible and reassuring in reinforcing the hospital as a homely place.

*Figure 6.10* 1900 Staff in an informal pose in the central courtyard of the Women’s Hospital. SLVPC.

*Figure 6.11* Nurse Gwendolen Luly with unidentified male on the verandah of Alfred Hospital. Simple planting of geraniums and use of wire screen are domestic in scale and character. Melbourne Museum.
Figure 6.12  Circa 1925 Nurses in back garden of Homeopathic Hospital sitting with babies in easy chairs in secluded part of the garden. Templeton between 142-143.

Figure 6.13 1925 Nurse in sick nurses’ ward entertaining a visitor in the backyard of the site. The relaxed attitudes of the people in this image suggest a domestic scene. Yule, 125.

Figures 6.14 and 6.16 1920s. Melbourne Hospital nurses on the flat roof of the nurses’ home which acted as a backyard to provide privacy and a place to relax. Sherson, 221-222.

Figure 6.16 1920s Alfred Hospital. Tennis party of nurses in the grounds. Alfred Hospital Archive.
Figure 6.17 1920s Staff posing with babies in the grounds of the Women’s Hospital, with hollyhocks in background. McCalman, 172.

Figure 6.18 1900 Women’s Hospital. Staff photograph in the private corner of the hospital courtyard with the staff wing of Genevieve Ward building in the background. McCalman, 135.
Figure 6.19 1929 Doctors washing babies on verandah of Women’s Hospital. McCalman, 197.

Figures 6.20 and 6.21 1940s. Nurses at Children’s Hospital undertaking domestic activities in the grounds of the hospital, recalling the routines of home. Yule, 245.

Figures 6.22 1925 Back of Casualty of Melbourne Hospital, staff washing chairs. Sherson, 229.

Figures 6.23 1920s. Gardener mowing front lawn of St. Vincent’s Hospital. St Vincent’s Hospital Archive.24
Although there were differences in the level of formality between front gardens and backyards, the front gardens of the hospital as charitable institution afforded privacy to patients and staff until modernization of hospital grounds in Melbourne. Figures 6.24 and 6.25 for example are taken in the front gardens of hospitals of the Melbourne and Alfred hospitals respectively, and illustrate the privacy of these areas which allowed the taking of photographs of personal significance.

**Figure 6.24** 1925 Nurses in the front garden of the Melbourne Hospital. The site retained its domestic front garden with privacy created by plant screen on the front fence. Sherson, 6.

**Figure 6.25** c.1910. Alfred Hospital with doctors posing for a personal photograph in the privacy of the front garden. Alfred Hospital Archive
For staff that lived on site in nurses’ homes, residential medical officer’s accommodation and sundry other housing provided for staff, the sense of home was reinforced by its domestic detail. The surrounding grounds of the medical secretary’s home for example, located in the north-west corner of the Melbourne Hospital site, had all the elements of a domestic garden including lawn, trellis shed, fernery and garden beds until re-building of the hospital in 1913 (Figure 6.26). The Cullen Wing (1911) in the grounds of St Vincent’s Hospital which contained library, common room, dining room and sleeping accommodation for resident staff was similarly domestic in style (Figure 6.27). The grounds complemented this style with narrow paths, shed and garden beds. The X-ray department was also housed in the building which provided patients with a familiar non-threatening setting for what was at

---

Figure 6.26 Excerpt from 1899 MMBW Plan of Melbourne Hospital showing Secretary’s Residence. This was separated from hospital site by fence and with separate entrance had all the domestic details of a home garden including lawn, trellis shed, fernery and garden beds. 1899 MMBW Detail Plan.

---

the time a new and strange technology. The photograph of a nurse serving tea to patients waiting for x-rays in the grounds indicate the type of activities that would normalize the stressful experience of attending hospital (Figure 6.28).

![Image](image1.png)

**Figure 6.27** c.1920 *The Daniel Cullen Wing (1911) in the grounds of St Vincent’s Hospital built in a domestic style contained library, common room, dining room, sleeping accommodation for resident staff. The surrounding grounds were also domestic with narrow paths, ornamental flower beds and shed. The X-ray department was located on the ground floor.* St Vincent’s Hospital Archive.

![Image](image2.png)

**Figure 6.28** *Outpatients being served morning tea in the grounds of St Vincent’s Hospital. The participation in everyday activities such as enjoying a cup of tea in the garden normalized the stressful experience of attending hospital.* St Vincent’s Hospital Archive.

---

17 This photograph was described as a nurse dispensing morning tea in Skewes, E. M., & St. Vincent's Hospital (Melbourne Vic.). (1989). *Mother Mary Berchmans Daly, foundress of St. Vincent's Hospital, Melbourne.* Melbourne: Spectrum in conjunction with The Hospital.
Photographs of patient activities reveal the grounds as places of exercise, play and social activities which provided an alternative to the sights and smell of the wards (Figures 6.29-6.40). At the Children’s Hospital children used the grounds as a domestic backyard to gain their strength and play games. Nurse Jennings Carmichael gives a vivid account in 1891 of patients in the hospital garden ‘….growing gradually stronger and stronger, until, from the first feeble totter by aid of something to hold by, they are able to chase each other round the garden paths, or play ball along the wide stone verandahs.’

Figure 6.29 c.1920. Boy in the grounds of Alfred Hospital. Garden stakes and small-scale garden beds suggest domestic backyards. Alfred Hospital Archive.

Figure 6.30 Children in grounds of Alfred Hospital playing in a sunny corner. ‘The Alfred’ June 1936, 28.

Figure 6.31 1900 Christmas Day patients and staff in the front garden of Melbourne Hospital. These children have been taken into the front garden presumably the benefit of its salubrity. The wheeled pram suggests this was a regular event. National Library of Australia.

Figure 6.32 c.1900 Patients being wheeled to a church service through the grounds of the hospital. In the privacy of the hospital grounds, activities that would have attracted notice in the public street, in this case transport of patients in beds, was a normal sight. Heidelberg Historical Society.

---

The presence of groups of children in the grounds, with sound of children’s voices and activities, allayed some of the strangeness and unfamiliarity of the hospital regime. The configuration of the separated buildings also provided experiences away from the hospital ward for in-patients who were taken for walks by nurses to other parts of the hospital through the grounds (Figures 6.33 and 6.34). Similarly, the Austin Hospital encouraged the normal activities of childhood in the garden where possible which contributed to the domestic character of the site (Figures 6.35-6.36).

Figure 6.33 1908 Outpatients during polio epidemic waiting in the grounds of the Children’s Hospital near Outpatient building on freshly mown grass. Yule, 129.

Figure 6.34 1912 Mother and children wait outside for outpatients appointment in grounds of the hospital, in proximity to the ornamental garden. Yule, 162.

Figure 6.35 Nurses and children sitting on the lawns outside the children’s ward. The children’s ward and nurses’ home were clustered together at the back of the site. Gault, 80.

Figure 6.36 A nurse presiding over childhood activities in the garden between the children’s ward and the nurses’ home. Caption reads, “At the instance of the Girl Guide movement a “Brownie Pack” has been formed among the little children at the Austin Hospital for Chronic Diseases, Heidelberg. The innovation is a source of great joy to those who are well enough to join, and is regarded favourably by the doctors. ‘The Argus’, June 29, 1928.

19 Interview with Dorothy McDonald (nee Hogg). (20th January, 2009).
Open balconies were an important normalizing element of the hospital experience for patients and staff. (Figures 6.37-6.41). Experiences of the grounds from open balconies and verandahs of low-rise hospital buildings alleviated the strangeness of the hospital world as indicated by this account of the Children’s Hospital in the 1890s:

The big ward on the upper flat has been well chosen for the lads, it has more sunshine than any other, and looks out with all its windows on to two public schools ….so the sick boys can look out upon their old playfellows as they romp in the grounds or go through drill, and hear merry voices all day long. It is no uncommon thing to see boys in the street below gesticulating to the children in the ward, or even holding conversations with them through the open windows.  

The open balconies of the Children’s Hospital provided patients with a view of the Exhibition Gardens and an opportunity to participate in events that diverted attention away from the hospital as a site of medical intervention. Dorothy McDonald, a nurse at the Children’s Hospital in the late 1940s, recalls that the open balconies were considered a treat by the children who enjoyed the novelty. Although, this use of balconies was incidental to their chief purpose, the interaction with the outside world was a beneficial outcome that was lost with the evolution of closed balconies or in the case of the new Royal Children’s Hospital in 1961, no balconies at all.

Figures 6.37 and 6.38

Open balconies normalized and enlivened the hospital experience and provided social contact and diversion for patients. The open balconies and proximity to the street connected patients, staff and the public in a way that would not be possible when the hospital moved to multi-storey sealed block in Parkville. Yule, 598 and 268.

21 Interview with Dorothy McDonald (nee Hogg). (20th January, 2009).
HOSPITAL GROUNDS AS PLACES OF HUMAN ACTIVITY

Figure 6.39 Early 1920s. Man on crutches on the verandah of St Vincent’s Hospital looking into the garden. Benches on the paths indicate that use was made of the garden and from the verandah patients could step out into the garden. St Vincent’s Hospital Archive.

Figure 6.40 Balcony of Queen Victoria Hospital gave patients access to the treed back yard and opportunities to observe the comings and goings of staff. Queen Victoria Hospital AR.

Figure 6.41 1905 Kronheimer Block with patients sitting on balcony overlooking a domestic scale garden bed and lawn. Patients that were able to do so helped with gardening on the site. National Library of Australia.
Fund-raising activities in the grounds also normalised the hospital experience for patients and staff (Figures 6.42-6.44). Events such as the ‘Annual Linen Tea’ held in the grounds of the hospital of the Women’s Hospital or three day market fair at Queen Victoria Hospital provided diversion and interest. The preparations and implementation of such events which included visiting bands, community stalls, displays of athletic prowess and the presence of dignitaries, enlivened the routines of the hospital.22 Similarly, it was common practice for community bands to play in hospital grounds to provide entertainment to patients and staff and as a way of supporting the institution.23

Figure 6.42 St Vincent’s Hospital 1937 Bazaar in the grounds of the hospital provided diversion and interest for staff and patients. These events brought the community and hospital into close contact and reduced the clinical atmosphere. St Vincent’s Hospital Archive.

Figure 6.43 ‘Apollo’ preformed feats of strength at the 1941 St Vincent’s Hospital Bazaar, seen here pulling a bus with his teeth. Patients were able to witness the display from the balconies of the 1905 building in the background. ‘The Argus’ February 26th, 1941.

Figure 6.44 Alfred Hospital 1929 Jubilee Fete. Caption reads: In carnival mood, the nurses of the Alfred Hospital joined in the fun yesterday, when the Jubilee Fete was opened. ‘The Argus’, March 23rd 1929, 17.

23 Alfred Hospital Hospital’s magazine for example listed two band recitals as playing in the grounds in October, 1933. See Anon. (December 1933). Music on the Lawns. The Alfred, 14.
HOSPITAL GROUNDS AS PLACES OF HUMAN ACTIVITY

After the 1920s however, as the modern medical complex became the dominant form, associations with domesticity and activities that normalized the hospital experience became less frequent. Tall buildings blocked sunshine, created wind tunnels and removed people from close contact with the grounds. On modernist sites such as the Royal Melbourne or Prince Henry’s hospitals, the association between hospital and the domestic residence was no longer considered relevant to a layout that now designed the grounds primarily as a means of accessing buildings (Figures 6.45-6.47) The distinction between front garden and back yard was correspondingly blurred and the activities that took place on the grounds became reduced in richness and variety. A shown in Figures 6.45 and 6.46 there is little difference between the front and back of the site on modernist sites.

Figure 6.45 View of front yard of Royal Melbourne Hospital looking north. The entrance area is open to the street and is designed for road traffic. SLVPC.

Figure 6.46 View of Royal Melbourne Hospital backyard looking south. Buildings separated from the main patient building are Boiler House (extreme right), Nurses’ House (right of main block) and Resident Medical Officer’s accommodation (behind main block). SLVPC.

Figure 6.47 The grounds of Prince Henry’s Hospital in the 1950s had no places in the grounds for patient use. SLVPC.
Modern medical sites are open to public view and access and there are no areas of retreat or private zones. The majority of services are provided within the building site and unlike the charitable institution form there is no necessity to leave the building to access medical treatments or undertake hospital duties. Experiences for patients and staff were connected to the interior of the hospital. Images of the hospital, do not include patient use of the grounds and it is reasonable to assume that there was limited appeal for patients to occupy public areas that provided little privacy or comfort.

