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*monthly*

michigan society of architects february 1963 50c





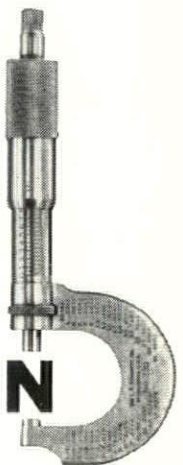
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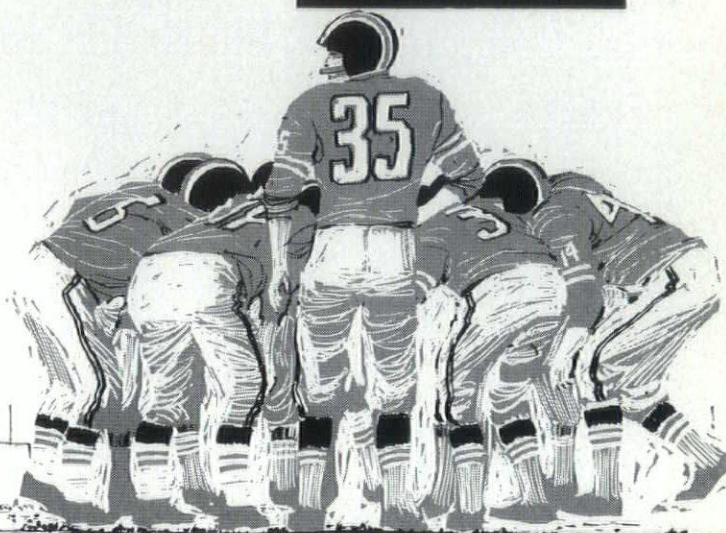




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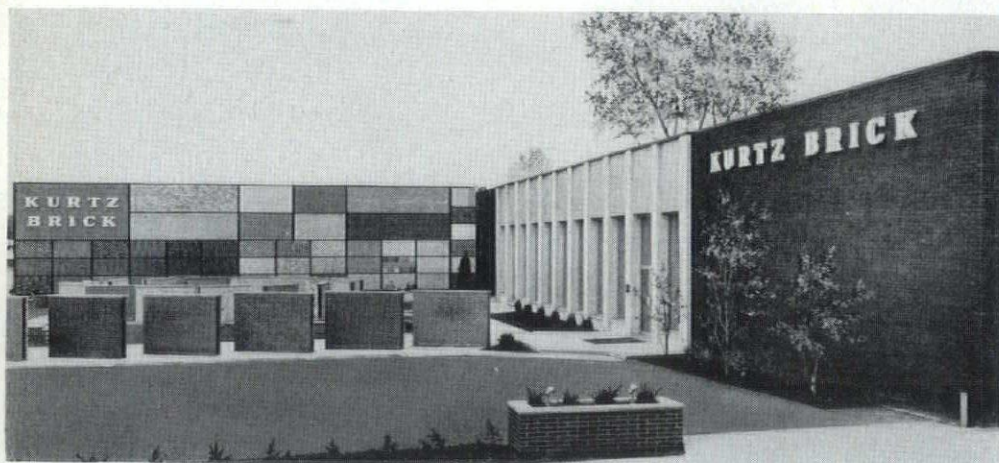
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# BULLETIN

*monthly*

*michigan society of architects* february 1963

THE MONTHLY BULLETIN IS PUBLISHED FOR THE MICHIGAN SOCIETY OF ARCHITECTS TO ADVANCE THE PROFESSION OF ARCHITECTURE IN THE STATE OF MICHIGAN.

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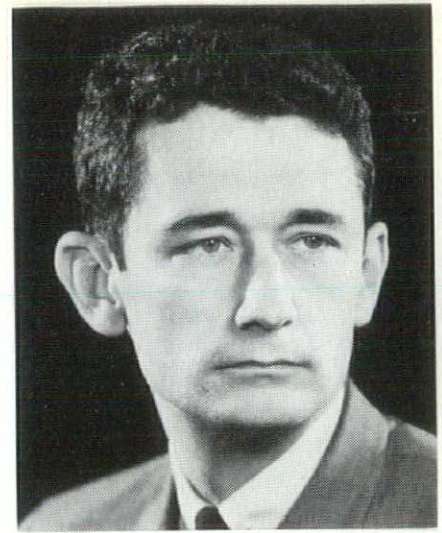
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#### Talmage C. Hughes, FAIA

As we go to press, we learn of the death of Talmage C. Hughes. Details will be published in our March issue.





Bruce J. Graham

## Convention Seminars Focus on

# Who Cares About

The theme for MSA's 49th Annual Convention—"Who cares about Architecture?"—will unify three seminars planned for the three-day meeting in Detroit. Convention dates are March 6, 7 and 8. Convention activities will be located at the Sheraton-Cadillac Hotel.

The featured seminars will explore the Architect's principal function to guide and direct appreciation of the value of design in the profession, the allied arts and the public at large. Lectures and discussions will aim toward the development and implementation of a vital program of design education improvement, re-emphasizing the fact that architects are designers, and pointing to the goal of convincing the public that architecture is an art as well as a science.

Such questions as:—What are the im-

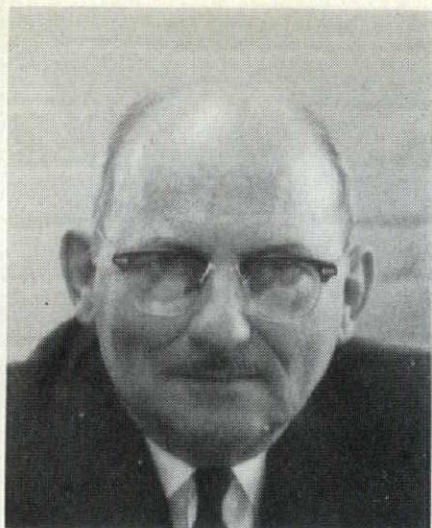
pacts of architectural design on the political, economic, cultural and social facets of our environment? What can be done within the profession to inspire the public's awareness of the value of good design in our environment?—will be investigated by outstanding practitioners.

Striving to arrive at some conclusions, they also hope to outline some new directions for solutions from the public's view, that of the client, and finally, the architect.

The role of "The Public" in answering "Who cares about Architecture?" will be examined in the first seminar, to be held Thursday afternoon, March 7. The influence of "The Client" will be the subject of a second seminar, scheduled for the morning of Friday, March 8. "The Architect" titles the final seminar, to be held Friday afternoon.

One of the speakers convention-goers will hear is Morris Ketchum, Jr., FAIA, head of the New York firm bearing his name, who has planned a wide variety of buildings in 30 of the 50 states and in Europe, South America and North Africa. They range from shops and stores, department stores and shopping centers to school and college buildings, office structures and institutional and public buildings. He has also modernized existing communities and planned entirely new ones. A director of the New York region of the American Institute of Architects, Mr. Ketchum is president of the Municipal Art Society of New York and an associate of the National Academy of Design. His book "Shops and Stores," is the standard textbook on store planning. In the teaching field, he has served on the design faculty of Yale, New York University, Pratt Institute and The Cooper Union.





*Dow K. Foraker*



*Morris Ketchum, Jr.*



*Carl Konzelman*



*Robert E. Johnson*

# Architecture?

Another seminar speaker will be Bruce J. Graham, AIA, general partner and chief of design for the Chicago office of Skidmore, Owings & Merrill. He has been responsible for the headquarters office buildings of the Inland Steel Co., Chicago; Kimberly-Clark Corp., Neenah, Wis.; Warren Petroleum Corp., Tulsa; Parke, Davis & Co., Ann Arbor; The Upjohn Co., Kalamazoo; Hartford Fire Insurance Co., Chicago; and Business Men's Assurance Company of America, Kansas City, Mo.

An active member of the Chicago chapter of AIA, Mr. Graham is deeply interested in architectural education and has lectured at various universities throughout the country. He is a visiting critic and regional advisor for the Washington University School of Architecture in St. Louis, the University of Florida in Jacksonville, and New York University in New York City.

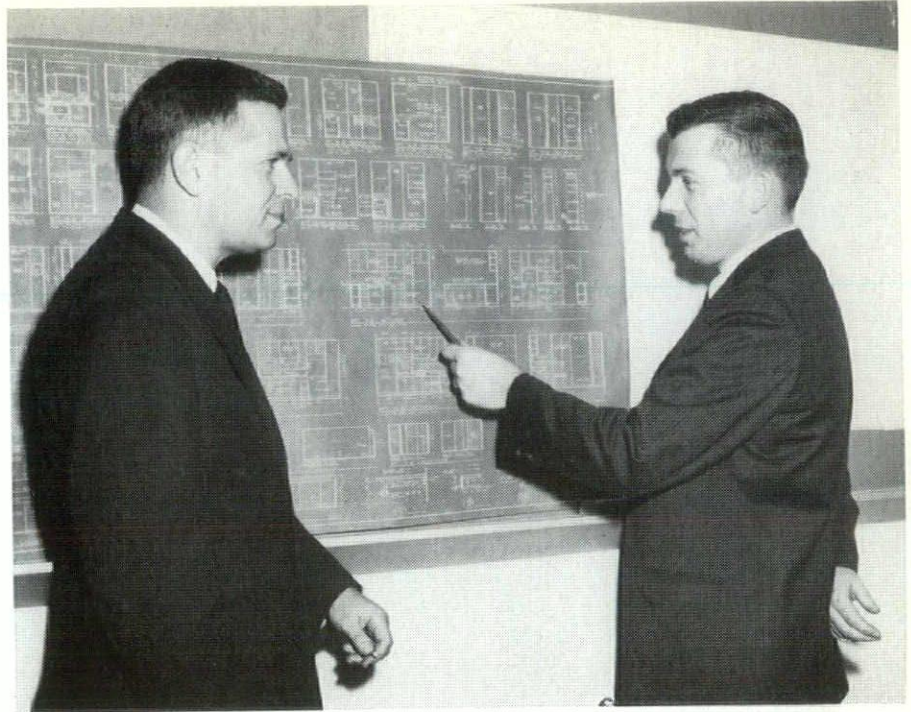
Seminar audiences will also hear from Carl Konzelman, home section editor, The Detroit News. A long-time newspaper man, Mr. Konzelman presents an interesting and enlightened view of the public's slant on architecture. His newspaper background spans more than thirty years, dating back to 1932 when he joined The Detroit Free Press. Army service saw him establish foreign editions of the Army News Service, Yank Magazine and the Stars and Stripes. Later he worked for New York City newspapers, returned to Detroit and various Detroit News editing capacities until 1953 when he was named Home Section Editor when Ernest Baumgarth retired. His education includes work at Wayne State University and Columbia University.

