

EXEMPLIFYING THE PANOPTICON: A CASE STUDY ON MODERN HOSPITAL ARCHITECTURE

Christelle Bucag



Christelle Bucag is a second-year studying Interdisciplinary Medical Sciences with a concentration in Pre-Clinical Professions at Florida State University. She is a member of Presidential Scholars and the Honors Program. Her research focuses on investigating the influencing effect of hospital architecture on patient-provider interactions through the lens of surveillance.

Abstract

Over the years, healthcare as an institution has increasingly become regulated to the point where surveillance has become the norm (Fraile et al., 2019). The naturalization of such guarded practices has produced asymmetrical power relations wherein providers subject their patients to what Michel Foucault refers to as the ‘medical gaze,’ reducing their individuality to a mere summation of illnesses (Foucault, 1980). These normalized mechanisms designed to check patient-provider interactions extend to both the users’ habits and spaces in such clinical settings. This study aims to show how the modern-day hospital ward exemplifies the concept of the Panopticon – an architectural configuration designed for surveillance and social management (Evans, 1971). This study will not delve into the ethics of asymmetrical power relations and ascribed subjectivities to both patients and providers, rather it will examine how the phenomenon of the Panopticon is (re)created in an everyday venue such as the hospital. In order to demonstrate the influencing effect of hospital architecture on its users, ethnographic photography was used in coding the different features of hospital spaces such as patient wards and waiting rooms. The results yielded by this study serves as preliminary insight on how the actions and (inter)actions of providers and patients in hospitals are affected by architecture. Understanding these implications can help in the continuous reform of healthcare as a patient-centered institution.

Foucauldian Analysis of the Panopticon

The creation of the Panopticon represents a unique shift in which power is imbued and administered in citizens. According to social theorist Michel Foucault, monarchical institutions before held sovereign power which allowed them to command and suppress their constituents. Monarchs in their states rendered power through “arms, physical violence, material constraints” – all of which are expensive ways to keep their people in line and may also run the risk of mass revolt due to the harshness of such governing measures (Foucault, 1980 & 1977). However, Western states in the eighteenth century began to adopt a new way of governance: pastoral power, which is a derivative from the mode of leadership in Christian institutions (Foucault, 1982). Foucault described this reinvented, pastoral power as a “matrix for individualization” since states seek to govern their constituents not only as a collective but also as individuals as well. Pastoral state power is unique in comparison with sovereign power as it ‘softly’ governs people by catering to their individual needs, while the latter enforces harsh and absolute means to keep their subordinates in check (Foucault, 1982). States now conduct matters relating to health, well-being, security, and defense of their constituents, thereby establishing their influence and power on the governed in a humane yet pervasive manner. This ‘soft’ power mirrors the ways in which the Panopticon establishes social control through catering to the comforts of the surveilled and rehabilitating them, rather than establishing grand acts of punishment.

In the late eighteenth century, Jeremy Bentham designed the Panopticon, a model intended for institutional control. This novel development in architecture entails a cylindrical structure with a central watchtower surrounded by ‘well-serviced’ individual cells (Evans, 1971). This design allows for an easy and efficient way to exert power and establish social control – wherein the few surveils the many and vice versa, embedding into each other the possibility of ‘being caught.’ In addition, as the cells are well-equipped and neatly kept, the dwellers are less likely to revolt due to the comfort of their surroundings – thus, making such institutional power irresistible to the inhabitants. This new approach to oversee individuals is groundbreaking in that it mirrors the ‘soft’ pastoral state power from a macroscopic, societal scale to microscopic, institutional levels such as prisons – imbuing social control smoothly rather than by brute force in these microcosms. For example, rather than punishing and reprimanding those who have deviated from society’s by-laws through public spectacles, such as executions; modern penitentiary facilities, which adopted the design of the Panopticon, use this all-seeing ‘gaze’ to prompt criminals to act accordingly in the name of reform (Foucault, 1980; Evans 1971). As prisons now focus on rehabilitating criminals in private through intense overwatch

while ironically veiling them from the public, prisoners become objects of reform. Through the Panopticon's solution to surveillance, individuals are not only subjected to submission but also become mere subjects of it, chipping away their agency and their humanity.