<table>
<thead>
<tr>
<th>ELEMENTS OF THE GROUNDS</th>
<th>CHARITABLE INSTITUTION</th>
<th>MEDICAL CENTRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Balconies</td>
<td>Private garden for patients</td>
<td>Open Balconies</td>
</tr>
<tr>
<td>Private garden for staff</td>
<td>Car parking on site</td>
<td>Private garden for staff</td>
</tr>
<tr>
<td>Car parking on site</td>
<td>Ambulance on grounds</td>
<td>Car parking on site</td>
</tr>
<tr>
<td>Three storeys or more patient building</td>
<td>Screen fencing</td>
<td>Ambulance on grounds</td>
</tr>
<tr>
<td>Screen fencing</td>
<td></td>
<td>Three storeys or more patient building</td>
</tr>
</tbody>
</table>

Melbourne
- Moved to new site

Women’s
- Built as medical complex

Alfred
- Built as medical complex

Children’s
- Built as medical complex

Homeopathic
- Built as medical complex

Eye and Ear
- Built as medical complex

Austin
- Built as medical complex

St Vincent’s
- Built as medical complex

Queen Victoria
- Built as medical complex

RMH
- Built as medical complex

Table 6.1 Hospital Grounds 1900 to 1948 showing the changed character of the grounds as the hospital evolved from charitable institution to medical site. The removal of these elements resulted in sites and grounds that offered little opportunity for staff involvement and patient treatment. Compiled: author.

Table 6.1 summarizes the elements related to the use and experience of the grounds that were impacted by physical changes to the site as the hospital moved from charitable
HOSPITAL GROUNDS AS PLACES OF HUMAN ACTIVITY

institution to medical complex and from private place to public space. Open balconies remained as the last concession to the concept of salubrity and were still being built in the 1940s at Prince Henry’s, Austin and Women’s hospitals. As wards however were located in upper floors, the distance to the grounds increased. The grounds and few remaining gardens were of value principally for views out rather than for day to day treatment for patients and staff. The inclusion of car parks and associated road systems combined with removal of screen planting and perimeter fences reinforced the public nature of the grounds. Ambulances now occupied the front gardens and reduced the domestic aesthetic and increased noise and bustle to the hospital (Figures 6.48-6.49).

Figure 6.48 The front garden of St. Vincent’s site circa 1915. The domestic garden with informal arrangement of pot plants and path recalled familiar and comfortable places of home and gave privacy for patients. St. Vincent’s Hospital Archive.

Figure 6.49 The front area of St Vincent’s Hospital in the 1940s had lost its resemblance to a domestic garden with the introduction of an ambulance bay on the site. St. Vincent’s Hospital Archive.

24 Kumm Wing at Women’s (1939), 3KZ Children’s Block at Austin (1944) and Leighton Irwin re-construction at Prince Henry’s (1939-1952).
Table 6.2 This table demonstrates the changed experiences and activities for staff and patients of hospital grounds from 1900 to 1948. Compiled: author.

Changes in the physical characteristics of the grounds necessarily resulted in changed experiences for staff and patients as Table 6.2 summarizes. While hospital grounds had previously provided opportunities for a range of activities that normalized the patient...
experience, for staff they had provided a link to personal and familiar activities and scenes of domesticity. With the introduction of new buildings and the re-configuration of hospital sites the purposes for which the grounds had previously been valued were replaced. As articulated by Thwaites et. al., ‘…landscape became largely cosmetic and bore no relation to historic ideas that natural areas could have a bearing on the healing process, stress reduction and the general well-being of patients, staff and visitors.’

By 1948, as evident in the new type of medical complex site represented by the Royal Melbourne and Prince Henry’s hospitals, the experience of the grounds by both patients and staff was reduced to a view from a high rise balcony. The grounds themselves were reserved for transporting vehicles and people from the street to the building.

25 Thwaites, K., et. al., op. cit., (2005), 528.
CHAPTER SEVEN

ALFRED HOSPITAL GROUNDS 1869-1948

7.1 Introduction

This chapter enriches looks in detail at the Alfred Hospital grounds from its establishment in 1869 to 1948 to further develop the themes introduced in the previous chapter. The Alfred was identified for a detailed case study as one of the early charitable institutions in inner Melbourne with the largest site of 14 acres (5.8 ha) with an extensive archive. The grounds and activities of patients and staff are analyzed within the parameters of front garden and back yard. This establishes the relationship between physical characteristics and the purpose and meaning of the site for staff and patients and the changing identity of the hospital.

7.2 Alfred Hospital site and grounds from 1869 to World War I

The Alfred Hospital opened in 1869 on 14 acres (5.67 ha) opposite Fawkner Park in Prahran, an inner suburb of Melbourne. The first buildings were described in the Australian Medical Journal according to medical ideas of salubrity prevalent at the time, as ‘designed with special regard to ventilation, light, and to cheerfulness.’¹ The central circular bed with conifer was a common entrance design for charitable institutions of this time and extensive planting of trees either side of entrance added privacy and sense of enclosure (Figures 7.1 and 7.2). Conifers were often planted near hospitals because of their perceived medicinal qualities and the Alfred planted a number of these before 1900.² Outpatient clinics were located in the

² Conifers are evident in photographs.
main building and patients entered the front gate and reported to hospital porter inside the building without the necessity of passing through a gatehouse.³

The were a large number of staff resident on the site prior to World War I, partly as a result of their duties as medical staff but also connected to the function of the hospital as a domestic site that required the services of gardeners, cooks and people to undertake associated activities such as securing gates and tending animals. ‘The Vagabond’ reported residential staff as including gardeners, engineers, outdoor patient porters, nurses, maids and night watchmen who often enjoyed cricket games and quoits with doctors and other servants in the grounds.⁴ Lack of easy transport also influenced the number of people who lived on site before the widespread ownership of cars and contributed to the atmosphere of a closed community.

The Alfred built a number of buildings for patients and new medical technologies circa 1900 but these had little impact on the character of the grounds which maintained strong residential features of shrubberies, garden seating, specimen trees, circular drive and buildings set back from the street (Chapter 5).

Front garden 1869-1895

John Stanley James, a reporter who used the sobriquet ‘The Vagabond’ and lived incognito in the hospital as a staff member for 3 weeks, described the site in 1876 as composed of a building for in-patients, outpatient services and living quarters for staff.⁵ He paid attention to the prospect and views from the hospital, an important aspect of salubrity:

…from the spacious verandah in front the view over Fawkner Park is rather circumscribed; but from the first floors one has a magnificent view over South Yarra, Prahran, Emerald-hill, St Kilda, and Hobson’s Bay. Melbourne is nearly entirely hidden from view.⁶

⁴ The Vagabond., op cit., (1877), 51.
⁵ Ibid.
⁶ Ibid.
Patients and staff had the benefit of the front grounds which are ‘pleasant with shrubs and flowers.’

Figure 7.1 c.1890 Plan of front garden and backyard areas of Alfred Hospital. Compiled and labeled from information derived from Annual Reports and MMBW Detail Plan 1895: author.

Figure 7.2 c.1890 Alfred Hospital Entrance. The grounds had developed significant shrubbery and trees by 1890 in accordance with nineteenth century ideas of salubrity. Conifers particularly favoured for their medicinal qualities were extensively planted. Charles Rudd. SLVPC.

7 The Vagabond., *op cit.*, (1877), 51.
Annual Reports from this time list large donations of trees, shrubs, bulbs, seed and plants from a wide range of contributors. Edward Henty, a board member from 1874 until his death in 1878, donated extensive plant material and took a personal interest in the planting out and appearance of the grounds. Other contributors included private citizens, nurseries and seed distributors companies of Melbourne. These contributions added to the hospital as place of garden areas and wooded grounds in keeping with a large domestic estate.

Backyard 1869-1895

The backyard sections of the Alfred Hospital were not laid out with formal garden beds and shrubberies and housed the usual out buildings associated with a backyard of the hospital, such as laundry, kitchen, stores and sleeping quarters for male servants, morgue and cottage for infectious diseases. The Vagabond commented on the lack of shade trees or shelter pavilions from the weather. This made use of the grounds unpleasant for patients and staff in inclement weather. The lack of trees was addressed in 1881 with the planting of over 600 trees supplied from the State Forest, Macedon. Although, the planting of trees was instigated as a way of dealing with night-soil from the hospital, the site was later described as "a splendid bush-like setting which was the pride of the hospital and the envy of every other institution in Melbourne." Until the hospital site was connected to Melbourne’s sewerage system in 1897 however, this part of the grounds was dominated by smells and sight of sewage and earth.

The south-eastern section of the site housed fever tents from 1887 over summer seasons for a number of years as a consequence of typhoid epidemics (Figure 7.3). Their location at the back of the site whilst related to infection control was in proximity to other buildings which treated conditions considered socially unacceptable. Removed from public view, the fever tents were clustered with the refractory, cottage wards and morgue, all of which dealt with conditions such as sexually transmitted diseases, insanity and death.

---

8 Alfred Hospital Annual Report. Year ending 30th June, 1875, 4; Alfred Hospital Annual Report. Year ending 30th June, 1876, 5; Alfred Hospital Annual Report. Year ending 30th June, 5; 1877 Alfred Hospital Annual Report. Year ending 30th June, 1878, 5.
9 Ibid.
10 Alfred Hospital Year ending 30th June, 1881. Melbourne: Alfred Hospital, 5.
12 Alfred Hospital Year ending 30th June, 1897. Melbourne: Alfred Hospital, 5.
13 Alfred Hospital Year ending 30th June, 1887. Melbourne: Alfred Hospital, 5.
A two acre vegetable garden to the east and west of the central axis of hospital buildings was close enough to buildings for the work of the gardeners to be observed by staff and patients. The land beyond this to Punt Road described as ‘unknown country’ by the hospital’s architect, contained no buildings but was thickly planted with trees.\footnote{Henderson, K. A. (March 1924). Alfred Hospital’s Growth described by its architect. \textit{The Alfred}, 18.} 

Front garden 1896 to circa World War I

Entrance buildings on Commercial Road built in 1890 included a lodge, dispensary, outpatient buildings and main drive entrance. The single arched entrance provided both egress and ingress to the site, with the new buildings creating a visual and physical enclosure (Figures 7.4 and 7.5).\footnote{Ibid.} This entrance now controlled public access and limited the people visitors to those who were granted permission. Apart from visiting doctors, board members, patients, tradesman and weekly visits by families and friends the site operated as a closed community. Visiting hours were strictly controlled and limited to a three afternoons a week and outpatients did not gain access to the site beyond the entrance buildings.
Figure 7.4 1915 Plan of Alfred Hospital. The Alfred Hospital as a large site had a number of backyard areas different in character to the front yard. Compiled and labeled from information derived from annual reports and MMBW Detail Plan 1895 and 1948: Author.

Figure 7.5 1910 Front entrance of Alfred Hospital showing restricted entrance for public. The building of the gatehouse and outpatient building created a barrier between the front garden of the hospital and the street. Fence and perimeter planting of trees contributed to the seclusion of the site. SLVPC.
Figures 7.6 1910s Front area of Alfred Hospital inside the front gate. The gatehouse and outpatient buildings created a private zone in which activities of the hospital could be conducted out of public view such as in this case, the transfer of medicines from the pharmacy to the main hospital. The outpatients were restricted to the front buildings of the hospital on Commercial Road. Alfred Hospital Archive.

Figure 7.7 c.1915 Nurses sitting in front garden of Alfred Hospital in the privacy created by planting on perimeter fence and shrubbery. Memorial fountain indicates a personal connection to the hospital site. Similarly, garden was personalized by distinctive rockery made from shells and range of plants rather than a generic planting scheme such as associated with modernist sites which favoured minimalist schemes. Alfred Hospital Archive.
Figures 7.8 and 7.9 c.1918 Front garden of Alfred Hospital with seat, private areas and complex planting. Alfred Hospital Archive. 1901 front balcony of Michaelis Pavilion. The Children’s Ward had close contact with the front garden and also views of Fawkner Park. The residence of the Medical Secretary in the background contributed to the sense of familiarity and home for patients. Melbourne Museum.