Seminar participants will also include: Vincent G. Kling, FAIA; Dow K. Foraker and Robert E. Johnson. Mr. John-

son is executive vice president of A. J. Etkin Construction Co. A 1949 graduate of Michigan College of Mining & Technology with a degree in civil engineering, he is a past president of the Society of American Military Engineers and a board member, Michigan BSDA, U.S. Department of Commerce, Business and Defense Services Administration. He holds memberships in The Economic Club of Detroit, Detroit Industrial Mission and Associated General Contractors of America, Detroit Chapter.

As superintendent of construction engineering at Parke, Davis & Co., Mr. Foraker was responsible for the company's \$50 million expansion program. Graduated from Tri-State Engineering College with a bachelor of science degree in mechanical engineering, his background includes nearly ten years with Western Electric Co. as a





*Samuel Popkin, left, draftsman competition chairman, and Philip A. Nicholas, MSA convention general chairman, discuss the annual MSA-SMCAD competition. Last day for receiving entries is February 15.*

development engineer. Joining Parke, Davis in 1934, he was appointed superintendent of engineering in 1950 and named to his present position in 1955.

One of the convention highlights will be the Architectural Exhibits, featuring exhibit material submitted from members throughout Michigan. Committee representatives are seeking exhibits of specific buildings completed or under contract in the last 18 months. Exhibit applications, already mailed to Michigan registrants and MSA members, should be returned to Richard M. May, Architectural Exhibits Chairman, 3107 W. Grand Boulevard, Detroit 2. Deadline for receiving applications is February 8. Exhibitors will be notified after the committee reviews the applications.

Another important convention activity

is the annual MSA-SMCAD competition sponsored by the Sheet Metal Contractors Association of Detroit Industry Fund. Qualified architects, engineers and draftsmen will vie for nine cash awards totaling \$1,000. Competition Chairman Samuel D. Popkin explained that the purpose of the competition is to stimulate greater interest and pride in the techniques of architectural and engineering drafting, and particularly to emphasize the need for quality of line, clarity of dimensioning, simplicity of lettering, completeness, conciseness of notations and details, good composition and logical arrangement of sheet.

First and second place awards (\$125 and \$75 respectively) will be made in each of four categories, architectural, structural, mechanical and electrical. There will also be a \$200 grand prize

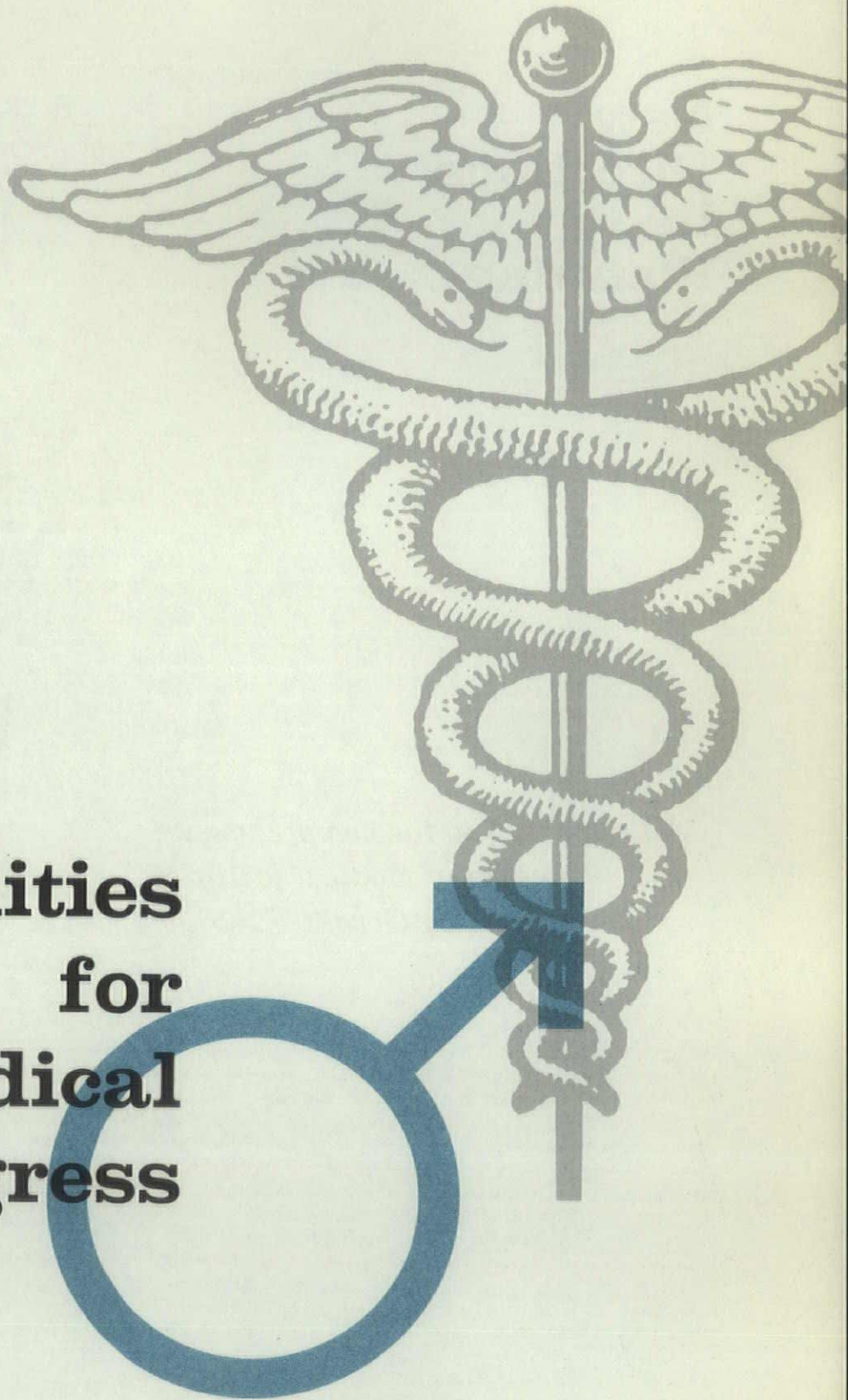
for the entry judged best in all categories. Announcement of winners and the presentation of prizes will be made at the Annual Awards Dinner on March 7.

Producers' exhibits on view during the convention will be located on the fourth and fifth floors of the hotel. As in former years, viewing of all exhibits will be encouraged through the awarding of a trip for two to a lucky member. Departing from the traditional Bermuda destination, this year's award will be a weekend for two at New York City's Waldorf-Astoria.

Inducement to visit fifth floor exhibits will be offered in the form of daily prizes and a special grand prize to be presented the final day of the convention. Only numbers registered at exhibits located on the fifth floor will be eligible.



**Facilities  
for  
Medical  
Progress**



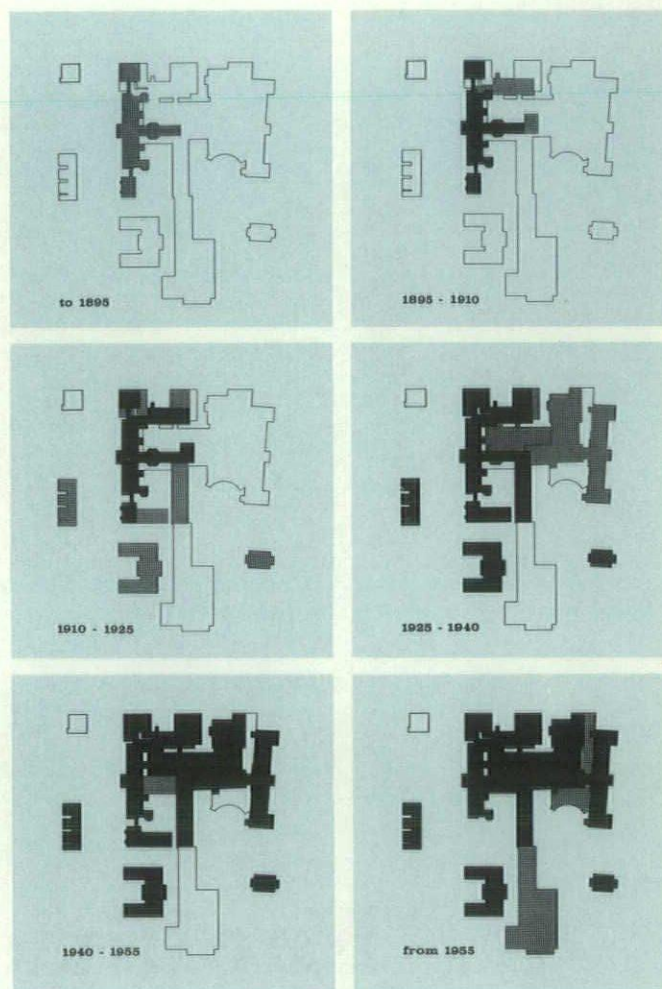


# New Directions in Planning

*An approach to the comprehensive  
design of medical facilities  
by Gerald E. Crane*

In recent years there has been an increasing awareness by both professionals within the hospital field, and by laymen beyond it, of the need to provide, locate and construct medical facilities according to some rational and preconceived plan, rather than in the haphazard piecemeal fashion traditionally employed. The increasing cost of all facets of medical care, the limited supply of trained personnel, and the growing costs of construction have forced a careful scrutiny of community needs prior to the location and construction of a major new medical facility. Too often new hospitals have been built only to find the supply of patients inadequate to fill the beds, or they have lacked the trained employees to staff them. In other instances a new facility has siphoned patients from existing institutions already having difficulties in maintaining an adequate patient census. Duplication of expensive facilities is a waste of time, effort and money that cannot be long tolerated.