Similar to the Panopticon's all-perceiving 'gaze,' nation-states began to adopt this mode of power to govern their subjects. In order to create and sustain its influence over the lives of many, state-established institutions needed to use Panopticon-like devices to maintain their watchful gaze over society. As such, reinvented state power is characterized as both totalizing and individualizing due to its all-perceiving nature (Foucault 1982). This power is totalizing in nature in that it oversees the common good of society and individualizing in that it subtly directs the individual to act in accordance with the 'set' norms. Such duality of state power makes it hard for constituents to resist since the state appears to not only tend to the collective's need but also heed to each individual's call. Hence, institutions keep their overarching colonization of everyday life due to the appealing nature of their dual power. Healthcare, as one of these institutions, makes use of this type of control.

Evolution of Hospital Architecture

Throughout the years, the evolution of Western hospital architecture has led to the transformation of its function as well. In the eighteenth century, hospital architecture changed to accommodate "the process of specialization" rather than being "a receptacle of the poor," signaling a modification in the functionality of healthcare (Fraile et al., 2019). This shift in the focus of healthcare meant that specialists in the different disciplines of medicine (pertaining to the different body parts) see patients based on their illnesses and aim to restore individuals to good health. Healthcare, as a state-established institution, is now focused on surveilling the state of their patients – inquiring about their vital signs, symptoms, and ailments – for the sake of advancing public health. As increasing specialization and evidenced-based medicine took place, biomedical facts took precedence over rapport in patient-provider dialogue (Wolf et al., 2012). Placing the power of diagnosis in the hands of hospitals not only produced asymmetrical power relations between patients and providers (resulting in the disparity between non-experts and experts), but it also fostered the domineering control of healthcare (as an institution) on each individual's body.

From this shift in the functionality of hospitals and clinics, arises the increased investment of the state in "facts of existence related to bodies and populations" (Redfield, 2005). Foucault termed this ability of the government to subject its constituents based on their genotypical and phenotypical features as

EXEMPLIFYING THE PANOPTICON

biopower. This new “power over life” not only disciplines each individual and their own body, but it also uses aggregated, biological demographics such as morbidity, mortality, and fertility to regulate society as a whole (Fuller, 2016). In this sense, this new biopower held by healthcare institutions over society is both totalizing and individualizing – characteristics that could be attributed to the nature of the Panopticon. Healthcare institutions employ this ‘all-seeing’ gaze in society by regulating the bodily rhythms of patients and policing providers to appropriately use their expertise to oversee the health of each individual. Understanding how this power is diffused in everyday life requires looking into the microcosms of healthcare. One such example – the modern-day hospital – is a facility viewed as the ‘normal’ place for treating illnesses and seeking medical advice. Hence, it is only imperative to problematize the agents (one of which is architecture) in hospitals which allow for the creation and diffusion of such power.

Methods

This study was conducted in the M.T. Mustian Center at Tallahassee Memorial Healthcare (TMH). As a college volunteer, I was able to observe the actions and relations between patients and providers (nurses, physicians, and patient care technicians) during my 4-hour shift every Saturday from January to March of 2020. I worked in the Surgical Care Unit (SCU); a 72-bed capacity floor meant to prepare patients for their surgical procedures. Since this study was meant to explore architecture and its implications on patients and providers, I combined ethnography and photography (ethnographic photography) by immersing myself as an observer in the clinical unit and taking pictures of the nurses’ station, the patient rooms, and the waiting area in order to capture the components of these spaces. Ethnographic studies are commonly used in qualitative research to report observed experiences in a narrative (Marvasti, 2011). While there are debates that question the legitimacy of ethnography due to its subjective nature, this still remains an effective research technique in examining social interactions and relations on an individual and personal basis. Through ethnographic photography, I was able to analyze how the careful arrangement of these designed spaces molded the patients and providers’ spatiotemporal rhythms, ascribed subjectivities, and their asymmetrical power relations/interactions.