Figures 7.10 and 7.11 Nurses in garden in front of Michaelis Pavilion. An avenue of elms and hedge was planted along the perimeter fence and enhanced the privacy of the site. The trees of Fawkner Park were visible as a borrowed landscape over the hedge, adding to the sense of seclusion from the city. Alfred Hospital Archive. c.1910 Front garden was quiet and private, a place where bicycles could be left unattended with no risk of being stolen by strangers in the grounds. Alfred Hospital Archive.

Figure 7.12 and 7.13 Nurses and patients using covered way and garden next to Michaelis Pavilion. Alfred Archive. c.1900 Cooking classes for trainee nurses could be held in the grounds without interruption from the public. Alfred Hospital Archive.
Privacy was further maintained by the planting of trees and shrubs which had matured into a highly ornamental garden by the early 1900s (Figures 7.6 and 7.7). The courtyard with its lush planting and privacy further enhanced by the new entrance buildings reinforced the sense of seclusion from the outside world. A memorial fountain erected in the front grounds in 1910 to the memory of the wife of Mr. Harold Walker, daughter of Mr. Robert Norman, Permanent Secretary of the Charity Organizations Society was a formal element that was consistent with a formal display front garden and indicated a personal meaning of the grounds for hospital personnel (Figures 7.7 and 7.8).16

Descriptions and images of the front grounds as ‘surrounded by rockeries and Moreton Bay fig trees’, suggest the residential quality of the grounds and a private zone in which staff and patients could retreat.17 A patient’s account of birds in the Moreton Bay figs and other trees published in The Argus, shows the interest and diversion provided by outdoor grounds for patients.18 The Moreton Bay fig was a favourite plant of public planting at this time, popularized by William Guilfoyle, curator of the Botanic Gardens who was listed as a donor of plants in 1884, 1903, 1899 and 1910 annual reports.19 This again illustrates the deep interest the grounds had for the public and others and also the idea of hospital gardens and outdoor grounds as a normal part of the hospital.

The trees beyond the perimeter fence in Fawkner Park also contributed to the sense of seclusion. The presence of this borrowed landscape emphasized the sense of separateness from the city. Further, the detached configuration of buildings necessitated walking by nurses through the grounds as part of daily routines and gave them experience of the garden as a workplace.

An ornamental garden area that extended along the front of the hospital site facing Commercial Road with an avenue of trees and hedge planted along the perimeter fence,
allowed patients to use the balcony and grounds in privacy (Figures 7.9-7.10). This area was associated with the Michaelis Children’s Ward and patients on the balcony had views and experience of the garden area in front of the building and views across Fawkner Park. Proximity to the domestic residence of the Medical Secretary which was built in 1898 contributed to the sense of familiarity and home.\textsuperscript{20} This building on the western corner of the site replicated a domestic home in its architecture and garden layout. The closed community of the hospital and the freedom this gave to staff and patients can be gauged by activities such as invalid cooking classes in the front gardens and the leaving of bicycles unattended under the covered way (Figures 7.11 and 7.13).

Backyard 1896 to circa World War I

By circa World War I, the difference between the formality of the front grounds and the informality of the backyard at The Alfred was marked. The front garden with wide formal drive, specimen conifer and complex ornamental flower beds was formal and imposing whilst the hospital backyard had less formal planting, narrow paths and simpler planting, predominantly of grass and trees.

Backyard area 1 circa World War I

In Backyard Area 1, buildings were smaller in scale as befitted activities dealing with services such as boiler room and kitchen. The buildings at the back of the site continued to be used for less respectable conditions such as mental illness, alcoholism, infectious and sexually transmitted diseases. They included the halfway house and cottage which were domestic in scale and form (Figures 7.14-7.16). Nurses were apprehensive of nursing in the cottage and refractory where they dealt with patients with medical conditions of extreme poverty and neglect, not to mention ‘the fighting drunks and raving lunatics and others considered too disturbing for the general wards.’\textsuperscript{21} Nurse Mavis Braid described the refractory ward as

\textsuperscript{20} Alfred Hospital Annual Report. Year ending 30th June, 1898. Melbourne: Alfred Hospital. Melbourne: Alfred Hospital, 5.
‘cubicles like cells with high barred windows and doors which could be kept locked and which had just a slot of a window so that staff could keep an eye on the patient.’

Figure 7.14 Backyard of the Alfred Hospital in vicinity of cottages and refractory wards. Removed from the rest of the hospital, hedges, trees and domestic buildings imbued this part of the hospital grounds with a relaxed homely aesthetic. Alfred Hospital Archive.

The privacy of the backyard at the Alfred enabled resident medical staff to participate in informal and unauthorized games and activities. G. Raleigh Weigall, a Resident Medical Officer (R.M.O) in the early 1920s describes how the grounds were used:

Golf had been a popular game around the Hospital for years, and considerable sadness was felt for those who enjoyed the longer course, at the inroads made into it by the new surgical block and the new house in the Punt Road corner, which had just been built for the Medical Superintendent…..

The longest hole left to us was a particularly interesting last hole, a pitch shot over the laundry and kitchen on to the lawn where the old oak tree stood outside the door of the Resident’s dining room (now occupied by the multi-storey building).

22 Ibid, Braid.
As an indicator of its informal backyard character, Weigall reported on the holes in the tin fence at the back of the site through which R.M.O.s accessed playing fields of the Blind Institute for games of cricket and a particularly violent form of hockey.\textsuperscript{24}

\textbf{Figures 7.15 and 7.16} 1900 Nurse standing in front of the 'Cottage' which had beds for eight women patients. Clipped hedges and narrow path suggest a domestic residence. Paterson, 46. Nurse standing outside 'Halfway House', one of the cottage wards in the backyard of the Alfred site for infectious diseases. The corrugated tin back fence with houses gave a suburban backyard aesthetic to this part of the site. Patient at the window had a view of hedges and trees at the back of the main patient buildings (See Figure 7.14). Holes in the tin fence were used by resident medical officers to access the playing fields of the Blind Institute for informal games of cricket and hockey. Alfred Hospital Archive.

\textsuperscript{24} Weigall, G. R., \textit{op cit.}, (1960), 3.
The staff reminisces of these buildings reflect their isolation from the rest of the hospital and physical characteristics of the grounds:

Up the narrow path was the Refractory! This was for the men and some were in cells with bars on the windows. It was for dangerous or infectious patients. “Halfway House” was another building halfway up to the Refractory from the Cottage. To get to these wards…one had to go under trees…to the back of the other hospital wards, quite isolated. Any case that was “dirty” or “dangerous” was sent there.  

Photographs of the back yard of the grounds at the back of the site at this time make evident the differences between front and back of hospitals. The domestic details typical of a backyard, that is pot plants, latticework and dog ambling into the background in Figure 7.17 accentuate their less formal and personal character as part of the hospital grounds. The makeshift tent ward is also typical of the type of structure to be found away from the public sections of the grounds.

---

Backyard area 2 circa World War I

*Figure 7.18* c.1900 A rough track through trees and rough grass lead from nurses’ home to the main hospital building. This was the ground planted out with over 600 trees in 1881 which added an element of wildness to the site (Area 2). Alfred Hospital Archive.

By the end of World War I the land between the main hospital buildings and Punt Road, planted with over 600 trees in 1881 had matured into ‘a forest’ which created a wild and unkempt character (Figure 7.18). Site elements included the first nurses’ home built on the Punt Road perimeter in 1909, tennis courts, two acre vegetable garden and an unpaved road flanked by an avenue of elms that lead from the rear entrance of the hospital to the circular drive at the entrance (Figures 6.19 and 20). A rough walking track ran from the new nurses’ home to the hospital buildings through trees and rough grass. A post and wire fence with barbed wire, informal planting and lack of hard landscaping of roads and paths invoked a rural character despite the hospital’s location near the city. As with the front garden, the personal and private character of activities the grounds are evident in photographs of tennis groups of nurses’ and doctors which appear to be taking place in a country location rather than an inner urban site (Figures 6.21 and 6.22).

26 *Alfred Hospital Annual Report. Year ending 30th June, 1881.* Melbourne: Alfred Hospital; Anon. (December 1933). "I Like This Old Place". *The Alfred*, 13.
Figure 7.19  Nurses’ home built in 1909 in unkempt area of the hospital site near Punt Road. Post and wire fence with barbed wire gave a rural character to this end of the site. Alfred Hospital Archive.

Figure 7.20  Elm Drive ran from the rear entrance of the site, near the nurses’ home to the front of the Linay Pavilion and the front circular drive. This portion of the road was rural in character, which is emphasized by the post and wire fence which divided the road from nurses’ home and vegetable garden. Alfred Hospital AR, 1916
Figure 7.21 View of tennis court looking towards the nurses’ accommodation. The refractory ward and ‘The Cottage’ were located to the right of the tennis court in this photograph, out of the way of public scrutiny. Planting and gardens elements were under less control compared to the display garden at front of site. Alfred Hospital Archive.

Figure 6.22 Matron Louisa Mann (1912-1928) with nurses and doctors watching a tennis game on the court which had been built on this section of the grounds in 1900. The memorial fountain in the front garden can be seen in the left background. Alfred Hospital Archive.
The backyard of the *Alfred* was more formal in closer proximity to patient buildings but as can be seen in Figure 7.23, it was still used for informal activities such as sitting under a tree. The chair in the shade of a large tree, garden beds of unclipped shrubs and trees, narrow paths and grass indicate a domestic scale and character commensurate with quiet enjoyment of the backyard setting.

![Figure 7.23](image)

*Figure 7.23* Grounds on the east side of the patient building near the nurses’ tennis courts and elm avenue were relaxed and less formal than the display garden at the front of the hospital. The chair under the trees suggests quiet enjoyment of the backyard setting. Alfred Hospital Archive.

Backyard area 3 circa World War I

![Figure 7.24](image)

*Figure 7.24* Child patients housed in temporary huts on the western section of the grounds. 1923 Alfred Hospital AR, 26.
A series of temporary buildings were built between Michaelis Ward and the Superintendent’s house in 1915 for the treatment of military personnel. When this proved to be unnecessary, the huts were converted to a number of uses including maid’s quarters and temporary accommodation for children during renovation of the Michaelis Ward in 1923 (Figure 7.24).

7.3 Alfred Hospital site and grounds after World War I to 1948

After World War I the hospital grounds underwent major transformation driven by changed attitudes that favoured neatness and uncluttered appearance for hospitals (Figure 7.25. See Chapter 5). Many of the trees were removed as part of a ‘smartening up’ program by the gardener, Richard Healey, during the 1920s. In a tribute to his work published in “The Alfred”, the hospital journal, under the heading, “I Like This Old Place”. Eighteen Years Service at the Alfred’ Healey’s emotional attachment to the hospital grounds is emphasized and his influence on its aesthetic appearance described.\(^\text{27}\) The article claimed that Healey ‘has really been responsible for making all the garden paths and roads in the hospital grounds, and for converting what was, when he came to the Alfred, almost a forest into the present beautiful lawns.’ Significantly, in terms of the impact of the nurses’ home on the appearance of the

\(^{27}\) Anon. (December 1933). "I Like This Old Place". The Alfred, 14.
grounds, Healey’s ‘special pride are the gardens and lawns in front of the Nurses’ Home, which he designed and worked up to their present delightful state’.

Elsewhere, the journal recommends that people stop to admire Healey’s prize dahlias.

Finally: ‘Dick can tell you the history of every tree, shrub, or perennial plant or flower there, some of them being given by various hospital supporters, some of them begged, borrowed, or stolen from anywhere within a fifty-mile radius of Melbourne, but each one having a story which amply demonstrates Dick’s love for the Alfred and his desire to make the grounds attractive. Most of the seedlings are grown by him in his little nursery plot at the hospital.’

This insight into the role of Healey in determining the character of the grounds is important for a number of reasons. Firstly, the reference to donations by ‘various hospital supporters’ demonstrates again the deep interest that the hospital and by extension its grounds, held for the general community. Donations to the garden were made with the understanding that the appearance of the grounds would be benefited. Secondly, it emphasizes the importance of personal connection in determining site characteristics and illustrates the attachment to the hospital as home for staff. Healy knew the history of every garden plant, people walking around the grounds stopped and chatted about his work, the appearance of the grounds is highlighted in the hospital magazine, all of these events emphasize the interrelationship between grounds, purpose, meaning and personal significance not for Healy alone but for staff and patients.