Were the supply of money and personnel unlimited, one might perhaps afford to be able to dispense with planning. Where this is not so, as universally seems to be the case, planning becomes not only desirable but essential, if the



*Piecemeal growth of a typical urban hospital.*

health needs of a community are to be met in the most efficient and economical way.

Planning is a process, applicable in a variety of fields at a variety of levels, seeking to establish a rational direction over future development. It attempts to outline programs of future needs and to make provision to meet these needs. Properly administered it takes into consideration changing conditions and makes continuous adjustment to these changes. If it is to be effective it must be oriented to action. It is not star-gazing, nor is it an end in itself, but a means to an end. Good planning leads to positive action and discernible results. It is not a panacea for all ills, but it is an immensely useful and cost-saving process if properly applied.

*Gerald E. Crane, architect-planner and principal in the firm of Crane and Gorwic, is a registered architect in Michigan, associate member of the Detroit Chapter, AIA, associate member of the American Institute of Planners, associate member in the Royal Institute of British Architects, and associate member of the British Town Planning Institute.*



### **Planning for Medical Facilities at the State and Metropolitan Level**

At this level the focus is directed toward community need, aiming among other things to insure the proper location and size of hospitals so as to avoid unnecessary duplication of facilities and the best utilization of available funds and personnel.

Twenty years ago only one metropolitan hospital planning agency existed—the Hospital Council of Greater New York. Today there are agencies of a similar nature in some twelve major cities. Other groups are in the process of formation. Since the passage of the Hill Burton Act by Congress in 1946 agencies have been established in each of the States to administer the Federal program of subsidies for hospital construction. Both the American Hospital Association and the U. S. Public Health Service have been most active in the field.

While planning for medical facilities at the state and community level has a long way to go before reaching universal acceptance and application, progress is substantial and in some instances rapid.

At the other end of the spectrum—the architectural design and construction of medical facilities—there has been a reasonable response to changing medical needs, and to new building methods and materials. Although the aesthetics of many modern hospitals leaves much to be desired and while experimental architectural research has yet to find its place, the architect's role as a member of the planning team is widely accepted.

But is this enough? Is it enough for the metropolitan hospital planners to find the right location and size for a new facility and for the architect to design and construct it to the best of his ability? One has but to examine any older hospital to reach a negative conclusion. In almost any institution that has been established for some years, buildings, (probably well-designed in themselves) additions and renovations have been constructed piece by piece as the needs of the moment became apparent. Different architectural styles, different materials and a conglomeration of physical elements, overcrowded on sites, following little or no logical pattern have resulted in confusions and contradictions of both function and form. The aesthetic results of this mode of growth have been universally unfortunate.

If the situation is to be avoided in the future there needs to be interjected an intermediate level of planning and design between that carried out on the metropolitan scale and that executed at the scale of individual building or building element.

### **Planning for the Growth of the Building Complex**

To understand the need for this level of planning it is necessary to appreciate the organic growth that takes place in a major medical facility, a growth both in space and in time. A new hospital is not a static thing, even though it is invariably conceived of as such. On the contrary, once initially built it will inevitably grow, adding new beds, which subsequently require more medical and non-medical service areas, housing, parking, related institutes and so forth.

In this sense the hospital is more like a city than a building, developing in time and space.

In the past, there has been little or no attempt to anticipate such changes and to cater for them in advance of their occurrence. The result is the addition of new construction, which, however well-designed in itself, viewed in the time-space spectrum will be restrictive, obstructive and perhaps destructive of the growth of the whole.

If this type of development is to be avoided in the future the planning process must be applied to the physical development of the building complex. In the case of an existing hospital this will involve identifying the problems and appraising what exists, projecting future needs and preparing a long-range plan to meet these needs. Finally the proposals contained in the long-range plan must be implemented, i.e., carried out over a period of time.

### **The Application of the Planning Process to the Building Complex**

More specifically this process involves (in the case of an existing facility):

- (a) A Survey and Analysis of the Physical Conditions of the Hospital. Each hospital has certain conditions and problems which are unique. They must be defined, well understood and carefully analyzed as to their influence on the future. The conditions to be covered range from the overall physical relationships to the delineation of floor areas by functional element and department. Included should be a review of the site, buildings and circulation patterns. With such documentation at the beginning, the stage is set for the next step in the process.
- (b) Determination of the Future Medical and Operational Objectives of the Hospital. This includes a review of the particular hospital's role in the community and if the hospital is part of an institutional complex, its function and relationship in this setting. The major policies of the hospital regarding medical staff, services, administration, personnel, finance and physical facilities need to be established. These policies and objectives can then be translated into space requirements for the preparation of future plans.
- (c) Preparation of a Development Plan in Two and Three Dimensions Covering an Extended Period of Time, Incorporating the Findings in (a) and (b). It reflects the physical development that is desired and serves as the framework for site acquisition and the location of future additions and improvements to the hospital. With such a document it is possible to locate future additions of beds, medical and non-medical service areas, housing, parking and so on, not in splendid isolation, but according to some preconceived pattern of order and organization. The three dimensional development plan should not attempt to be too specific in character, since while it is reasonable to predict and to direct the general growth of the building complex, particularly if ultimate site limitations can be established, it is a brave and probably a foolish person who



will try to predict what the specific architectural effect will be of particular future developments in medicine. In other words, the development plan will be self-defeating if it attempts to go into too much architectural detail too soon.

- (d) Implementation. Once the development plan is complete and adopted by the policy making board of the institution, it must be put into effect. Without a really effective mechanism for implementation the development plan will have little more than pictorial, public relations and perhaps fund-raising value.

The implementation phase is a continuous one. It consists of a series of construction stages interspersed with modification and improvement to the long-range plans in which changing conditions are constantly being reflected. Without a mechanism for continually acquiring data and information to make logical modifications and secondly a feedback mechanism to institute these modifications the physical planning process collapses.

Obviously, if mistakes are to be avoided in the future, the design of any major new facility should be approached on a similar basis. The Survey and Analysis can be largely eliminated but the long-term establishment of policy and of planning far beyond the initial phases of construction must be carried out.

#### **The Urban Hospital and Urban Renewal**

There has recently come into being yet another phase of planning which can be of immense value to the urban institution. If combined with the process outlined above, it can create a veritable renaissance for the institution that has been established for many years.

A large proportion of what are today urban institutions, when first founded were in open fields on the city's periphery. More than adequate land was available and little thought was necessary or given to future physical development. Additions were periodically constructed and the hospital grew by a system of accretion. At the same time a phenomenal expansion of the urban area took place with the result that the hospitals found themselves not on the periphery but in the center of an aging, usually blighted, city.

This double difficulty of an antiquated poorly planned facility and a less than desirable environment has had serious ill effects on the hospital. Land for expansion is difficult to acquire and extremely expensive if available. Provision for the addition of patient beds, research facilities and for those functions which are an essential part of a modern hospital such as housing, parking and open spaces becomes virtually impossible. Often as not growth patterns are determined not by medical needs or architectural criteria, but by the availability of a site. Frequently these blighted central areas have high crime rates and congested traffic conditions, and access to them from the institution is hazardous. These adverse conditions reverberate throughout the hospital, multiplying the difficulties of administration and operation.

Some hospitals faced with such apparently insoluble problems have fled to suburbia. There land is available, cheaper and neighborhoods more wholesome. Such attempts to evade the evils of the blighted central city may prove abortive in the long run, for the initial symptoms of the advanced environmental disease that today affects the central city already appears in almost all suburbs. The movement

to suburbia is at best likely to prove an expedient solution, fraught with its own shortcomings and difficulties.

What then is the alternative? The urban hospital has very real and pressing problems which must be tackled if it is to survive in its urban location. A blighted environment will not disappear of its own volition nor can it be wished away. The situation calls for action, action of a kind not traditionally considered within the province of hospital administration or of medicine. The situation demands that the urban hospital begin to concern itself with physical planning and with urban renewal. The urban hospital and the architect concerned with its design must widen their horizons and interest themselves with the problems of environment and the means of solving the problems of that environment. More specifically the urban hospital that finds itself surrounded by slums must take steps to secure the clearance of those slums. In so doing it will not only eradicate the evils of the adverse environment but it will make land available for the expansion of the existing services and the addition of other related facilities.

For the urban hospital this is a task of no small dimensions and one which calls for the closest collaboration with City and Federal governments if it is to succeed.

#### **Urban Renewal**

For the hospital embarking upon such a course today the task of land clearance has been infinitely simplified by the enactment of the 1949 Housing Act, particularly those sections relating to urban renewal and rehabilitation. The act has greatly facilitated clearance of blighted area by providing federal funds for the considerable costs involved. Cities may apply for Federal funds for land clearance, the net cost of such clearance being shared between the City and Federal Government in a ratio usually of  $\frac{1}{3}$  to  $\frac{2}{3}$ . The land then cleared is made available to both public and private developers to rebuild within the framework of a development plan, subject to restrictions imposed relating to the plan.

Recently this legislation was given even greater relevance to the urban hospital by the extension of the system under Section 112 of the 1949 Act, whereby expenditures by a hospital for items such as land acquisition prior to approval of a clearance project can be offered as a non-cash local grant in aid by the local government undertaking clearance. Simply stated this means that the local communities share of the cost of clearance can be reduced by an amount up to the sum of expenditures for land clearance incurred by the hospital. These costs must have been incurred within a period of seven years prior to the date of authorization for a loan and grant for the urban renewal project.