Results

Working as a volunteer in the Surgical Care Unit (SCU) meant that I was only to observe nurses (RNs) in clinical and assist patient care assistants (PCAs) in non-clinical roles. In my time as a volunteer, I have observed that weekend (Saturday) shifts are not busy. Only two to three RNs work on the floor during

the day and one to two PCAs are present. Physicians, particularly surgeons and anesthetists, come in from time to time to check in on their patients who are preparing for surgeries. On average, only two to three patients are admitted to the SCU for pre-operative procedures. In the following pictures, I will be detailing how the users of these spaces make use of the architecture and technology in these two different places: the nurses' station and waiting area. I will be differentiating the users of these spaces between these two categories: providers, defined as those working at the hospital and includes RNs, PCAs, physicians, and office coordinators; and patients, defined as those seeking medical attention and care.

Fig. 1 captures a panoramic view of the nurses' station. The nurses' station acts as a vantage point in surveilling patients, providing an adequate view to patient rooms in its vicinity. There are four stationary desktops in the nurses' station. Additionally, there are two portable computers which otherwise known as 'workstations on wheels' (WOWs) parked near the two monitors which show patient information. These computers and monitors are used by providers to access patient information, look at treatment orders, and check the status of the unit as a whole. Two telephones and three to four beepers are placed on the desks in the nurses' station. These communication devices are used by providers to interact with their patients and with other nurses as well. Phones serve as the main line of contact between RNs and physicians or RNs and patients. It is notable many of these devices are placed in one area for accessibility.

Fig. 2 captures the view of patient rooms from the nurses' station. Here, the proximity of the patient rooms gives providers easy access when administering care to their patients. Two patient rooms flank each side of the nurses' station. Despite having glass doors, the patients' rooms have curtains behind them which allow patients to cover their space for privacy. During slow shifts such as weekends on Saturdays, rooms closest to the nurses' station are occupied first as they are the most accessible to providers.

Fig. 3 captures the view of and from the information desk in the waiting area. The desk provides receptionists a comprehensive view of the waiting area despite being positioned on the corner. Through this, they are able to surveil any passersby or loved ones interacting with this space. Monitors are placed in the desk for receptionists to access patient information when needed. Numerous chairs are placed for visitors and loved ones to sit by. The space is filled with multiple lights and is surrounded by glass windows which illuminate the area.

Discussion

Space both dictates and is dictated by its function. As such, a particular

EXEMPLIFYING THE PANOPTICON

Figure 1

Hospital Ward - View of the nurses' station at the Surgical Care Unit (SCU) in Tallahassee Memorial Healthcare (TMH), 2020. © Bucag

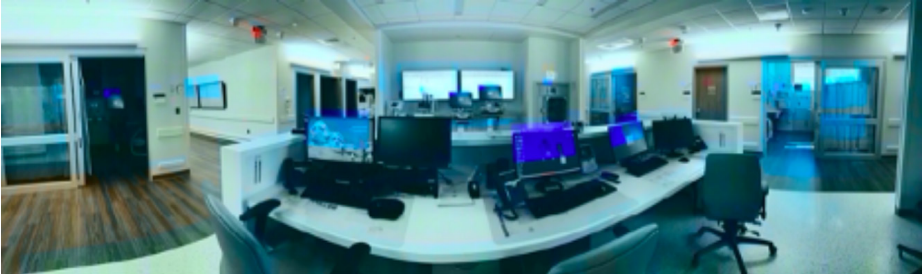


Figure 2

Hospital Ward - View from the nurses' workstation (left and right) in the M.T. Mustian Center at TMH, 2020. © Bucag