Front garden area 1 and 2 circa World War 1 to 1948

The front garden of the Alfred site was significantly modified during the building program of the 1920s. The grounds associated with the entrance were re-designed to admit cars via two entry roads either side of the re-modeled out-patient and casualty wards and a kiosk was built in the middle of the central courtyard (Figure 7.26). This and the removal of the central conifer which had dominated the main courtyard diminished the ornamental garden aesthetic and places of refuge for patients and staff. The quiet of the garden retreat was

28 Anon. (December 1933). “I Like This Old Place”. The Alfred, 14.
replaced by the noise and movement of motor cars and increased numbers of people onto the site. The road system with two new entrances meant that the practice of vetting visitors before gaining access to the site was no longer possible or presumably considered important. The hospital’s status as a private residential site gave way to the hospital as busy medical complex that was available to the general public. The grounds had moved from those of a private residence to that of a public space.

Figure 7.26 The front entrance was functional and modified for cars which are parked at random within the front courtyard. The large conifer was removed for The Ladies Auxiliary Kiosk in the middle of the courtyard and the covered way has been closed in. The memorial fountain that had stood in the rockery garden bed before World War I has been moved to the far corner of the courtyard. Mitchell (1977), 14.

The ornamental garden that had surrounded the Michaelis Ward had been removed in 1922 as part of the modernization of the hospital (Area 1) (Figure 7.27). This contributed to the reduction in privacy of the site but also reduced the experience of the grounds for patients. The removal of the shrubbery and trees and replacement with grass changed the hospital grounds from a place of quiet retreat to that of public display.

Figure 7.27 View of the Commercial Road frontage of the Alfred site. The army huts can be seen between the Secretary’s residence on the right and Michaelis Ward. The front balcony of the Michaelis ward had been built in and the ornamental garden that had surrounded it had been removed in 1922 as part of the 'modernization' of the hospital. ‘The Alfred’, December 1923, 15.
Building of the Edward Wilson Wing (1923) and intermediate hospital, Margaret Coles Maternity Wing (1942) on Commercial Road had increased the public frontage but had not provided a front garden commensurate with a residential property. The treatment of these areas was primarily cosmetic and designed for cars rather than people (Figure 7.28).

**Figure 7.28** The front garden of Margaret Coles Maternity Wing built in 1942 on Commercial Road was not intended for patient or staff use with cosmetic planting, car parks and access roads. Mitchell (1977), 201.

Backyard area 1 World War I to 1948

**Figures 7.29 and 7.30** show the informality of the activities in the backyard and its association with the garden as part of patient treatment. The caption underneath the patient on stretcher reads ‘Sr. Bell has a cheery word with her small patients outside ‘Half-Way’ House’. The Alfred, June, 1926. 1938 Nurses holding baby and kitten in backyard of the Alfred Hospital near Halfway House is further evidence of the homely atmosphere. Paterson, 114.
As with the front garden, the backyard areas of the Alfred Hospital, were reduced as a result of building programs after World War I. Significantly, area 1 at the rear of the hospital lagged behind the modernization that had had altered other sections of the grounds. In these areas patients and nursing care resembled nineteenth century medical practices of salubrity and the grounds maintained its informal domestic scale. Sr. Bell for instance, who had worked in the cottages for a number of years is described as dealing with special cases, a position in which ‘tact, firmness and human understanding’ are listed as important in treatment rather than medical science (Figure 7.29). This commentary is linked to a picture of Sr. Bell dealing with a patient on a stretcher bed out of doors, as an example of the type of treatment that was undertaken in this part of the hospital. Nursing in the cottages it is suggested, represented human empathy and care rather than technical expertise and modern buildings. The presence of pets in the backyard further suggested the backyard as an alternative site of hospital treatment in which informal domestic activities and the comforts of home survive whilst the front of the hospital is modernized with car parks and lawns (Figure 7.30).

Eventually however, in 1941 the domestic cottage made way for the new boiler house and chimney stack which was viewed with regret by former staff:

With the growth of the hospital the path and lawns were first to go, and the old pepper tree that offered shade and seclusion, and had weathered many a storm, defied the axeman's prowess and, with the secrets of many hidden in its branches, fell from its home before the door of "The Cot," after Nature in one of her wild and mischievous moods had shaken and disturbed the roots of the old tree... my thoughts went back two decades or more and a picture of the narrow path lawn, swept on either side, leading from the main part of the hospital to the Isolation Ward came vividly before my eyes .... When the refractory bell was rung that little path with its lawns on either side became an open track and the entire hospital staff competed in an all-age race to save, perhaps, some person from the clutches of a delirious or mental patient.  

31 Anon. (June, 1936). Sisters Go Abroad. The Alfred.  
Backyard area 2 circa World War I to 1948

Figure 7.31 1933 Aerial photograph of Alfred Hospital site. Vegetable garden, trees and large section of elm avenue was removed creating a large open site that was easily observable from the street. Alfred Hospital Archive.

Elsewhere in the site, the building of Hamilton House and extensive extension of the nurses’ home resulted in partial loss of elm avenue and large number of trees that had been described as ‘almost a forest’, converting the previously secluded part of the site to large open areas (Figure 7.31).33

After World War I, the *Alfred* began a series of large fetes and other fund raising activities in the grounds of the hospital. Although this indicated the extent to which the hospital had lost its status as a refuge from the city, it also represented the connection between community and the hospital. Widely reported in *The Argus* from the 1920s to early 1930s, the grounds were used for a series of bazaars and fetes that included stalls, music programmes, animal and fairground rides (Figures 7.32-7.34).34 Fetes added liveliness and diversion to the

33 Anon. (December 1933). "I Like This Old Place". *The Alfred*, 13.
hospital experience which were attended by both patients and staff and could also be witnessed from balconies and verandahs. The following excerpt from *The Argus* gives some indication of the excitement of these events and its public nature, able to be seen both from within and outside the grounds. Mention of medical students, dignitaries and hospital board members also demonstrates the way in which these events brought the hospital and community together:

At half-past 2 o'clock on Friday afternoon Lady Irvine will be met at the main entrance to "Colourland," in Commercial Road, by the board of management of the Alfred Hospital, and welcomed by the president (Mr. George Fairbairn). She will be escorted through an avenue of Venetian masts to a central position in the grounds, where she will declare the fete open. Immediately following the opening ceremony, and in full view of spectators, both inside the grounds and out, Bell, the magician, will be pinioned by a policeman in uniform and a detective, and placed in a straight jacket, being then hoisted head downward from a yardarm 30ft. in the air. Thus suspended he will endeavour to liberate himself within two minutes. The general festivities will follow. These will include many forms of amusement, including an Egyptian revue, in which many showgirls, well-known musical and other performers, and medical students, will take part. A jazz palais in one of the large new wards of the Edward Wilson wing will be directed by medical students, and for this four of Melbourne's leading orchestras are giving their services. The Scottish feature on Saturday promises to be very attractive. Myers Ltd. are supplying the whole of the costly decorations for the revue. The Misses Lorna and Toots Pounds will both attend the fete on Friday afternoon. Miss Lorne Pounds is dressing for presentation to the committee a doll to resemble her own costume in "Colourland."35

The construction of Hamilton Russell House (1931) and the Margaret Cole Wing (1942) however, removed the land which had previously been the site of the annual fetes and by the 1940s these were no longer held within the grounds.36 This construction also resulted in

---

the rural back entrance road becoming widened and resurfaced to accommodate vehicles associated with a new car park on the southern boundary.\textsuperscript{37}

\textbf{Figure 7.32} 1927. The caption reads: Scenes at the Colourland Fete, which was opened by the Lord Mayor (Sir Stephen Morell) in the grounds of the Alfred Hospital yesterday afternoon. Left: A doctor and nurses enjoying a ride on the merry-go-round. Right: Stallholders putting finishing touches to their stalls. The fete will be continued until Saturday. Friday 9 December 1927, 'The Argus', 13.

\textbf{Figures 7.33 and 7.34} Carnivals and fetes in the hospital grounds provided entertainment and socializing events for staff and patients and diverted attention away from the dull routines and clinical atmosphere of the wards.

\textsuperscript{37} Alfred Hospital Annual Report. Year ending 30th June, 1925. Melbourne: Alfred Hospital.
Backyard area 3 circa World War I to 1948

Figure 7.35 Linay Pavilion after the construction of balconies illustrated in Annual Report and ‘The Alfred’ hospital magazine. The garden beds have been built over and the areas adjacent to the building are replaced by grass. Alfred Hospital AR 1923.

The garden elements of Area 3 were reduced with the removal of vegetation and garden beds associated with the modernizations of buildings in 1920s. Balconies and sun rooms were added but were notably utilitarian and the associated grounds were similarly severe and lacking in places of refuge and retreat (Figure 7.35). Significantly, despite the modernization rhetoric of the period, patients were still using the balconies as places of rest and occupation into the 1950s much as they had done before World War I. A nurse’s account of the period for instance, recounts how patients were given small jobs such as rolling bandages and were encouraged to sit on the balcony or verandah in the sun.\(^{38}\) The two storey buildings provided experiences of the hospital grounds in ways which would not be available to the patient in the multi-storey patient blocks that were later built on the hospital site. The capacity to listen to music routinely provided by visiting bands playing on the lawns is another example of the type of experience that would be precluded for patients in multi-storied ward blocks.\(^{39}\)

---

\(^{38}\) Interview with Margaret Royston, (27th January, 2009). Former nurse at the Alfred in the late 1940s and early 1950s.

7.4 Alfred Hospital site and grounds 1948

Figure 7.36 1954 aerial of the Alfred site indicating the spread of buildings across the site that eradicated many private and personal activities. The former lawn areas have been converted to a car park, either side of the Administration Building. The cottages at the back of the site have been replaced by large psychiatric ward and Boiler Building (1941). Alfred Hospital Archive.

Figures 7.37 and 7.38 Backyard of the Alfred Hospital with former buildings crowded out by modern buildings and cars parked within the grounds. The building with external staircase was the eight storey Centre Block built on the site of the oak tree made into Memorial Board. Alfred Hospital Archive.
By the 1940s the garden aesthetic of the Alfred site had largely been lost. A row of trees along Punt Road boundary had been retained but the rest of the site was predominantly grass or tarmac (Figures 7.36-7.38). Cars were widely distributed across the site which was crisscrossed by roads and devoid of areas of quiet retreat. Unlike the smaller hospital sites, there was distance between buildings and also grass areas but the idea of the site as a place of patient convalescence in which the grounds provided treatment by contact with beautiful surroundings was no longer evident. The variety of experiences previously available in the grounds was curtailed and patients and staff remained within buildings as the opportunities for outdoor activities were largely lost.

7.5 Hospital grounds as places of human activity

Chapters Six and Seven have described the activities that took place in the hospital grounds of the hospital as charitable institution as domestic, personal and connected to the everyday activities of home. Feeding chickens, patting dogs, watering pot plants, hanging out washing, nursing babies in the garden recalled home, as did the associated elements of the site such as fowl yards, flower pots and clotheslines. In the grounds, staff and patients experienced positive attributes of garden as well as formal and informal social interactions. This connection with the grounds humanized the hospital experience in ways that was significantly different to the experience of the medical complex, where patients and staff had limited contact with the exterior grounds. All of these activities which were dependent upon the physical characteristics of the grounds were significant to patient and staff well-being identified by Thwaites et al.40 Largely these benefits have not been documented in the history of the built environment of hospitals, but as has been indicated in these chapters they form a significant theme.

Opportunities to use the grounds of hospital were reduced on existing sites by the expansion of buildings and on new hospital sites by the modernist design aesthetic. The strong modernist form of hospital sites favoured by the Charities Commission and promoted by architectural firms from 1922 contributed to functional and minimalist sites which were part of

the de-humanizing of experience there. Grounds were with little purpose and were considered only in terms of the hospital’s function as dispenser of medical interventions by hospital bureaucracies, architects and to some extent medical staff. The evidence of hospital histories, photographs and personal accounts however, suggest that for patients and staff the grounds were important to their sense of belonging to the institution as a place of personal meaning. Removal of these places of activity removed the connection to everyday life experiences which had reduced stress of hospitals and engendered ‘emotional fulfillment’ important in human well-being.\textsuperscript{41} Not recognized at the time by experts, evidence of the activities undertaken on the site demonstrates the relationship between spatial changes and personal meaning as significant factors in the history of the built form of hospitals.