This section of the act obviously gives the urban hospital a powerful additional argument when it sets out to persuade the community of the need for redevelopment in the vicinity of the hospital.

#### **In Conclusion**

These and many other developments in the field of planning and building facilities for medical care, teaching and research will affect the architect and his work directly and indirectly. Specialization and skill in the more specific and detailed aspects of hospital design will be of little avail unless the architect can at the same time comprehend and master the design of the whole as well as of the individual components in time as well as in space. Unless this is widely appreciated and widely practiced a substantial proportion of new facilities for medical care, teaching and research are likely to become obsolete within a few years of the ground-breaking ceremonies.





## **The Detroit Medical Center**

*The creation of an environment for medical progress*



Heralded as one of the nation's foremost medical facilities, the Detroit Medical Center is writing significant pages in Detroit's record of civic design and urban redevelopment. Eight-plus years of coordinated community effort are producing one of the most notable projects undertaken to meet the health needs of a sprawling metropolis.

The project had its real start in 1954. Directors of The Grace, Harper, Woman's and Children's Hospitals met to discuss their mutual problems arising from blighted environment. They later met with Charles Blessing, Secretary-Director of the City Plan Commission, and other city officials to discuss the creation of a medical center around the existing hospitals, utilizing the urban renewal process as a means of clearing land. Subsequently, the four large hospitals joined forces with Wayne State University College of Medicine to establish a concentration of facilities for medical care, teaching and research.

The Detroit Medical Center Citizens' Committee, chaired by Ray H. Eppert, was formed. Membership includes the hospital directors and trustees, and Dr. Gordon H. Scott, Vice-President for Medical College Development and Dean of the College of Medicine, Wayne State University.

The firm of Crane and Gorwic, planning and urban design consultants to the Committee has been developing and implementing the overall master plan in conjunction with the efforts of the City. The Citizens' Committee also retained hospital consultant Dr. Anthony J. J. Rourke to advise upon the medical aspects of the Center.

In one of his reports, Dr. Rourke stated: "The opportunities in one generation to take advantage of modern and complete planning of health facilities and programs are rare. Detroit, through the foresight of its community and leadership, is now afforded by urban redevelopment, an opportunity to establish a foundation for another hundred years of health care."

Extensive research and consultation with local and federal officials began. The project travelled through countless meetings, including sessions of hospital boards, medical groups, the City Plan Commission, the City Housing Commission, the Detroit City Council, and many, many other interested organizations.

A future land use plan evolved. It called for application of the following principles:

- Elimination of unnecessary streets, and the creation of a carefully planned road and land use pattern.

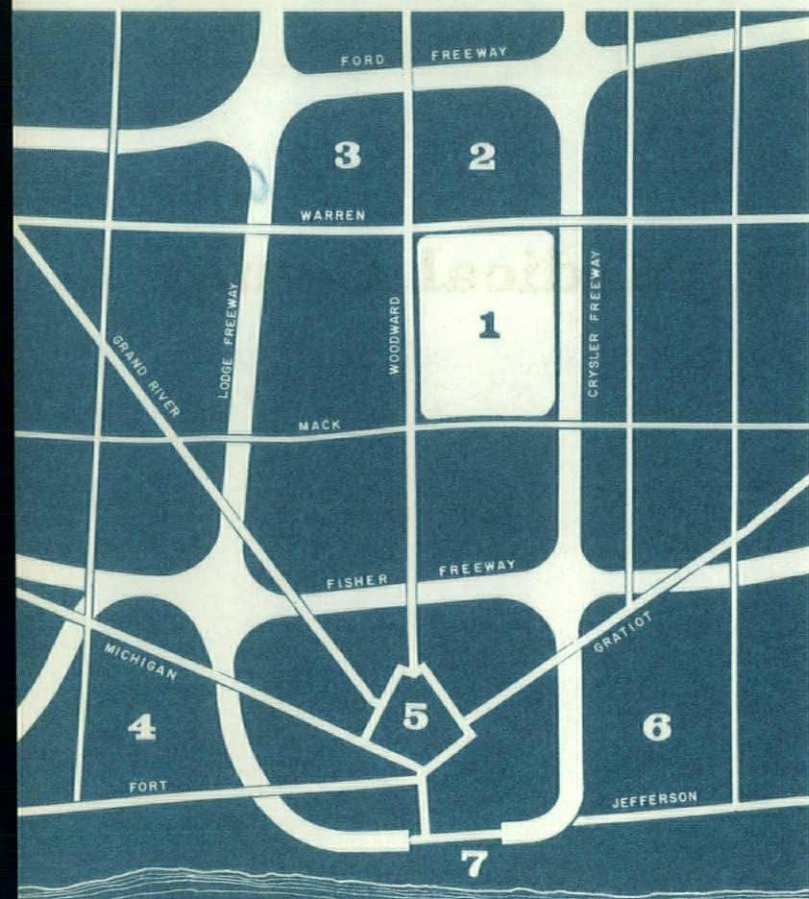
- Assembly of existing city blocks into larger units or superblocks rebuilt with single or compatible uses.

- Maximum possible separation of pedestrian and vehicular traffic.

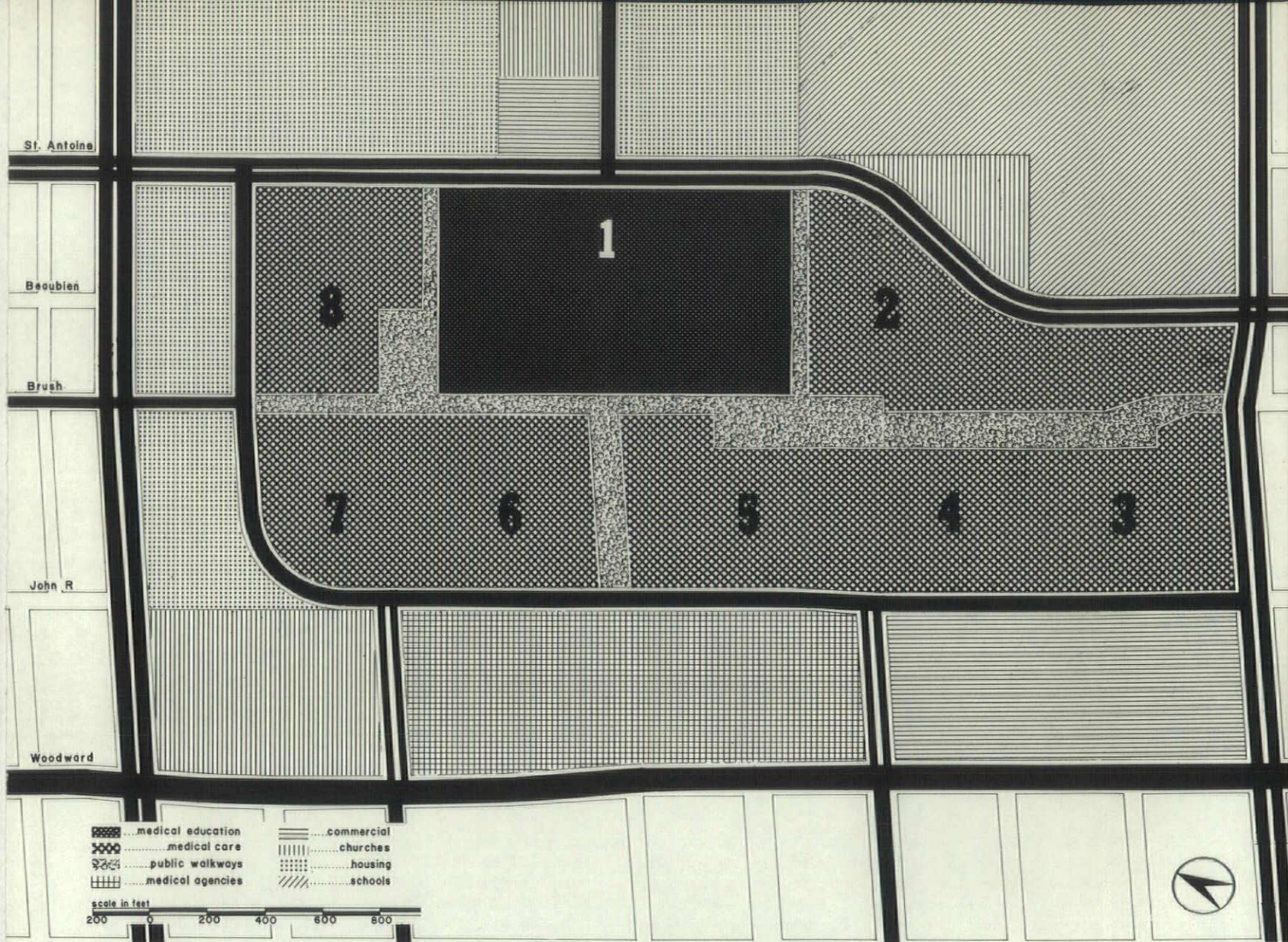
- Maximum utilization and enhancement of existing institutions.

The master plan shows how these principles are being applied in reconstruction of the area.

*Heart of the City—The Medical Center lies at the crossroads of the entire metropolitan area. The map shows the locale of the Center in relation to other major projects. 1—Medical Center, 2—Cultural Center, 3—Wayne State University, 4—West Side Industrial District, 5—Central Business District, 6—Gratiot-Lafayette Housing, 7—Civic Center.*







*Medical Center Master Plan—This diagram shows the layout of streets and uses of land in the project. Boundaries are the Chrysler Freeway, Warren, Woodward and Mack. Medical facilities in the core include: 1—Wayne State University College of Medicine, 2—New Children's Hospital, 3—Rehabilitation Institute, 4—Harper Hospital, 5—The Grace Hospital, 6 & 7—future hospitals, and 8—Woman's Hospital.*

The entire project covers some 250 acres of land, with the medical core centered on 97 acres. The whole area extends from Mack Avenue on the south to Warren Avenue on the north, and from Woodward Avenue on the west to the Chrysler Freeway on the east.