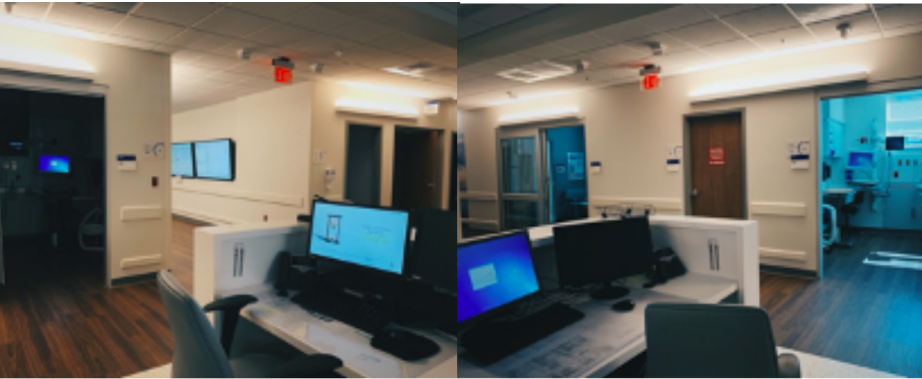


Figure 3

Waiting Area - View of the information desk (left) and from the information desk (right) in the M.T. Mustian Center at TMH, 2020. © Bucag



space provides power to its users if that space's function is to diffuse power firsthand – proving that power can, indeed, be translated through space. Due to the power they hold, spaces do not remain neutral, but rather they are ordered. Designed spaces are said to be “formed in action” by “particular technologies of governance,” proving how spaces are organized not only based on the interactions they hold but also the effect of those spatial interactions (Simonsen et al., 2020).

In the hospital, this ordering of spaces is reflected by the hierarchical importance of the users' interactions in such spaces. Power is disproportionately placed at the hands of providers due to their expertise in the field; hence, the spatial practices of doctors, nurses, and patient care assistants are much more prioritized. Patients, on the other hand, are only given the opportunity to interact with hospital spaces under the discretion and guidance of providers, emphasizing the ordered nature of both patients' and providers' spatial interactions in the hospital. As increasing regulation and surveillance occur in healthcare, hospital architecture remains one of the ways in which this technique of power is enacted. Viewing the phenomenon of hospital surveillance through the lens of Foucault's biopolitics (*vis-à-vis* biopower), it is apparent how this mode of power not only alters subjectivities but power relations and spatiotemporal rhythms as well.

While architecture is stagnant in a sense as it is fixated on a certain location, this does not mean that it is static, nor does it lack agency, the ability to influence the action of its surroundings. Rather, architecture is interactive since designed buildings do not only follow its users but also shape the space's usage. Despite being seemingly immovable and permanent, buildings “remain open to interpretation and (re)construction,” proving how designed spaces in themselves are interactive and are therefore catalysts in (re)creating how the users make use of such areas (Martin et al., 2015). By ensuring that the design of a space simultaneously follows and creates its function, architects are able to mold and scrutinize the actions of the users of such areas – further underscoring the impact of such designed spaces.

Ascribed subjectivities

The influencing effect of architecture is exemplified in modern-day hospital wards through the ascribed subjectivities and power relations engendered in these spaces. For example, it is common for units to have a central workstation (known as the nurses' station) wherein healthcare providers can see each of the patient rooms (Figure 1). Due to the central nature of this workspace, bedside providers are able to watch over their patients with relative ease, while providers with managerial positions are able to oversee their staff more clearly.

EXEMPLIFYING THE PANOPTICON

Additionally, technological features such as beepers, pagers, and monitors enable providers to oversee both patients and other providers even if they are not within close proximity.