\textsuperscript{41} Thwaites, K., et.al., \textit{op cit.}, (2005), 525.
CHAPTER EIGHT
HOSPITAL SITES AND GROUNDS IN TRANSITION

8.1  Introduction

The study of hospitals in Melbourne from 1848-1948 has provided insight and clarity into the purpose and meaning of hospital sites and grounds and the consequences of their decline for patients and staff. Findings include the emergence of modernist grounds in the International Style in Melbourne, ahead of similar developments in North America; the development of modernist hospital grounds independent of architectural styles; the importance of hospital grounds to patients and staff, and the role of heliotherapy in the use of hospital outdoor areas.

Overall, the process of change was shown to be influenced by social, cultural and economic factors. These factors however, did not fully explain the removal of gardens. This was linked to a cultural shift in the understanding of the role of gardens in patient treatment and the changing identity of the hospital. The hospital, no longer a charitable institution but a modern medical centre, looked to streamlined, functional grounds to reflect its new identity. The traditional residential style of garden which had previously been associated with hospitals, was now considered inappropriate for a modern hospital. Added to this, nineteenth century ideas of salubrity, which prescribed hospital gardens as part of treatment, were superceded by new medical treatments based on technology and scientific knowledge. These findings supplement a gap in the literature on hospital development which has previously focused on buildings independent of the grounds and their use and provides important information and background for design of hospitals in the twenty-first century.

This chapter discusses the main findings under the themes of the hospital’s transition from charitable institution to medical complex, loss of purpose and meaning and implications for contemporary hospitals.
8.2 Hospital sites and grounds in transition from charitable institution to medical complexes

The transition of hospitals from charitable institutions to medical centres marked the decline of hospital grounds as significant places for convalescence and activity for both staff and patients. The changing purposes of the grounds can be linked to a number of interrelated factors. Of particular importance to the appearance and use of hospital sites was the demise of salubrity as a medical approach that offered cure. Emphasis on new scientific treatments such as heliotherapy weakened the legitimacy of beautiful surroundings and gardens as a valid component of hospital sites. Secondly, the evolution from a residential refuge for the sick poor, to a public site of scientific treatment for the middle-classes, changed the identity of the hospital. Under these social changes, hospital grounds to their indigent inhabitants were no longer considered relevant. Instead, hospitals authenticated their role as a medical complex by complementing the stream-lined aesthetic of modernism in the International Style with its rhetoric of progress and science. Other impacts of scientific medicine included more and larger buildings for new medical treatments such as surgery, X-ray and pathology and buildings for increasing patient numbers and staff. On sites with limited space, this led to loss of gardens and overcrowded sites. Economic pragmatism, increasing bureaucratization and the centralization of hospital building programs under a government board which favoured modernist hospital sites also contributed.

While all of these factors influenced the development of hospital sites they do not fully explain the removal of gardens, shrubberies and trees from hospital sites, particularly in the 1920s. This thesis argues that these changes were expedited by a shift in cultural understanding of the relationship between hospital landscape and patient well-being. Gardens were now considered irrelevant to cure. This changed attitude to the relationship between hospital grounds and health contrasted with nineteenth century ideas of landscape and marked the advent of the types of hospitals sites that remain with us today.

Chapter Four discussed how the purpose of the hospital - to provide a refuge and a place of treatment for patients - in the nineteenth century was based on a belief in salubrity. This belief influenced the location and configuration of hospital sites and their grounds as well as their buildings. The strength of the idea of salubrity in Melbourne is demonstrated by the
fact that all hospital sites in Melbourne before 1890 were sited near gardens and open and elevated ground. Similarly, balconies, covered ways and places for convalescent activities such as sitting in the sun and walking in the garden were evident. These attributes were widely referred to in the popular press and medical literature as positive because they provided contact with fresh air, sunshine and the beautiful surroundings considered important in the treatment of illness. Changes to the landscapes hospitals after World War I therefore need to be considered in relation to a changed understanding of the relationship between hospital landscapes and patient treatments, rather than merely a change in aesthetics.

After WWI, the ideas formerly advocated by Florence Nightingale that a garden and cheerful outlook promoted cure by promoting a positive state of mind were considered unscientific. The mechanisms by which these factors made people better could not be demonstrated scientifically and therefore were not considered as important as the cures for which a scientific rationale existed. In contrast, the scientific basis of heliotherapy was widely accepted in the medical literature and may account for the continued provision of balconies and accessible flat roofs until well into the middle of the twentieth century, long after most ground level gardens had disappeared.

Other factors may also have contributed. Modernist ideas of the appearance of hospital sites for instance favoured a functional aesthetic, balconies and flat roofs. The style of gardens that had previously been associated with hospitals as a charitable institution was now considered old-fashioned. Further, hospital bureaucrats found it difficult to justify gardens and extensive grounds under the competing demands of other medical practices that were considered scientifically proven.

Significantly, the comparison between hospital sites and other charitable institutions demonstrates that, whilst, prominent on hospital sites, balconies and covered ways were not features of orphanages, benevolent asylums and institutions for the blind. Again, this indicates

HOSPITAL SITES AND GROUNDS IN TRANSITION

that these are defining features of hospitals from the nineteenth century. These were specific to hospital treatments of the period and the medical purpose for the hospital site.

Hospital grounds in form and garden style on the other hand, were by and large indistinguishable from other charitable institutions. This finding enriches the argument by Adrian Forty that pavilion hospitals of the nineteenth century were an ‘unmistakable’ form when compared to earlier hospitals in the eighteenth century that had resembled domestic villas. Hospital grounds in contrast, are shown to be generic rather than ‘unmistakable’ and did not move to a new form to accompany the new form of pavilion building. The grounds in so far as they were domestic in character, were similar to previous hospital villa sites of the eighteenth century. The way the outdoor attributes of pavilion hospitals were spoken about and used as described in Chapter Four however, indicates a strong justification for their inclusion in medical institutions as treatment for patients. This deepens the meaning of hospital grounds beyond other justifications such as civic pride and moral rectitude common to all residential charitable institutions in the nineteenth century. In this finding can be discerned a shift in attitudes to hospital grounds from the eighteenth century which, as has been shown in Chapter Two, was mainly associated with a civic rather than a medical identity for the hospital.

After WWI, hospital sites changed rapidly whilst the grounds of charitable institutions remained essentially unchanged until the end of the twentieth century (Figure 8.1). This again indicates the diminished importance of the garden in hospital treatment and its reduced relevance to the identity of the hospital in its function as a provider of medical services to middle-class patients. On the other hand, the nineteenth century garden aesthetic for other charitable institutions indicated the non-medical function of these places with a continued traditional role of residential care for the poor and disadvantaged. The four photographs of the Deaf and Dumb Institute taken in 1997 indicate how little its landscape had changed from the nineteenth century. Hospitals however retained and continued to build covered ways and

---

3 The Deaf and Dumb Institute changed its name to Victorian College for the Deaf in 1995 and operates as a non-residential school for hearing impaired students.
balconies until the 1950s as in the case of *Prince Henry’s Hospital*, indicating the continuing importance of fresh air and sunshine even as the grounds became less important.

*Figure 8.1* The four photographs of the Deaf and Dumb Institute taken in 1997 indicates how little the landscape had changed from its appearance in the nineteenth century. This is in contrast to hospitals which had initially resembled these sites but had changed radically after 1900 as its identity and purpose changed. Victorian Heritage Database Number H2122. Compiled: author.

After World War I changes in the character of the grounds reflected the changing status of Melbourne hospitals as they evolved from charitable institutions to medical complexes (Chapter 5). The site characteristics that specifically demonstrated this transition were:

1) Removal of perimeter fences.

2) Replacement of garden beds and ornamental trees with lawn areas.
HOSPITAL SITES AND GROUNDS IN TRANSITION

3) Increasing numbers of storeys for patient buildings.

4) A reduction of private areas that had previously been the domain of staff and patients.

These new site characteristics were to become strongly associated with the International style modernism of hospital sites from the mid-twentieth century onwards. Significantly however, these features were already evident before the emergence of hospital buildings in the International Style on sites of Melbourne hospitals. The Alfred Hospital for example, introduced these elements in juxtaposition with its nineteenth century buildings in 1922, before constructing any International Style buildings. The finding that modernization of garden areas pre-dates modernization of built fabric challenges the commonly held idea that International Style modernist architects such as Stephenson and Turner, were responsible for its introduction in Melbourne. Instead, it suggests that other cultural factors were driving the move to International Style modernism to which architects responded. Architects rather than being the initiators of change, were interpreters of changed attitudes, including those that considered the nineteenth century hospital garden no longer considered relevant. This links with Annmarie Adam’s assessment of hospital form as reflecting cultural and social norms rather than being driven by the creative ideologies of architects.4

This thesis also established that whilst architects did not initiate the appearance of hospital grounds, the role of gardeners is unclear. The views of Richard Healey, the gardener who oversaw the modernization of the Alfred grounds are not recorded. He is credited with removing trees and installing the lawn areas but also kept traditional garden beds consistent with nineteenth century styles, in front of the nurses’ home. Gardeners on hospital sites were trained in horticulture and not landscape design and there is no association of a well-known garden designer with hospital grounds after the involvement of William Guilfoyle, Curator of the Royal Botanic Gardens from 1873 to 1912. The evidence suggests that hospital gardeners as hospital staff members were implementing orders rather than initiating designs.

The grounds of sites which promoted the modern scientific agenda of medicine such as the *Alfred Hospital* in the 1920s, contrasted with hospital sites in North America. These have been described by Annmarie Adams as deliberately using old-fashioned gardens to allay fears of the radical changes in medical practice happening within the buildings. The *Alfred* and *Homeopathic* hospitals provide evidence that in contrast, Melbourne hospital used the grounds to promote rather than conceal the narrative of scientific medicine.

In the years after World War I, the grounds and built elements such as balconies and flat roofs retained some importance due to their use for the scientifically credible treatment of heliotherapy. Heliotherapy, as the new interpretation of salubrity however, emphasized the scientific merit of ultra-violet light from sunshine on the body rather than the psychological and emotional benefits of experiencing beautiful surroundings. Patients in beds on lawns in full view of the public now replaced exercise in sheltered shrubberies and private places in the garden that had previously offered opportunities for recreation, exercise and socialization (Chapter Five). With its emphasis on physical rather than psychological benefit, heliotherapy signified the shift towards rationalization of the grounds and gardens. Access to fresh air and sunshine provided physiological benefit by a mechanism that could be explained scientifically. Ideas that cheer and emotional well-being derived from contact with beautiful surroundings may be as important to patient treatment as ultra violet rays were losing medical credibility. Outdoor areas including balconies were for sunlight provision rather than contemplation of nature. Ornamental gardens and secluded areas for the purpose of quiet retreat and emotional rejuvenation were no longer required for treatment and lost importance. As discussed previously however, this along with other factors influenced hospital grounds rather than being the sole cause of their disappearance.

By 1948 heliotherapy had itself lost much of its legitimacy as a cure. Antibiotics were introduced and produced dramatic improvement in medical conditions such as tuberculosis that had previously been associated with solar treatments. The grounds were legitimized principally as a space for buildings to house medical technologies and increasing numbers of patients and staff. There was an increase in buildings for private patients, X-ray, pathology and operating theatres, built over ornamental areas and places used for recreation and exercise for patients and staff. Existing hospital sites, identified as chaotic sites in this thesis and
elsewhere, became overcrowded with buildings and car parks replacing ornamental gardens and open space. While, the loss of grounds for patient and staff use later came to be seen as a negative consequence at this time the new buildings were hailed as a modern improvement and of direct benefit to patients and staff.

Economic pressures have been implicated in the demise of grounds after World War I. A need to reduce maintenance costs combined with rising land values it is argued, made retention of garden areas difficult. The degree to which economic factors are implicated remains problematic. From foundation, hospital sites were under financial pressure but what is evident is that despite this, hospital grounds during the period leading up to World War I were given priority as an integral part of hospital treatment. After World War I as priorities changed and while economic pressures were evident, it was the buildings which hospital management now preferred over the grounds in the spending of their limited budgets. Even on sites where hospital authorities had the space to provide new buildings, garden beds and shrubberies such as at the Alfred and later at the Royal Melbourne, lawns and a functional aesthetic for ornamental areas became the preferred approach. Further, the introduction of lawns did not result in less maintenance but as was demonstrated at the Alfred site in Chapter Five, the removal of trees and established shrubberies changed the duties of gardeners rather than reduced their workload.