Streets will be drastically changed, making present ones unrecognizable. Brush and Beaubien will be completely eliminated, as are all the east-west streets between Mack and Warren. John R is closed at its northern end and becomes a two-way service drive linked with Hancock. Through traffic is taken by a new boulevard thorough-

fare which starts at the junction of Beaubien and Mack and swings across to the present alignment of St. Antoine, and continues north.

The revolutionized road pattern divides the land in two basic parts: the medical core and the peripheral belt.

The medical core, ringed by Mack, John R, St. Antoine and Hancock, contains the existing Woman's Hospital, The Grace Hospital, Harper Hospital and the Rehabilitation Institute. Within this core, land is provided for the basic functions of medical care, education and research.





At the core's center will be Wayne State University's College of Medicine, centrally located to be equidistant from all hospitals and clinical facilities, and thus surrounded by existing and new institutions for medical care. The campus of the College of Medicine will be comprised of basic science, instructional and research facilities, an auditorium, library, and food commons. The first building on the new campus is a \$4 million medical research building designed by Smith, Hinchman and Grylls, Architects and Engineers. Construction began last fall and is scheduled for completion in 1964.

Also within the core, to the east of Harper and the Grace Hospitals, will be constructed the new Children's Hospital of Michigan. Designs executed by Albert Kahn Associated Architects and Engineers provide accommodations for 320 patients. Construction is slated to begin in 1964.

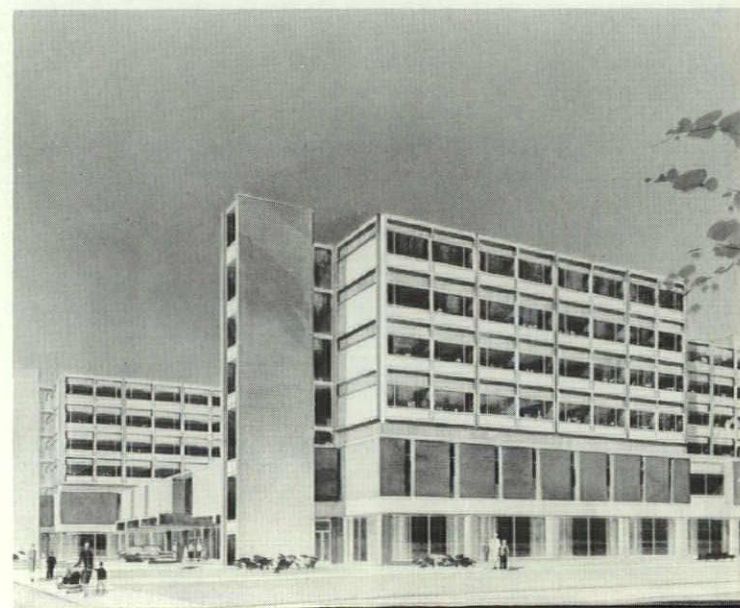
Along the roads encircling the medical core parking facilities will be strategically located. Parking lots and multi-story parking structures will be used. Covered ways will connect parking areas with Medical Center buildings.

Surrounding the medical core is a belt of land, one city block wide and about 120 acres in area. Designated as the peripheral belt, this section will contain housing for those working in the Center as well as for the general public. An area is to be developed as a neighborhood shopping center serving the residential area and the Medical Center. The belt also contains sites for churches, schools, paramedical agencies and offices, stores and commercial development.

One of the first buildings to be constructed in the peripheral belt is the new Spain Junior High School. It is to be located adjacent to the existing Abraham Lincoln School. Designs for this \$2¼ million facility accommodating 900 students were prepared by Hammond, Quinlan and Fowler, Architects.

Just to the north of the schools will be constructed the new Friendship Baptist Church. Construction of this facility designed by Wallace K. Kagawa, Architect is scheduled to begin this spring.

*The New Children's Hospital (Albert Kahn Associated Architects and Engineers)—This 320-bed facility is to be located east of Harper and The Grace Hospitals.*





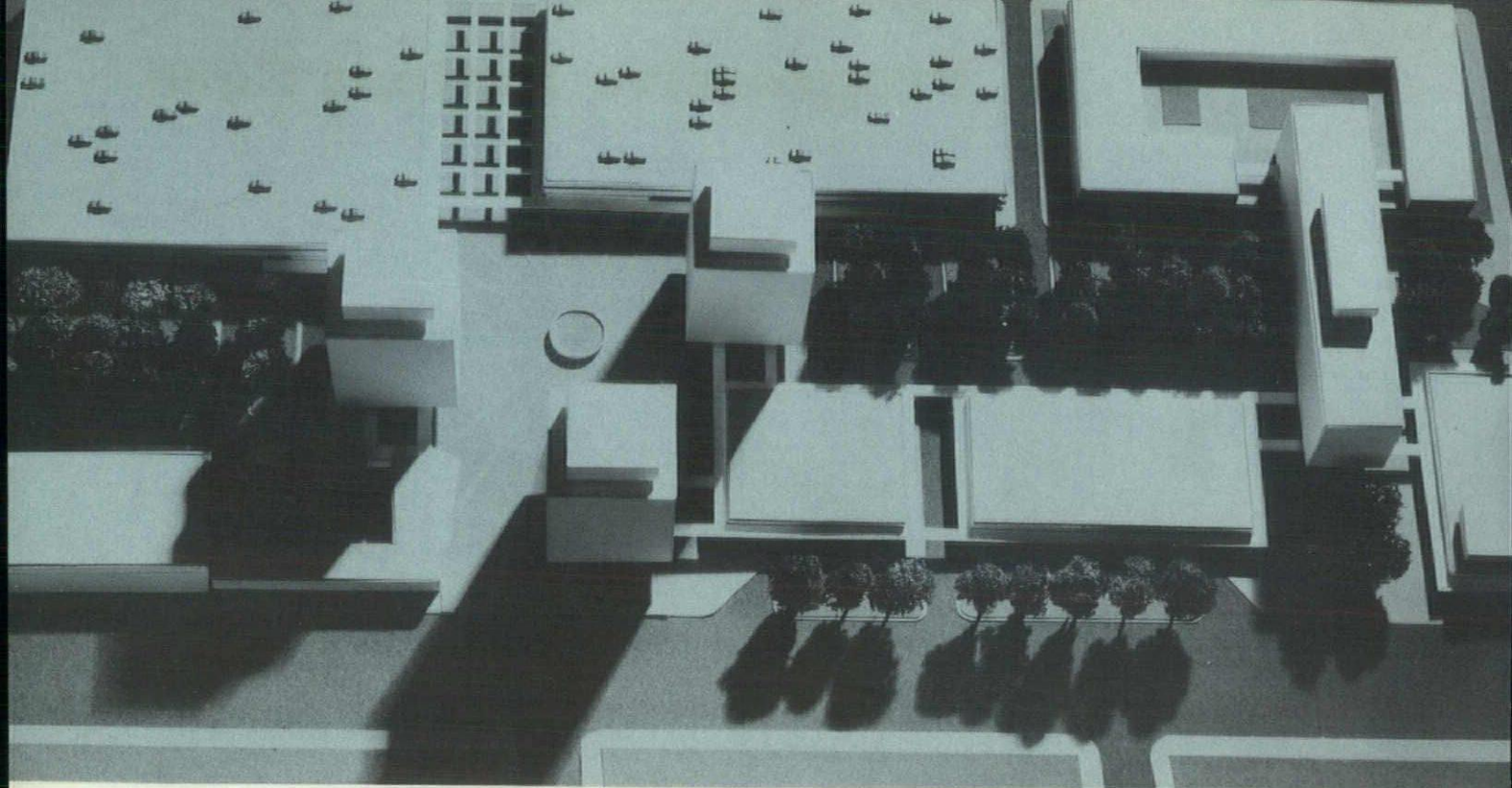


*Medical Research Building (Smith, Hinchman & Grylls, Architects and Engineers)—This \$4 million structure, first of many Wayne University College of Medicine buildings, is under construction at the intersection of St. Antoine and Canfield. Design features provided include maximum flexibility of laboratory size and maximum availability of laboratory services. All research areas are grouped around a central, longitudinal utility core which contains all mechanical and electrical services. The repeating pattern of the interior laboratory modules is expressed in the exterior facade. Subtle variations within its modular pattern will lend interest to the surface. Variety thus established will be repeated in new and appropriate ways in the adjacent buildings to follow.*

*Ground-breaking ceremonies for the Medical Research Building show, from left: Clarence Hilberry, president of Wayne State University; Mayor Jerome Cavanagh of Detroit; Leonard Woodcock, chairman of Wayne State's Board of Governors, and Ray Eppert, chairman of the Detroit Medical Center Citizens' Committee.*







*Medical Office Building Complex. This \$25 million project fronts on Woodward Avenue (in the foreground) from Alexandrine to Mack. The 16-building complex includes professional Office buildings, stores, shops and multi-level parking facilities for 1750 cars. (Crane and Gorwic, Architect-Planners)*

A \$25 million dollar medical office building complex is to be constructed on a 15.4 acre site along Woodward Avenue from Mack to Alexandrine. Owners and developers for the project are M. E. Arden and H. F. Campbell. The 16-building complex includes three 11-story professional office buildings, a 7-story general office building and 1-story structures for offices, stores and shops and multi-level parking facilities for 1750 cars. Architect-planners for the project, Crane and Gorwic, have started drawings for the first parking structure and the first 11-story professional building. Groundbreaking for the parking structure is scheduled for late spring of this year.

Land Clearance for the Detroit Medical Center Project is being accomplished under the City and Federal Urban Renewal Program. Cost of land clearance and site improvements amounts to \$30 million. The federal government and the city share the cost at a ratio of two to one. Cost of reconstruction is estimated at \$250 million.