With the panoramic nature of most workstations, it is apparent how architectural design and devices available in most hospital wards translate the ‘all-seeing’ gaze of healthcare institutions on a microscopic scale. Internal-visual cues that suggest the surveilling nature of workspaces can ascribe subjectivities to its users. For example, providers are the only ones expected to inhabit the nurses’ station while patients are assumed to always be in their rooms unless they are with a nurse or a patient care assistant (Figure 2). Receptionists are assumed to be in the information desks to surveil visitors and patients who are checking in the hospital (Figure 3). The fact that spaces can create the identities of its users – who are the patients and who are the providers – and delineate between such users – à la experts (providers) and non-experts (patients) – reveals the vital role designed spaces play in the workplace.

Power relations

Power relations between the different users stem as a result of the ascribed subjectivities promoted by the internal-visual cues in designed spaces. For example, the exclusivity of the nurses’ station to providers allow RNs, PCAs, and physicians to only use this space. The restrictive nature of this nurses’ station is unique in that it implies that users with expertise in the field of medicine and patients can use the area (Figure 1). On the other hand, providers can enter patient rooms from time to time to check on patients’ needs and vitals, proving that patient rooms are not as restrictive as the nurses’ station (Figure 2). In another example, receptionists at the waiting room are expected to stay at their desks during the entire shift since they are experts on patient check-in and verification, (Figure 3). The surveilling nature of the Panopticon is translated in hospital architecture as it promotes asymmetrical interactions between patients and providers, similar to the disparity of status and power of wardens and inmates. It is apparent how spaces promote relationships of power between the different types of users. The way designed, hospital areas dictate who gets to interact with what space gives power to those who can use it. The expert-nonexpert relationship hinted by designed spaces can engender an imbalance of power when providers and patients interact with each other. Asymmetrical relations between both is further emphasized as providers retain authority in administering patient care.

Spaciotemporal rhythms

Consequently, such subjectivities and imbalance of power are reflected in

the differing spatiotemporal rhythms of both patients and providers. Patients, in their everyday rhythm at the hospital, are confined to their room – expected to never act out of the norm, to stay in bed, and to always call nurses or patient care assistants when they want to do something. On the other hand, providers, in their everyday rhythm at the hospital, are confined to their workstations and to each patient’s room – predicted to always heed to each patient’s need, to almost always know all of the diagnosis and appropriate treatment plans for each patient, and to always be correct in administering patient care. We can see how the spatiotemporal rhythms and social roles of both patients and providers are shaped by architecture, one of the agents responsible for this phenomenon. Such agents operate based on the idea of surveillance and control in the healthcare system, translating subjectivities and power relations into microcosms such as the hospital.

Likening to the Panopticon

In comparing the surveilling nature of hospital architecture to the Panopticon, it is important to look at how such spaces ascribe subjectivities, promote asymmetrical power relations, and mold the spatiotemporal rhythms of its users. While some evidence points to hospital architecture mirroring aspects of the Panopticon and its implications on social interactions, it is important to note that this is not at all absolute. The difference between the functions of modern penitentiary facilities and hospitals, the purpose of medicine versus prison reform, the role of healthcare providers versus wardens amongst others play into the complexity of such comparison. It is important to note that this research is a preliminary one and little to no literature has been done in comparing these occurrences. Further research from other healthcare institutions to see if similar phenomena occur. If so, future research should explore ways to minimize the subjugating nature of hospital surveillance while still maintaining quality patient care and processes to promote more patient autonomy in treatment without interfering with the expertise of providers.

Conclusion

Analyzing how hospital architecture exemplifies the Panopticon is important in understanding the effects of surveillance, a modern technique of power that is now pervasive in everyday life. Surveillance in the hospital is an essential aspect of patient care since observing and recording the physical and mental states of patients is vital in maintaining the good health of individuals. However, intense surveillance may impede on the privacy of patients and at times may seem intrusive. Understanding the implications of patient surveillance can help foster changes in patient care to make it less invasive, and more collaborative.