The inability to expand hospital sites due to the high cost of land is countered as a reason for loss of gardens and outdoor grounds, by the example of the Royal Melbourne Hospital. This site at 11 acres (4.5 ha.), had ample room for shrubberies, large trees and areas for private patient and staff recreation and exercise. These were not however provided. Grounds consisted of a car park, flat and exposed lawn areas, minimal planting and open path and road systems. The function of the grounds became one of providing a platform for viewing the buildings from the street and space to convey people and vehicles freely between them. These findings provide further evidence to support Sloane’s critique of twentieth

century hospitals as sites which did not recognize the functional and psychological benefits of the grounds to patient care. The demise of the grounds as places of importance to patient treatment and to human well-being contrasted with nineteenth century ideas of the garden and reveals a new understanding of outdoor areas particular to the post-World War I period in Melbourne. This finding reinforces the argument that hospital grounds were determined by cultural as well as medical, economic and architectural imperatives.

Although most hospitals became associated less with ideas of salubrious landscape after World War I, this was not true for all types of hospitals. Hospital grounds which continued to value salubrity were associated with two particular types of patient, namely incurables (Austin Hospital) and children (Convalescent Cottage, Sherbrooke Convalescent Cottage, Frankston Orthopaedic Hospital). Continuing belief in the significance of landscape for the treatment of these two types of patients is evident in the location of these sites, the characteristics of their grounds and the ways in which these attributes continued to be discussed well into the twentieth century (Chapters 4 and 5). In contrast with the sites of other medical hospitals these represented a continued belief in landscape as able to transcend incurable disease and restore a connection with nature severed by city slum living and poverty. Located in semi-rural Heidelberg, seaside suburbs and temperate rainforest, they were geographically and ideologically separate from the inner-city sites that offered cure through modern medicine. Here, landscape, rather than the tools of modern medicine such as drugs and new medical interventions such as radiology, provided treatment.

The Austin Hospital continued as a garden site well into the 1950s and contrasted with inner urban sites which promoted their treatment in terms of medical technology, such as the Queen Victoria and Royal Melbourne. With little or no garden suitable for patient use or staff well-being, these sites allayed their identity with the technology occurring within the buildings (Chapter Five). Of particular relevance is the residential garden form of the hospice site, Caritas Christi, established in 1941 for patients in the last stages of incurable illness. The site, with its extensive gardens, again indicates, that in cases where modern medicine could not

offer a cure, former ideas of salubrity served as the treatment philosophy. The idea of transcendental landscape for incurable conditions is current today as is apparent in the example of Ken Worpole’s book specifically on hospice design and the importance of including gardens. Here the nineteenth century ideas of hospital landscape persist. The garden is a refuge and place of transcendence as an alternative to scientific treatments.

Using these examples, hospitals can be classified as either sites of cure by medical technology or of care with landscape as solace and compensation. Under this classification, inner-urban medical complexes associated with medical treatments of scientific cure, developed primarily as sites to house modern technologies. The outdoor grounds were unimportant to patient treatment. Hospital sites in outer-urban areas associated with incurable disease and children from urban slums as at Sherbrooke Convalescent Cottage, provided grounds with ornamental gardens and other landscapes which were seen as important to compensate this type of patient. The outer-urban sites for children provided the connection with nature not possible on the Carlton site or at their own homes.

There is also a question as to whether hospital staff and patients as users supported the replacement of gardens by buildings. The findings of this thesis suggest that the uncritical acceptance of buildings as more important than grounds by experts and those in control contributed to a poorer quality environment for patients and staff of most hospitals. As part the International Style approach to site design, the use of the grounds for human purposes was unimportant. Under this rationale, the opinions of the users are irrelevant as there is no program for human activities for the grounds beyond that of moving efficiently around the site. This recalls Verderber’s argument that experts influential in the design of hospitals of the International Style were ‘curiously unaccountable to the needs of the people who use the building’ and ‘lacked specific knowledge (and interest in) the implications for patients and the general public.’ The significant aspect of hospital grounds in the International Style in support of this criticism is that their form was later identified by environmental psychologists

---

such as Stephen Kaplan and others as adverse to human well-being. Questions of International Style modernism and human preference are implicit here.\textsuperscript{10} Is this design approach of inimical to human needs and emotions? The lack of places in the grounds in this style for human activities identified by Thwaites, Thompson and others as important is human well-being would suggest this is the case (Chapter One). The reasons why International Style modernist grounds became the dominant form despite their inadequacy for human purpose leads back to the recurring theme of this thesis that argues the importance of cultural attitudes in determining landscapes.

Further the influence of expert opinion, not only in the appearance of hospitals but the ways in which the architecture and site layouts were validated, points to broader implications for the study of the history of the built environment. Commentary on hospital sites of the time is dominated by expert opinions of architects and bureaucrats who promoted the International Style modernism in hospital design as evidence of medical progress and professional expertise. Their views and opinions were widely disseminated through their own writings in journals, annual reports, newspapers and promotional literature. Human experiences of the grounds in contrast to these permanent records are ephemeral and often go unrecorded. The grounds themselves are more ephemeral than the hard infrastructure of buildings which can be of a much larger scale and of more permanent material such as brick or concrete. For these reasons, the opinion of the users of the sites is difficult to ascertain despite the personal meaning and connection generated by the lived experience of the grounds. As a consequence of the imbalance between the lived experience and architectural narrative, there is a risk of perpetuating the perception of the grounds as unimportant in the built environment. This self-perpetuating bias in favor of buildings over grounds, particularly in terms of human use and experience, has implications for designed hospital landscapes today.

Another aspect of the neglect of the site in the history of the built environment of hospitals is to overlook the significance of a particular site and its physical characteristics in influencing hospital history. This thesis has demonstrated that differences between location, topography and size of site influenced the rate and type of change and the ways in which the site was experienced.

The physical characteristics for example were significant in the range and extent of activities undertaken in the grounds. The Alfred and Children’s hospitals developed different site characters and consequently uses, although established around the same time and under the same ideas of salubrity. The larger site of the Alfred produced an ornamental garden typical of a stately home with large areas of grounds for patient and staff use and other activities such as bazaars and band recitals. In contrast, the Children’s had cramped garden areas which came under increasing pressure for patient and other activities as new buildings encroached. The differences in activities appear to be directly related to available land rather than to medical ideas of cure or the hospital’s status as either a charitable institution or a medical complex. Similarly, the location of the hospital site influenced types of treatment. The Convalescent Cottage’s proximity to the sea for instance, promoted activities such as children being wheeled around the streets and to the beach, activities not undertaken in the hospital’s city location.

The size of the site was also found to influence building location, exemplified by smaller sites where patient buildings were placed close to the street such as at the Children’s and Women’s. In the nineteenth century all hospital sites in Melbourne had been surrounded by screen fences which prevented public views of the grounds and contributed to their use as a private retreat (Chapter Four). Buildings close to the street with patients on balconies in full view of the public eroded the seclusion of the site and its function as a refuge from the city. These changes foreshadowed the transition of the hospital site from that of a private residence of a charitable institution to that of a public site of the medical complex that gained momentum after World War I. It is important to note however, that the size of the site influenced the period in which this happened. For the Children’s this happened as early as 1903 with the building of the Princess May Ward on Drummond Street. The Alfred on its much large site did not construct buildings with open balconies close to the street, although as
has been noted, it did place children’s cots close to the public entrance after World War I (Chapter Five). Similarly, the re-building of the *Melbourne Hospital* in 1913 on its relatively large site of 4¾ acres (1.92 ha) placed only nurses’ home and administrative buildings close to the street (Chapter Four and Five). In this case, the nurse’s home which on other sites resembled a middle-class domestic residence (*Alfred, Homeopathic, Women’s, Children’s, Austin*) was built as a block of flats. This was a compromise between the size of the site and the prioritization of benefit to either patients or staff for fresh air, sunshine and garden vistas. In 1913, the *Melbourne Hospital* decided that the association of nurses with traditional domestic architecture and garden vistas was less important than for its patients. Other sites such as the *Alfred* with its larger site were able to provide these for both staff and patients.

Attention to specific hospitals sites demonstrates that the period when hospitals can be assigned as places of refuge for the sick poor is complicated by the physical characteristics of the site as well as changing patient populations and medical treatments. Although it is generally true that the introduction of private patients and changes in the government legislation in the 1920s signaled the end of the charitable institution in an administrative sense, the erosion of the charitable institution as a site of refuge had started as early as 1903. These findings support the importance placed by this thesis on researching multiple sites to examine the relationship between changing ideas of health and landscape.

### 8.3 Loss of purpose and meaning

As the purpose and physical character of the sites changed, so too did the types of activities and range of experiences for patients and staff. This in turn reduced their meaning. (Chapter 6). In the era when the hospital was modeled on a domestic residence, the grounds (including front garden and backyard) and activities there, recalled many of the associations of home. Sitting in the garden, playing games, walking beneath trees, afternoon tea outside, bathing babies on the back verandah, all took place within the configuration of the hospital landscape as domestic residence. As hospitals became transformed to medical complexes, the grounds in which these activities took place were lost to building. Hospital fetes were no longer held in the grounds, staff walked between floors rather than between buildings, there were no places for animals such as dogs and cats, trees that had provided shade or could be seen from a window were removed.
Multi-storey buildings reduced the opportunities for patients and staff to go into the grounds. Instead of simply stepping outside from a verandah or wheeling a bed into the garden, several floors and lifts needed to be negotiated. Cars, roadways and car parks changed the experience of the hospital grounds for pedestrians and increased noise. Beauregard’s argument that the definition of site needs to recognize the transformation of a space to place by the ‘complex symbolism grounded in lived experience’ is relevant here.\textsuperscript{11} The grounds of charitable hospitals had not merely been the site for buildings. These had been places of everyday activities that forged an emotional connection to place for patients, staff, volunteers and the general public. This is most evident in the reminiscences of staff and the numerous photographs of staff and patients in the grounds of the Alfred Hospital and of all hospitals described in Chapters Six and Seven.

Implicitly, histories of individual hospitals support the importance of the idea of the hospital as an important place as well as architectural space. It is the personal memoirs of the staff that make explicit the importance of the physical characteristics of the grounds in their experience of the hospital as an institution. Their narratives discuss the hospital in terms of the dedication and commitment of staff to the institution. The changing form of hospital sites after World War I altered the experience of the hospital for both patients and staff. The opportunities for the creation of shared experiences and memories were reduced. Personal memoirs of staff were framed in terms of their regret at changes and suggest that the loss of grounds to building was an important and an often negative influence on their experience.

\textbf{8.4 Implications for twenty-first century hospitals in Melbourne}

Although unrecognized at the time the removal of garden areas and outdoor grounds was detrimental to the well-being patients and staff. Since the 1960s recognition of the value of hospital grounds has led to growing interest ‘to bring back the open spaces and human-scale of earlier hospitals.’\textsuperscript{12} This renewed interest in hospital grounds has been supported by the


work of landscape theorists such as Catharine Ward Thompson and Kevin Thwaites. Their work has argued that contact with nature provided by gardens leads to good health outcomes for patients. The work of Roger Ulrich and Stephen Kaplan has been pivotal in this appraisal of the therapeutic value of earlier hospital sites and grounds. Ulrich’s seminal research in 1984 linked views of trees and greenery to a positive impact on recovery from surgery for hospital patients. His other work since then has continued to focus on the link between natural environments and well-being. Kaplan’s theories on the relationship between spatial layout, natural elements and well-being have also provided justification for hospital grounds. Writing and further research on hospital landscapes in the late twentieth century to the present has used this research to argue for inclusion of outdoor grounds and gardens on hospital sites. Nineteenth century ideas of salubrity, provision of gardens, fresh air and sunshine, have emerged as the new framework for appraising and designing hospital sites. A new term ‘salutogenic environments’ to describe places that contribute to well-being, has emerged in the


academic literature as an indication of this renewed emphasis on the relationship between natural environments and health.\textsuperscript{19}

While, this suggests a new era in the design of hospital grounds, there has been however disquiet that research on the benefits of nature and gardens has not been implemented. Curtis and Gesler \textit{et al.} in their study of new British hospitals for example, note that hospital gardens are reported by patients as being too small.\textsuperscript{20} Wil Gesler has suggested that instead of new humane hospital sites, they remain emblematic of the professional power and prestige, much as the modernist hospitals of an earlier era.\textsuperscript{21} Criticism has also been made of North American hospital grounds by Yuko Heath and Marcus and Barnes for being tokenistic and unused by patients and staff.\textsuperscript{22} As with hospitals in the United Kingdom, patients criticize the insufficient grass areas and lack of suitable places for retreat. Annmarie Adams and David Theodore have similar criticisms in relation to the therapeutic design of the grounds for the new superhospital in Montreal.\textsuperscript{23}

A review of contemporary hospital grounds in Melbourne provides an interesting comparison to their past configuration and uses. The original 1941 site of the \textit{Royal Melbourne Hospital} crowded with new buildings, including the addition of a new \textit{Women's Hospital} in 2008, is a good example of this (Figures 8.2 and 8.3). The expanse of lawn has disappeared under buildings, roadways and car parking areas, whilst flat roofs once seen as a positive attribute of hospital buildings for patient use, are devoted to helipads and air-conditioner infrastructure. The recent additions and infrastructure changes indicates that ideas

\begin{footnotesize}
\footnotesize
\begin{itemize}
  \item \textsuperscript{19} Thompson, C. W., Bell, S., \& Aspinall, P., \textit{op. cit.}, (2010), 2.
  \item \textsuperscript{21} Gesler, W. M., Bell, M., Curtis, S., Hubbard, P., \& Francis, S. (2004). Therapy by design: evaluating the U.K. hospital building program. \textit{Health and Place}, 10, 118
\end{itemize}
\end{footnotesize}
of salutogenic environments have received little attention. Meanwhile, it is a common sight to see patients in pajamas, some with drips or in wheelchairs occupying the footpath outside the hospital near the bus stop and taxi rank, amidst the noise and fumes of the street (Figure 8.4). These are the only outdoor places available and the presence of patients on the street suggests that even this outdoor experience is preferred to the hospital wards.