Detroit's Medical Center presents a unique opportunity. Land clearance through urban renewal in conjunction with comprehensive long range planning for reconstruction provides for the maximum utilization of available land and establishes a logical framework for all future growth and development. It presents the opportunity for the Detroit Medical Center to become an environment in which physical expression meets the challenge of medical progress.

*The owner-developers and architect-planners for the new medical office building complex view a model of the project unveiled on January 22, 1963. From left to right, Gerald E. Crane, H. F. Campbell, Norbert H. Gorwic and M. E. Arden.*





# Progressive Patient Care

This central theme is the organization of facilities, service, and staff around the medical and nursing needs of the patient. Each patient is in the right place, at the right time, with the right services and includes intensive care, intermediate care, self-care, long-term care, and home care. Four of the five elements are contained within the hospital. The fifth, home care, is the extension of services into the community.

Patients are grouped according to their degree of illness and need for care. Nurses are assigned according to their particular capabilities to serve the several groups of patients.

A progressive patient care program benefits patient, physician, nurse, hospital and community, and it strengthens the concept of the general hospital as a community health center. Therefore, hospital administrators, staff and board members, involved in a new building program, can be properly concerned with preventing their new building from being obsolete, before it admits its first patient, by proper architectural planning and administration of the project.

Certainly, they will be asking for an out-of-date hospital if they permit traditional concepts of operation to be applied in the design of their new building. Their only hope of achieving functional originality is to make a clean break with preconceived notions and to apply logical processes to every step of the planning work. To overcome this tremendous inertial drag, the progressive administrator, staff, etc., have no option but to shake professional colleagues from ultraconservative attitudes that stand in the way of planning originality.

The administrator will be wise to expend his initial efforts in the study of new developments with respect to the philosophies and methods of operation in various departments. There must be a careful analysis of current operating problems in terms of how others are meeting them and how they may best be resolved in terms of local problems.

All of these functional problems, and perhaps revolutions, must be faced squarely in terms of whether the present staff can be sold on their values or educated into adopting new methods. As a matter of fact, it may even be necessary to measure with a cold, analytical eye the ability of department heads to meet the challenges of greater responsibilities.

In the realm of nursing there is considerable lip service given to team nursing in some instances where actual adoption of its principles is rather slow. One new hospital building, opened about five years ago, was designed en-

tirely around the concept of team nursing and the facilities were built to take advantage of its potentialities for better patient care. It was bitterly disappointing to see these facilities being utilized in a pattern completely divergent from the philosophy behind their planning by a director of nursing, with a great deal of seniority, who was psychologically unable to adapt to the principles of team nursing.

All activities that must be housed in the new structure must receive the same scrutiny and critical analysis by a mind that has been conditioned to disregard the compulsive decision that "the way we are doing it now must be good because it has been successful for the last 20 years." This studied departure from the traditional must be particularly applied to the whole problem of hospital logistics. It must apply to the handling of supplies from the tailgate of the truck to the bedside.

It is vitally important in the production aspects of hospital operation, as for instance in the operation of the central sterile supply department. Now that the central sterile supply department is acknowledged as supplying the entire hospital with sterile materials, it may be found that there is no valid reasoning that relegates its administration to the surgical supervisor. The needs of the department of surgery, as well as obstetrics, nursing units, and outpatient departments, can secure adequate recognition, for instance in the development of an active central sterile supply committee. Therefore, this department might better be independently organized with a registered nurse as its supervisor and staffed by production workers. This same investigation of better methods should apply equally to patient care areas and areas generally dominated by medical staff.

*Mr. Roessling is vice president in charge of medical facilities at Smith, Hinchmann and Grylls. A Detroit Chapter member, he is serving on the chapter, MSA and AIA committees on Hospitals and Health. He is also a member of the Michigan Gerontology Society and the International Hospital Federation.*

It is obvious that a long look at methods may well raise questions as to the chain of command and who is going to administer what. If the building is to be larger and to give more services, it may become necessary to increase the supervisory staff and to decrease the span of some supervisory controls. The development of a new organizational chart, based on a new approach to operations, may well have a substantial effect on what functions should be grouped physically together and which ones may be separated because controls have changed.

To use an example, obstetrical nursing may be responsible for formula preparation for the simple reason that the



formula room currently adjoins the nursery. If on examination the preparation of infant formulas appears to be a function of dietary production, the new organizational pattern would reflect such a change and require an architectural decision to place the formula room near, but not in, the kitchen. A more unique decision might be that infant formula preparation is a matter of sterile techniques and therefore should come under the control of the central sterile production department. In any event, in the development of a new organizational pattern, every function should be examined for its true relationship to other functions, without too much worry of how it's now being done.

With the chart of organization completed, the next job is to devise a staffing table calculated to take advantage of the estimated savings that can be accomplished as a result of the study of new methods and new distribution patterns. Preparation of this staffing pattern will present a new opportunity to weigh the decision with respect to organization and arrive at a final, well-sifted plan of operation. This staffing pattern should then be priced in terms of hospital personnel policies and predicted salary schedules. When this work is done carefully and a budget is prepared on the basis of such staffing table, unpleasant surprises with respect to the operation costs of the new building may be avoided well in advance of construction.

The architect's function in the development of the program is essentially that of a data processing machine, in that he will absorb the various data previously developed by the administrator and resolve the desired results of the building program into a written architectural description. He will require information as to construction budget, required functions, required physical relationships between functions and conclusions reached with respect to the number of beds according to medical services. He will be helped considerably if the administrator's research into methods organization and staffing has been summarized in concise written form. However, any such written book will require augmentation by a series of conferences with the administrator, and in some instances key supervisors.

The architect's development of the schematic drawings are small scale drawings that are used by the architect to develop the over-all shape of the building and its internal arrangement. At this stage, the architect determines how broad and tall the components of his design will be.

Of much more concern to the administrator at this stage is the internal arrangement of blocks of functions or departments that the architect will be fitting into his design scheme. As the administrator is able to give guidance to the architect during the course of these schematic drawings on the basis of the organizational studies, advantageous or awkward lines of traffic flow and material handling will be established or avoided. From the standpoint of effective over-all operation of the hospital, this is the most important phase of all of the planning effort.

Later work in the development of internal department layouts is important but can be changed after the building

is operating if mistakes have been made. However, there is no retreat from the broad decisions as to structural arrangement that are made in this schematic drawing phase.

Successive generations of administrators will be required to live within the framework irrevocably created when schematic drawings are finally approved. For these reasons the administrator, in working with the architect during the schematic phase of design, must be objective and uncompromising in undertaking to achieve with the architect the best possible interrelationship of activities and traffic flow. The architect should spend all the time necessary to arrive at the best plan at this stage, since all of the ensuing work in planning will be facilitated if the schematic drawings are as perfect as the combined ingenuity of the planners can achieve.

One means of working toward this goal of perfection is to continue the challenging of opinions. For instance, if it appears sensible to put the surgical suite, the x-ray suite and the emergency department in the basement, this could mean that in turn the kitchen might have to move to the second floor. The administrator should never accept the statement that "we never put kitchens on the second floor." The only way to find out whether or not such a plan is feasible is to look at it, study it, analyze it and try it. It is just possible that even though the bare idea might sound weird, its successful incorporation into the plans might bring many advantages.

In testing the schematic drawings the following questions should be asked: Has travel been minimized? Are bedside requirements available to the nurse with minimal expenditure of her time? Does the plan locate each department in its highest possible priority location? Can each department be expanded in the future without undue cost? How can future functions be added?

The final test of the schematics comes when this phase of the work is ready for approval and when once more the architect estimates cost, and the planners compare the cost estimates with the budget. It may be necessary once more to make planning adjustments in order to avoid unpleasant surprises when the bids come in.

On the basis of the schematic drawings, the architect is ready to begin the preparation of the preliminary drawings, which will show every room, every counter and cabinet and every door. With this phase of the work, the architect should be expected to bring along the development of the mechanical system in order that when working drawings are prepared later on there will not be the sudden appearance of a ventilating or pipe shaft in a strategic location in a room previously ideally planned.

In this phase of the work the designing will be department by department, with each department being confined within the limits previously established in the schematic drawings. Department heads must understand that the schematic limits of their area are budgetary considerations that they must live within, just as they operate their departments with a dollar budget.



It is in this stage of the work that all of the methods improvement studies the administrator has made will begin to assume practical significance. Production areas will require attention in detail. Department heads must have an opportunity to participate in the development of facilities that will affect their work but always with the administration providing leadership and questioning the validity of opinions.

So far all that has been written has dealt with efficiencies and economies and on the surface has not appeared to be concerned with patient care. This apparent indifference to the care of the patient, however, is only superficial, since experience indicates that when proper handling of materials has been achieved, the nursing staff will be relieved of messenger duties and other tasks that take them away from bedside care.

As the planning of the nursing unit goes on and the constant questioning proceeds as to the validity of traditional arrangements, it is inevitable that a constant inquiry is likely to be "How can we bring the items required for bedside care as close to their point of use as possible?" Thoughtful planners have achieved this in a variety of ways, but new approaches are always possible once planners are convinced that departure from yesterday's hospital planning is not necessarily heretical. It does take courage to be original, but a fresh approach is insulated if it is based on sure and solid study.

Every possible decision that can be made in the preliminary phase of work should be made. When the planning team has finished with the preliminary drawings, every detail should be so well thought out that no changes will be required in the working drawings. Every item of counter and case-work should be decided on with care. Under-counter cupboards and high cupboards should be scrutinized with the question as to whether or not they are indispensable. A survey of many hospitals will show that many inaccessible pieces of casework are dispensable. Decisions of this kind with respect to all manner of equipment and finishes will release budgeted construction funds for use in the upgrading of other elements of the building.

Again, at the conclusion of the preliminary drawing phase, the architect will provide another and more authoritative estimate for comparison with budget. If any sacrifices to budget are to be made, they must be made now, since adjustments in the working drawing can be difficult to the point of frustration. For overall comfort, it is far better at this stage to be pessimistic as to how bids will come in than to take the optimistic view and find that bitter sacrifices must be made after the bids are opened.