EXEMPLIFYING THE PANOPTICON

In recent developments in healthcare systems, person-centered care (PCC) has been adopted to cater to each patient's need (Wolf et al., 2012). For example, clinical self-tracking (CST) and therapeutic hospital architecture can be adopted in an attempt to (re)establish a partnership between patients and providers. In CST, patients with type 1 diabetes are encouraged to have more agency in their management by actively participating in recording their glucose levels (Maine et al., 2017). In another example, implementation of therapeutic hospital architecture expands patient care intervention not only to diagnosis and administered treatment, but to their physical environment as well, emphasizing the importance of designed spaces and how these promote interaction between patients and providers (Fenko et al. 2014; Cotton et al. 1984).

These only prove that there are ways to minimize the alienation between patients and providers, and at times, between providers themselves. These changes can be adopted by altering providers' workflows or even the architecture of hospitals and clinics. While there are limitations to the level of autonomy patients can attain in their treatments, it is nonetheless important to promote continuous partnership between patients and providers in order to gap the bridge between such asymmetrical power relations. Through promoting intervention which centers on personal need of each patient, healthcare transforms into a venue of partnership rather than subjugation.

References

- Bucag, C. F. (2020). Hospital Ward. Image Series.
- Bucag, C. F. (2020). Waiting Area. Image Series
- Cotton, N. S., & Geraty, R. G. (1984). Therapeutic space design: Planning an inpatient children's unit. *American Journal of Orthopsychiatry*, 54(4), 624–636. <https://doi.org/10.1111/j.1939-0025.1984.tb01532.x>
- Evans, R. (1971). Bentham's Panopticon: An Incident in the Social History of Architecture. *Architectural Association Quarterly*, 21-37.
- Foucault, M. (1980). *The Eye of Power. Power/Knowledge: Selected Interviews and Other Writings 1972-77*, ed. Colin Gordon, 46-65.
- Foucault, M. (1982). The Subject and Power, *Critical Inquiry*, 8(4), 777–795.
- Foucault, M. (1977). *Discipline and Punish: The Birth of the Prison*, Trans. Alan Sheridan. New York, Vintage, 1977, 3-8.
- Fraile, P., & Bonastra, Q. (2019). Surveillances, Social Management, and Architectural Morphologies: An approach to the Prison and the Hospital in 19th Century Spain. *Journal of Historical Sociology*, 32(2), 189–214.

<https://doi.org/10.1111/johs.12212>

- Füller, H. (2016). Pandemic cities: Biopolitical effects of changing infection control in post-SARS Hong Kong. *The Geographical Journal*, 182(4), 342–352. <https://doi.org/10.1111/geoj.12179>
- Martin, D., Nettleton, S., Buse, C., Prior, L., & Twigg, J. (2015). Architecture and health care: A place for sociology. *Sociology of Health & Illness*, 37(7), 1007–1022. <https://doi.org/10.1111/1467-9566.12284>
- Marvasti, A. (2011). Story-driven models. Writing In: *Qualitative Research in Sociology* (pp. 10-11). SAGE Publications. <https://dx.doi.org/10.4135/9781849209700>
- Piras, E. M., & Miele, F. (2017). Clinical self-tracking and monitoring technologies: Negotiations in the ICT-mediated patient–provider relationship. *Health Sociology Review*, 26(1), 38–53. <https://doi.org/10.1080/14461242.2016.1212316>
- Redfield, P. (2005). Doctors, Borders, and Life in Crisis. *Cultural Anthropology*, 20(3), 328–361. <https://doi.org/10.1525/can.2005.20.3.328>
- Simonsen, T. P., & Duff, C. (2020). Healing architecture and psychiatric practice: (Re)ordering work and space in an in-patient ward in Denmark. *Sociology of Health & Illness*, 42(2), 379–392. <https://doi.org/10.1111/1467-9566.13011>
- Wolf, A., Ekman, I., & Dellenborg, L. (2012). Everyday practices at the medical ward: A 16-month ethnographic field study. *BMC Health Services Research*, 12(1), 184. <https://doi.org/10.1186/1472-6963-12-184>