Figure 8.2 2010 Site of Royal Melbourne Hospital and Women’s Hospital. Patients in pajamas are frequently observed in the street taking a break from the hospital ward, talking to visitors, smoking or merely standing in the sunshine. Google Images.

Figure 8.3 2011 Site of Royal Melbourne Hospital and Women’s Hospital. The site is taken over by building with no provision for outdoor grounds or places of retreat for patients or staff. Internal roads are for use of vehicles and the flat roof for a helipad or to accommodate chimney flues and air conditioning infrastructure. Nearmap. Labelling: author
Figure 8.4 Patient in wheelchair talking to visitor outside the Melbourne Hospital in 2011. Bus and car fumes, lack of privacy and noise of the street do not deter patients from seeking outdoor areas away from the hospital ward. Author.

Nor are the Royal Melbourne and Women’s Hospital sites isolated examples. Generally, hospital sites in Melbourne are overcrowded, with minimal outdoor grounds for patient use or access to views of gardens. Other examples include the Alfred Hospital and Mercy Hospital sites (Figures 8.5-8.7). Although, the Alfred remains on its original site opposite Fawkner Park, the former garden entrance is now a roadway and the view of the gardens blocked by a helipad that overshadows the hospital. The Mercy Hospital, a public maternity hospital, moved from its salubrious location opposite the Fitzroy Gardens in East Melbourne to the north-east corner of the Austin Hospital site in 2005. The former position of the Mercy gave views over the nineteenth century park. Families visiting the hospital would also visit the playground there and patients and staff could break the hospital routine to enjoy the greenery and landscape. The new hospital in contrast is surrounded by concrete and car park, with no gardens to relieve stress or provide diversion (Figure 8.7).

---

24 Based on the authors association with the hospital over twelve years from 1984-1996.
Figure 8.5 Front entrance of Alfred Hospital with direct exposure to the trams and traffic of Commercial Road. The entrance has been re-configured for cars. Google Images.

Figure 8.6 The helipad in front of Alfred Hospital blocks views of the gardens and overshadows the hospital. The noise of the helicopter dominates the surroundings. Google Images.
New hospitals on greenfield sites in Melbourne which offer an opportunity to design sites with gardens similarly show little commitment to ideas of salubrity. In the grounds of Sunshine Hospital built in the western suburbs of Melbourne in 1991, ideas of garden and private places of retreat for patients are not evident. The new three storey ward (built circa 2002), provides patients with an uninterrupted view of the Western Ring Road, an eight lane freeway, across a treeless car park (Figure 8.8). There is no garden or buffer from the noise or visual impact of the freeway. In contrast to research which advocates the provision of nature and gardens in hospital architecture, the stark façade is commended for being in harmony with the industrial character of the area:

Its new exterior fronts up to the diffuse public environment of Melbourne’s outer west – freeways, arterial roads, car parks – and gives something back to it …The views available are not beautiful in any conventional sense, but they are lively with the comings and goings of the car park in front, then Furlong Road, and the raised scimitar of the freeway beyond…

The ‘lively’ car park and expanse of bitumen bereft of trees or garden areas does not reflect research recommendations for therapeutic landscape. The experience for patients, staff and visitors is justified according to a design critique that ignores the hospital’s purpose as a place of patient treatment.

Children’s hospitals have requirements, in addition to expert recommendations for gardens and complex outdoor environments as with general hospitals, for developmental needs and for specific conditions such as congenital and chronic diseases.\textsuperscript{26} Autism Spectrum Disorders (ASD), in particular has experienced a large increase in diagnosis internationally and in Australia.\textsuperscript{27} Patients with this condition experience sensory processing deficits for which gardens are recognized as a useful tool in treatment and management.\textsuperscript{28}

\textsuperscript{28}Wilson, B. J. (2006). Sensory gardens for children with autism spectrum disorders. University of Arizona. Sensory gardens can be either stimulating or calming depending on the sensory profile of the child. Dr. Winnie Dunn, an American occupational therapist has pioneered much of this work in understanding the sensory needs of children with autism. The Sensory Profile Assessment tool she has developed is used widely by therapists and clinicians. See Dunn, W., Saiter, J., & Rinner, L. (Fall 2002). Asperger Syndrome and Sensory Processing A Conceptual Model and Guidance for Intervention Planning. Focus on Autism Other Developmental Disabilities 17 (3), 172-185.
recommendations included calming or stimulating garden areas and elements that engage the child in motor co-ordination activities. Water, sand, swings, rocks for climbing and jumping, fragrant shrubs and trees, garden nooks and mazes are some of the elements that are recommended. These elements are recognized as therapeutic for a wide range of conditions and further also provide diversion and respite for other members of family and staff to reduce the stress of hospital visits and treatments.

In Melbourne hospitals dealing with children such as the Austin, Monash Medical Centre, Northern Hospital and the present Royal Children’s Hospital are yet to include this type of outdoor environment. The new Royal Children’s Hospital due to open in November 2011 is the latest hospital to be developed in Melbourne. Its position adjacent to the existing hospital on the fringe of Royal Park, a large public parkland in Melbourne, and its promotion by the hospital architects suggests that ‘nature’ is recognized in the design as an important element:

The first stage of the new Royal Children's Hospital will be completed in 2011, opening the doors on a structure that draws as much from the pioneering work of American academic Roger Ulrich and biologist E. O. Wilson as Scandinavian artist Olafur Eliasson; in their respective disciplines, each examines the way nature and the elements affect our moods and sense of spiritual well-being.

---

30 Ibid, 337.
31 Kristen Whittle, director of Bates Smart, the architects with Billard Leese of the new hospital quoted in Power, L. (Friday December 10, 2010). Architecture Turns Over a New Leaf. The Age.
The images supplied by the architects give little indication of the use of the grounds however, beyond functional movement of people around the site to access the building (Figure 8.9). The buildings are described as ‘skirted by a series of gardens, each of which is splashed with light at different times of the day’ but there is little indication of how these are intended to be used, by whom and for what purpose.32 Meanwhile, as with the hospital in Montreal described by Adams and Theodore, there is disquiet amongst staff about the emphasis put on design philosophy at the expense of patient outcomes.33

The extent to which the new Children’s Hospital design and management supports the use of the grounds by patients and staff can only be assessed, as this thesis has demonstrated, by an analysis of its use. Patients, clinicians, family members interacting with water, rocks, playground equipment, undulating terrain, variety of plant material and configuration will indicate a well-designed and therapeutic garden. Patient beds under trees where children can connect with the natural world outside the hospital building is another positive indicator, as are wheelchair swings for wheelchair dependent patients. This is an analysis yet to be made

32 Ibid.
but the site is watched with interest by those interested in the therapeutic benefits of hospital grounds.

![Aerial view of new Children's Hospital in January 29th, 2011](image)

Figure 8.10 *Aerial view of new Children’s Hospital in January 29th, 2011. The success of the hospital grounds in providing therapeutic outcomes can only be assessed by the extent to which the grounds are used for therapeutic purposes. Nearmap.*

These examples suggest that despite the rhetoric of nature and gardens for patient treatment, recently developed hospital sites in Melbourne continue to focus on buildings whilst ideas of salubrity or, salutogenic environments, in connection with patient treatment are not given priority. Hospitals are complex to build and design and need to balance competing design philosophies and requirements for patient treatment as pointed out by J.M. Westphal. Economic pressure to justify hospital gardens and their maintenance to shareholders and insurance agencies are other factors that impinge on design decisions. In the era of public private partnerships under which hospitals such as the new Children’s are being built, the need to make a profit is an overarching requirement for the consortiums that are contracted to build them. Hospitals need to include such commercial entities as shops and food outlets, as well as facilities for medical treatment. As Adams and Theodore have noted this can complicate the

---


35 Ibid., 213.

This calls into question cultural attitudes to gardens and outdoor grounds for twenty-first century hospital landscapes. As was shown in this thesis, one of the reasons hospital grounds were prominent in the nineteenth century was the community acceptance of their moral, physical and psychological benefits. Under this understanding of landscape, hospital gardens were retained despite economic pressures and changes in medical theories. In the twenty-first century, the legitimacy for gardens to be included is less persuasive in Melbourne despite research and increasing awareness of their importance to health. This points again to a fundamental difference between nineteenth and twenty-first century cultural attitudes to landscape and health and suggests that the underlying cause for the loss of hospital grounds is to be found in this difference. It also suggests that despite calls by academics, landscape architects and others for a return to the ‘open spaces and human-scale of earlier hospitals’, this is unlikely to happen unless cultural attitudes to the relationship between landscape and health also change.  

Hospital grounds and the activities that happen there need to be seen again as an essential element in patient treatment. Good hospital design that recognizes the link between landscape and health will then complement the medical treatments happening within the building.

---

This thesis began by asking what ideas of hospital, landscape and health could be read in these images (Figure 9.1). Why did these hospitals look the way they did, why did they change, what was their purpose and meaning for patients and staff and what do these changes reveal about cultural attitudes to hospital landscape? The contribution of this thesis has been to develop a spatial and cultural history of hospitals in Melbourne which explored these questions. This study contributed three major findings that make a significant contribution to
the scholarly literature on hospital landscapes of this period. Firstly, hospital sites in Melbourne were a full generation ahead of North America in exhibiting International Style aesthetic. Secondly, that existing hospital grounds adopted International Style modernism before it was evident in the buildings and finally, that the belief in heliotherapy as a treatment justified the use of sun balconies and flat roofs after gardens had disappeared. Further, a research approach that focused on the purpose and meaning of the grounds to staff and patients demonstrates the importance of analyzing human activity when researching the built environment, an aspect that is usually missing from historical studies in architecture.

Important insights provided by close examination of the site include the significance of the lived experience of the grounds, establishing that the site has importance not only as a space for buildings but as a place where things happen and meaning is created. This recognizes the role of the grounds in forming an emotional connection to place for staff and for patients, important in physical and mental well-being. Although institutional histories generally refer to the hospital as a place to which people form strong attachments, how that attachment is created not been made explicit. By linking personal memoirs and evidence of activities within the grounds with physical characteristics of the site, this thesis provides new insights into the interaction of these factors and how attachment happens. The dissonance between the public story of progress and improvement against the personal accounts of regret indicates the way in which the grounds as places of personal significance and memory are important in architectural history. Further, systematic attention to the particularities of each site reveals that while there were common features, there were also important differences. The site was not a passive factor in hospital development in Melbourne, a point relevant to academic commentaries that seek to relate hospital form to medical treatments, or architectural styles (Chapter 2). Annmarie Adams has indicated the pitfalls of this approach and this work contributes evidence to support her criticism of the inaccuracies that may eventuate from broad claims not based on attention to particularities, in this instance, the particularities of site. Finally, these examples illustrate the importance of including physical characteristics of site as
argued by Meyer, Beauregard, Hess and Redfield, to enrich an understanding of landscape and the built environment (Chapters One and Two).¹

Research into the material evidence of hospitals in Melbourne has also made an important contribution to further academic study of hospital grounds locally and internationally. By undertaking a detailed examination of Melbourne hospital sites in Australia this thesis addresses the imbalance in the literature which favours northern hemisphere hospitals.² This not only contributes to the scholarly work on hospitals in Australia but provides an important basis for international comparisons about typology and cultural differences. This data could also be used to determine the extent to which sites and grounds in Melbourne were similar to international sites and how they differed. Melbourne could also be compared to other major cities in Australia to determine if the emergence of International Style modernism interwar was experienced elsewhere.