No one can successfully provide a substitute for the leadership of the administrator. When ready to embark on a hospital planning project, administrators who accept responsibility for guiding the planning team must train themselves to challenge opinions and be prepared deliberately to test and examine every recommendation, no matter how authoritative its source appears to be.

## Role of the Hospital Architect

The hospital architect is responsible to his client and his project in many different ways. He must draw upon his experience to meet the requirements of the community intelligently and realistically. His plans should provide a hospital that will meet the needs of the future population of the community, as well as immediate problems.

The solution to this important problem of future needs is to design a functional building which can be modernized and expanded as changing requirements dictate. Foresighted planning along these lines will prevent the hospital from becoming obsolete for those who must someday use it for new and different purposes. The hospital should be designed so that new equipment and additional floor space can be added at a minimum of expense.

Hospitals are essentially utilitarian structures; therefore, they should be designed around the activities of those who use them. To integrate the complexity of activities inherent in a modern hospital is a major undertaking. This is often a difficult task for the hospital architect, because the scope of hospital work is constantly expanding, and methods are constantly changing.

The architect must have an intimate knowledge of how a hospital functions in its various departments. He must make every effort to obtain the opinions of those who will work in the hospital, because these people are in reality the experts on function. We feel strongly that every interested person should be given a chance to express his views. Of value, too, are the general views which can be obtained from outside sources, such as social service and health groups.

A well-planned hospital must allow for changing functions within the original structure. For example, it might be decided in a few years to devote more space and facilities to obstetrics. It should be possible to accomplish this without major re-organization or new construction.

For this reason, the architect should have an intimate knowledge of the newer developments in construction and equipment. Adequate plumbing, wiring and air ducts, for example, should be placed so that they are accessible and expandable if necessary. Plumbing in lateral walls between rooms should be kept to a minimum. Provisions for expansion in any direction should be made before the building is erected. Building materials should be properly selected so that the hospital's maintenance costs will be kept to a minimum throughout its operation.

We who have a part in planning hospitals have been able to identify certain trends in post-war hospital development which help us in our planning for the future. Among these factors are education, changing patient types, employer and employee relationships, group medical practice, research and many others. The competent architect is fully cognizant of these trends, and can make good use of them in his design.

A. R.



# Growth Trends in the General Hospitals

In a talk about medical progress before the recent convention of the American Medical Association, the speaker referred to 1962 as the year of the "breakthrough." 1962 was undeniably a big year but progress in all branches of medicine has been phenomenal during the past decade. The ever increasing amount of research into every phase of medicine and medical nursing procedures indicates that each coming year will produce important discoveries and continue improving existing techniques. Improvements in equipment have been coming along regularly and others now said to be "in the works" may make antiques of today's latest models. The year 1962 looks like only the beginning of a breakthrough which will continue for years and create new space problems for the hospitals. These the architect must anticipate in plans now in preparation.

If anyone desires proof of the growth and/or change which has taken place, he has only to compare the plans of today's hospitals with those of ten or fifteen years ago. It was, therefore, suggested that this article be a commentary on anticipated growth due to other than an increase in bed capacity. Only 300 to 400-bed general hospitals, of which so many are now being built, have been considered. Those for special diseases, medical centers and for teaching are a specialty to which the following comments would be unlikely to apply.

Propheying trends in any changing, highly complex field is hazardous. Patterns have been formed and appear to be continuing, slower in some areas, rapidly in others. We must study them seriously, get opinions from those known to be deeply involved and well informed as to what is going on, and plan accordingly.

By departments, the growth trends seem likely to be as follows:

1. **ADMINISTRATION.** Volume of work and personnel has increased perhaps twofold or more during the past decade because of the growth of hospitalization, accident and medical insurance. Growth because of insurance may continue but much less rapidly. The boom seems to have leveled off leaving the percent-

age of bed occupancy high. It will likely remain this way as long as the public can pay the premiums which may not be for long.

Medicare, if and when it comes, will result in the discontinuation of an appreciable number of policies by the elderly. If insurance costs continue to rise, Medicare will be expanded for medical and hospital protection is here to stay in some form or other. If the government becomes involved, the paper work will undoubtedly expand and divisions of the administrative department will have an increased work load.

Automatic business machines have helped keep down space requirements, but some expansions appear probable and provision should be made for it.

2. **PURCHASING.** Purchasing personnel has been increasing proportionally to the number of items procured. This number has been increasing gradually and purchasing trends have been undergoing a change. Buying in quantities is paying off if storage is available. Thus the need for general storage, which is part of the purchasing department, has increased fantastically during recent years because of the trend toward the use of disposables which, being used up rapidly, are purchased and stored in large quantities. Supplies of the new drugs resulting from the continuing experimentation and research must also be stocked.

The general storage room should be large and of a shape and arrangement permitting the use of power hoist trucks. The lighting layout must be flexible so that the lights may be readily rearranged to accommodate re-arrangements of the storage cabinets and piles of supplies.

There has, I am told, never been enough general storage space. Allow for enlargement.

3. **FOOD SERVICE.** If the food service is adequate for present day needs and is efficiently planned and equipped with the latest up-to-the-minute equipment



it seems doubtful that more space will be needed; in fact, a little less may suffice. The increasing use of pre-prepared foods is reducing the work load in the kitchen considerably. The use of certain pieces of food preparation equipment and some space-using procedures may from time to time be discontinued thus recovering space for other purposes.

More efficient equipment can be expected. The work load should continue to be more readily handled. The need for additional space seems improbable.

4. **LABORATORIES.** Here there has been a lot of growth in both work load and the number of procedures. This is expected to continue but less rapidly. The difficulty of obtaining and retaining competent technicians led to the development of automatic equipment the trend toward the use of which is very strong today. It looks as though the future laboratory will perform most of its routine work by automation with a few highly trained technicians doing the special determinations but it may be a little too early to make such a prediction.

First class facilities for medical education are necessary for the internes. Most hospitals require their internes to do a research problem or two annually, and the place where this will be done we will, for lack of a better name, call the Research Laboratory. In this facility chemical manipulations, microscopy and some treatments will also be done. Once adequate for the needs of the full quota of internes, expansion seems improbable.

A lot could happen to the laboratories so they should not be fenced in with no way to expand. It would be a good idea to have them on the outside wall so that space may be added without disturbing work-as-usual.

5. **PHYSICAL MEDICINE.** Rehabilitation has not been getting the "play" it has deserved. Its importance is at long last being recognized and it seems destined for more support and rapid growth. It should be so located that substantial expansion in both work load and treatments can be provided.
6. **X-RAY—THERAPY.** This department gets a large and increasing amount of work from outside the hospital. The number of "shots" per patient continues to grow. The volume of special procedures is growing by leaps and bounds. The special procedure room should not be less than 18' x 18' and the tendency is toward an increase in height. Even then a new and larger room may be required within several years as equipment and procedures develop. The volume of GI work indicates a trend to make this a separate division of this department complete with developer, etc.

Therapy, too, will need more room. The trend now is toward the betatron or similar high voltage equipment. Not every hospital of this type will install one owing to the high first cost and, thus far, comparatively small volume of work. They don't pay off but, nevertheless, that's the trend.

*Mr. McGrew is project director for medical facilities at Giffels & Rossetti, Inc. A member of the Detroit Chapter, AIA, he is registered in Michigan and Illinois. He holds a bachelor of science degree in Architecture from the University of Illinois and completed graduate work at the American Academy in Rome, Italy.*



7. **RADIOISOTOPES.** This department is in its infancy with most of its development ahead. The number of treatments is increasing. The writer knows of a rather large recently-built department where the patient load is said to have increased over fifty percent during the last two years and necessary expansion will dislocate the neighboring facilities.
8. **SURGERY.** The operating rooms, particularly those used for heart surgery, will be increased in size. Larger equipment is said to be coming. One or two rooms should be equipped with TV. Procedures can be expected to change and volume increase but not enough to make it necessary to provide for much expansion. After all, the volume of surgery is closely related to the number of beds for surgical cases and we are assuming that their number is to remain constant.
9. **OBSTETRICS.** The number of available maternity beds controls the size of the delivery area. Changes in techniques, etc., are not expected to require increases in space requirements.
10. **PARKING.** The writer desires to comment on parking, although it is entirely apart from the hospital building. It is important but, nevertheless, seems to have been overlooked in the overall planning of several recently-built hospitals. Requirements vary depending upon the location of the hospital. The administrator of a 385-bed outlying hospital told the writer that they had made an exhaustive survey of similarly located hospitals and had concluded that three parking spaces per bed would be necessary to satisfy their peak demands. The lot was so built and is none too large. In this case, nearly all employees drive to work. On our 375-bed Providence project, we provided space for 640 cars but adjacent space is available for another 400 cars if it is found necessary. The importance of adequate, convenient parking must not be underestimated. Too many hospitals have lots so located that visitors must walk far to get to the hospital entrance which they sometimes cannot

see from the lot. The best parking is at grade in front of the principal entrance.