The survey of hospitals in England and North America undertaken in the literature review suggests that the importance given to the grounds in the nineteenth century was universal. Twentieth century sites however varied in emphasis on grounds and their use. Photographs of patients and staff in the grounds of St Bartholomew’s Hospital in the 1960s for

³ Henderson, J., Horden, P., & Pastore, A., op. cit., (2007), 27; Most hospitals in Australia have produced an institutional history which may give some incidental background to the site but not in any systematic analysis. Histories relevant to Melbourne Hospitals are referred to in this thesis and are included in the bibliography; Willis, op. cit., (2004) on the work of hospital architects Stevenson and Turner.
example, indicates that England still valued their use for patient treatment whilst American hospitals were more focused on building interiors. Melbourne, in this context followed more closely the American rather than English model but this can only be a superficial appraisal and more intensive analysis would need to be undertaken to understand the nuances and implications. One question of interest is the extent to which Melbourne’s temperate climate influenced activities and use of the grounds compared to such countries as England and Canada who were subject to much colder temperature extremes. Similarly, a comparison of use of balconies and covered ways as places of patient treatment and the date of introduction of modernist treatments to the grounds of nineteenth century sites would also provide interesting data on cross-cultural attitudes to landscape. This need not only be confined to English-speaking countries but also include such places as India, Spain or Russia. Germany would make a particularly interesting comparison because of its established histories of outdoor space and hospitals.

An important outcome of this collection of material has been the consolidation of data from multiple sources. In particular, the identification and redrawing of hospital plans from the 1890 series of MMBW Detail Plans has created a rich resource of benefit to other researchers locally and internationally. The range of hospitals analyzed demonstrates that whilst there were similarities between hospitals, there were also important differences that relate to ideas of purpose and meaning of landscape. A cohesive narrative of the development Melbourne’s hospital system 1848-1948 was also produced from primary and secondary sources to provide context for their built environment. The collation of tables and data providing information on staff, patient numbers and bed stays for all hospitals will be of particular interest to historians in developing more detailed histories of the Australian health system. This supplements a gap in the historical account of hospitals in Melbourne which has previously focused on individual institutions rather than the hospital network and health system for this period.

The process on which this research and discussion of hospital grounds is grounded in the analysis of detailed and specific examples could be usefully applied to other sites of medical treatment such as psychiatric hospitals and sanatoriums. A comparison between the grounds of psychiatric hospitals and medical complexes today would provide fascinating
insights into how ideas of landscape and health have evolved. Of particular interest would be an exploration of the types of grounds that are associated with the treatment of mind verses body disorders in the context of dualistic medicine. Sites of potential study in Melbourne could include Yarra Bend and Kew asylums, Mont Park and Royal Park Insane Hospitals, Heatherton and Greenvale sanatoriums. Such research would enrich the understanding of ideas of health and landscape in Melbourne and would form a basis for international comparison. Similarly, military sites could be examined as a way of extending and supplementing the discussion of cultural understandings of landscape. The influence of modernism and the disappearance of nurses’ homes from hospital grounds could also form a useful study.

The overall contribution of this thesis has been to demonstrate that attention to the history of hospital sites and grounds has not only enriched the understanding of how these were formed and why they changed but has provided important insights of ways to provide meaningful and successful hospital environments in the future.
Archives

1. Hospital Archives
   Alfred Hospital Archive
   St. Vincent’s Hospitals Archives
   Children’s Hospital Archive
   Austin Hospital Archive
   Women’s Hospital Archive
   Eye and Ear Hospital Archive
   Alfred Hospital Clinical Reports

2. State Library of Victoria
   State Library of Victoria Picture Collection
   Historic Plan Collection including Stephenson and Turner Collection and MMBW series
   Microfilm Newspaper Collection
   Picture Illustrated Newspaper Collection
   Postcard Collection
   Imaging nineteenth century Victoria Digitising project

3. University of Melbourne
   Archives – architectural drawings (J.J and E.J Clark Collection 1883-1929)
   photographs (Lillias Alice Collins Collection 1915-1925)
   Cultural and Special Collections – The Australian Medical Journal (1856-1950)
   The Australian Modern Hospital (1949-1955)
   Historic Map Collection
   Victorian Parliamentary Papers Charitable Institutions, Charities Board of Victoria, Hospitals and Charities

4. Public Records Office
   Government Files –
   15899 Historic Plans Collection 1836-1984
   Public Building Department (Building Services Files), 1874-1998
   609/P0000/04 Austin Hospital Matron Reports (1915-1923).
   609/P0000/5. Austin Hospital Reports 1891-1923. Melbourne
   1016/P0000/13 Miscellaneous Correspondence Files. Melbourne Hospital Site. 1843-1886.

5. National Library of Australia
   Digital Archives Collection
Primary References

Annual reports


Alfred Hospital Annual Report. Year ending 30th June, 1876. Melbourne: Alfred Hospital.


Austin Hospital for Cancer and Chronic Diseases Annual Report for the Year ended June 1934 Austin Hospital, Heidelberg.

Austin Hospital for Cancer and Chronic Diseases Annual Report for the Year ended June 1948 Austin Hospital, Heidelberg.
Austin Hospital for Chronic Diseases Annual Report for the Year Ended June, 1927. Austin Hospital, Heidelberg.


Government Documents


Interviews

Dorothy McDonald (nee Hogg). (20th January, 2009).

Margaret Royston. (27th January, 2009).
Maps, Plans and Architectural Drawings

Alfred Hospital. General Development. Site Development, V140/45560. Stephenson and Turner. 66 feet to 1 inch. 1962. Stephenson and Turner Collection, SLVMC.

Alfred Hospital. General Development. Stormwater, Sewer and Fire Service, CA 3/72428. Stephenson and Turner. 66 feet to 1 inch. 1963 Stephenson and Turner Collection, SLVMC.


Children’s Hospital, Carlton. Extensions to Boiler House. 20887. Various scales. 1956. Stephenson and Turner Collection, SLVMC.

Children’s Hospital, Carlton. Block Plan of Buildings on Site. 1978/26. 16 feet to 1 inch. 1956. Stephenson and Turner Collection, SLVMC.


Map of Melbourne and its Vicinity. 40 chains to I inch. 1880. Melbourne: McCarron and Bird Co. SLVMC.


Melbourne Hospital. Plan of Elevation of Block F. J.J. and E.J. Clark. 8 feet to 1 inch. 1913. University of Melbourne Archives.


Royal Children’s Hospital, Carlton. New Work. New Steel Fire Escape. B10/32389. 1 foot to ½ inch. 1955. Stephenson and Turner Collection, SLVMC.

Royal Children’s Hospital, Carlton. New Work. Block Plan CA8/30110. 1 foot to 1/16th inch. 1956. Stephenson and Turner Collection, SLVMC.

Royal Melbourne Hospital Site Plan. n.t.s. Stephenson and Turner, 1946. Stephenson and Turner Collection, SLVMC.
St Vincent’s Hospital Site Plan. Master Plan Lawrence Nield. Lawrence Nield and

Women’s Hospital, Nurses’ Block, Ground Floor Plan, J.J. and E.J. Clark, 8 feet to 1 inch.
1908. University of Melbourne Archives.


Newspapers, pamphlets, books and journals


1869. Edinb.: Livingstone.

Anon. (January-June 1951). The Alfred Hospital, Melbourne. The Australian Modern
Hospital, 1(3), 41.


Anon. (Thursday 30th June, 1921). Alfred Hospital Building. New Home for Nurses. The
Argus, 7.


. Anon. (1st September, 1923). Alfred Hospital Fete. The Argus, 32


Anon. (Friday 15 December, 1922). Annual Linen Tea. The Argus, 10.

Almost Doubled. The Argus, 14.

Anon. (Tuesday 19th June, 1928). Austin Hospital The Sun News-Pictorial.


Anon. (Saturday, 30 January 1926). Hospital Construction. Lecture by Dr. MacEachern. The Argus, 31.


Anon. (September 1926). The Hospital of the Future. The Alfred, 13-17.


Anon. (December 1933). "I Like This Old Place". The Alfred, 14.


Anon. (April, 1869). The New Hospital..Shall we have a New Hospital or go on adding to the Old One? Australian Medical Journal, 112-115 Anon. (October 23rd, 1866). The New Hospital. Shall we have a New Hospital or go on adding to the Old One? Melbourne.


Anon. (Saturday September 2, 1922). Portion of the old section of the Women’s Hospital which it is desired to replace with modern hospital buildings. *The Argus*, 23.

Anon. 1888 *Popular guide to the Centennial Exhibition: with which is incorporated the strangers' guide to Melbourne. 2nd ed.* Melbourne: W.H. Williams, Printer.


Anon. (Saturday April 18th, 1891). A Stroll through the Melbourne Hospital. *The Age*.


Anon. (Wednesday February 26th, 1941). This would Make Your Teeth Ache. *Sun News-Pictorial*.


Davidson, K. (June 27, 2011). Hospital PPPs show no signs of good health. Taxpayer dollars are wasted as financiers make a fortune. *The Age*.


Graduate. (Thursday, 24th May 1928.). A University Hospital. Some ideals and suggestions. The Argus, 17.


Turner, W. J. G. (1926). *The Austin Hospital for Incurable and Chronic Diseases*. Heidelberg: The Austin Hospital for Incurable and Chronic Diseases


Books and articles


SECONDARY REFERENCES


Helm.


Cunningham, E. S. (1940). *History of Women's Hospital, Melbourne 1856-1940*. Melbourne: Royal Women's Hospital.


of the Institute of British Geographers 13(3), 275-287.


SECONDARY REFERENCES


Gross, A. (1980). *Charles Joseph La Trobe, superintendent of the Port Phillip District 1839-
1851, Lieutenant-Governor of Victoria, 1851-1854. Melbourne: Melbourne University Press.


Food Service.


Loudon, J. C. (1838(1982)). *The suburban gardener, and villa companion*. New York:
Garland


Moore, F. P. L. (September 2010). Tales from the archive: methodological and ethical issues in historical geography research. Area, 42(3), 262-270.


York: Cambridge University Press.
Lang.


Works. In C. Burns & A. Kahn (Eds.), *Site matters: design concepts, histories, and
strategies* (pp. 185-222). New York: Routledge.


Richardson, H., Goodall, I. H., & Royal Commission on Historical Monuments (England).

Kirklin & R. Richardson (Eds.), *The Healing Environment: Without and Within* (pp.

University Press.

New York: Arnold; Oxford University Press.

Porter (Eds.), *The Hospital in history* (pp. 41-59). London; New York: Routledge.


Rose, G. (2000). Practising photography: an archive, a study, some photographs and a
researcher. *Journal of Historical Geography, 26*(4), 555-571.

Freidson (Ed.), *The hospital in modern society* (pp. 1-36). New York: Free Press of
Glencoe.

SECONDARY REFERENCES

York: Basic Books.


Swinburne, G. H. (1934). *The Queen Victoria Memorial Hospital: a history, the first forty years*. Melbourne: Queen Victoria Hospital.


SECONDARY REFERENCES


Yule, P. (1999). 'It was just like Camelot.' The New Hospital. In *The Royal Children's
Hospital: a history of faith, science and love (pp. 370 -385). Rushcutters Bay, N.S.W.: Halstead Press.


Theses


Websites


Near map - http://www.nearmap.com/

Walking Melbourne - http://www.walkingmelbourne.com/
Author/s: BOURKE, ANNE

Title: Changing purposes and meanings of hospital sites and grounds in Melbourne 1848-1948

Date: 2011


Persistent Link: http://hdl.handle.net/11343/36619

File Description: Changing purposes and meanings of hospital sites and grounds in Melbourne 1848-1948

Terms and Conditions: Copyright in works deposited in Minerva Access is retained by the copyright owner. The work may not be altered without permission from the copyright owner. Readers may only download, print and save electronic copies of whole works for their own personal non-commercial use. Any use that exceeds these limits requires permission from the copyright owner. Attribution is essential when quoting or paraphrasing from these works.