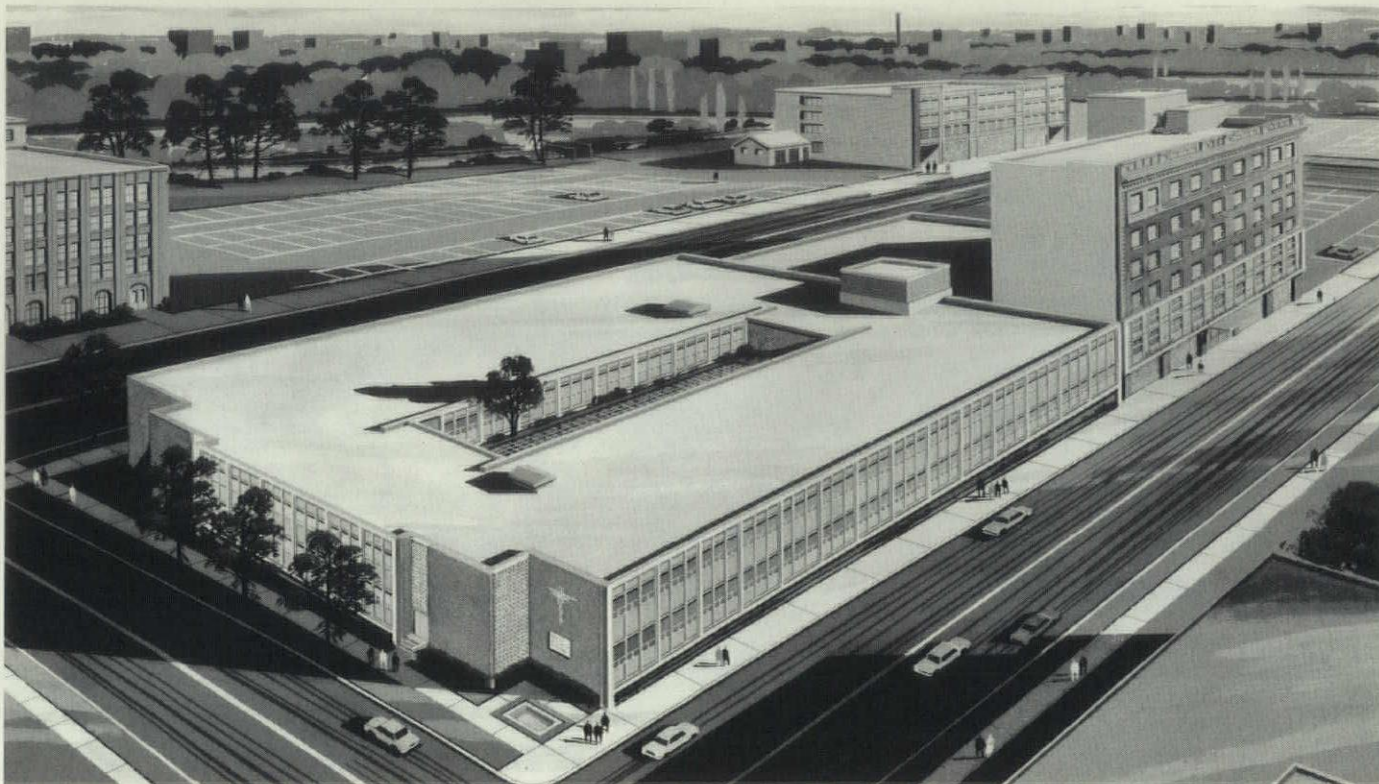
With the exception of Surgery and Maternity all of the above departments would be better, for one reason or another, if not above the first floor. The hospital should have open space around it on all sides so that the lower stories may be built out to provide for growth for the department requiring it.

The architect, who strives to produce the ideal hospital which is up-to-the-minute in all details, with the very latest facilities at the minimum construction and operational cost, must read incessantly to familiarize himself with the development in the complex, numerous and ever-changing branches of medicine as well as keep up with his own not-so-static profession. He could conceivably become a jack of several trades and a master of none. The conclusions are obvious: Architecture he must know; he would do well to lean on others for the authoritative and detailed information on the functions and procedures which he is to house.

Keeping fully informed on current practices, and on the trends and possible future expansions which may result from the increasing experimentation and research is a full time job in itself. In our office we prefer that the client engage a hospital consultant—one who devotes his entire time to consulting work. If the consultant has been observing and studying these matters for years, is sensitive to the trends which could affect the plans and future expansion and is well informed on what the equipment manufacturers are developing, he should contribute immensely to the soundness, up-to-dateness and success of the project.

Finally, the writer wishes to thank the many medical and hospital people who have through the years taken their good time to demonstrate the operation of new equipment, explain their new procedures and the advances being made in their respective fields of endeavor. They are a dedicated lot, who desire to make life for all of us more comfortable and longer. They appreciate the role of the architect and seem ever willing to aid him.





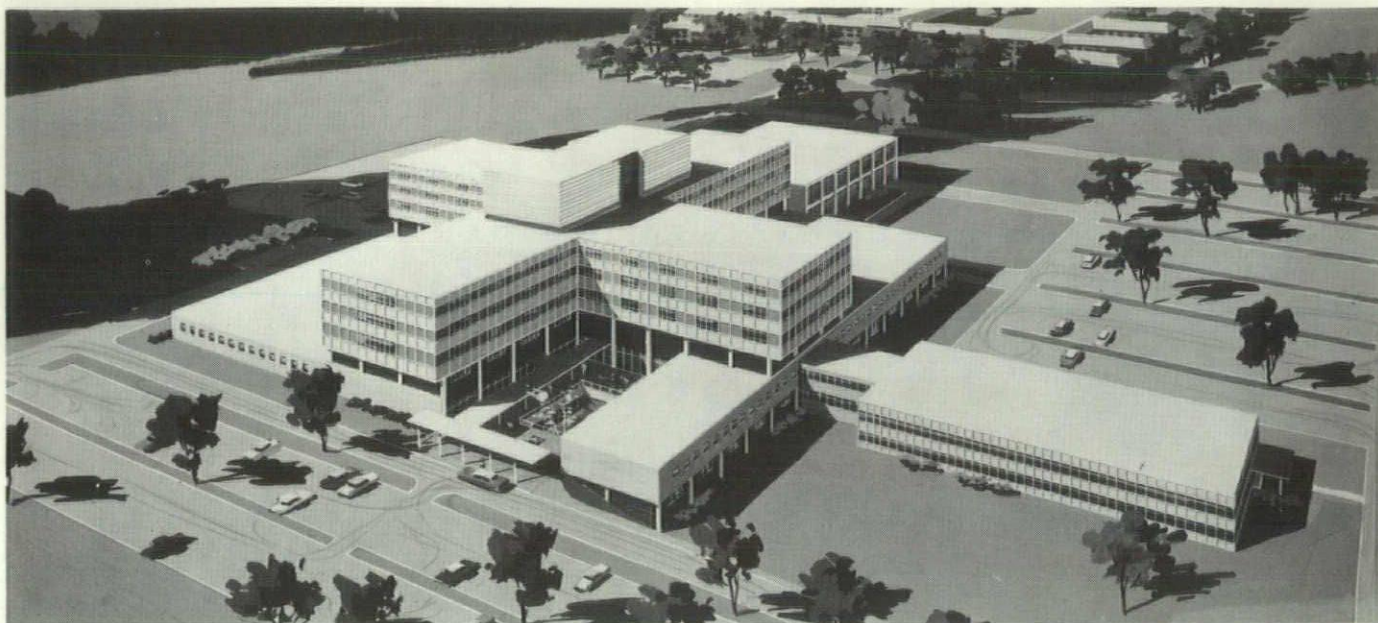
*Pontiac Osteopathic Hospital*

*Pontiac, Michigan*

*Sedgewick, Sellers & Associates Architects*

*Contractor O. W. Burke Co.*





### *Wayne County General Hospital*

*Eloise, Michigan*

*Smith, Hinchman & Grylls, Associates, Inc. Architects*

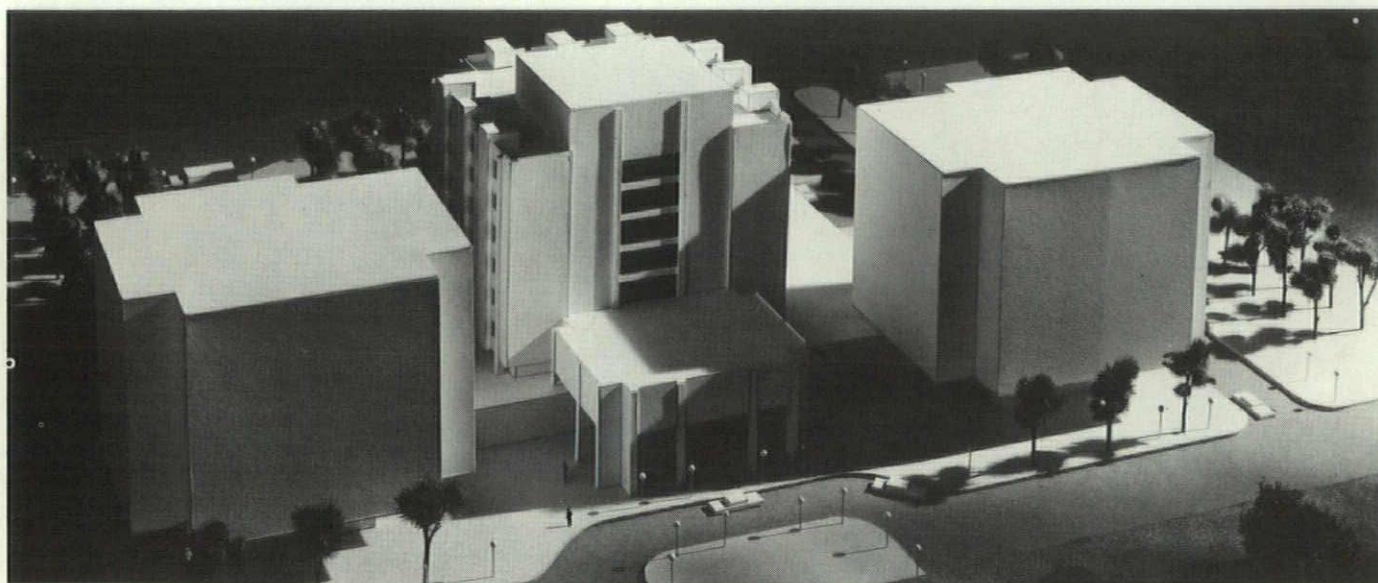
*Contractor Bryant & Detwiler Co.*

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### *South Macomb Hospital*

*Warren, Michigan*

*Harley, Ellington, Cowin & Stirton, Inc. Architects*

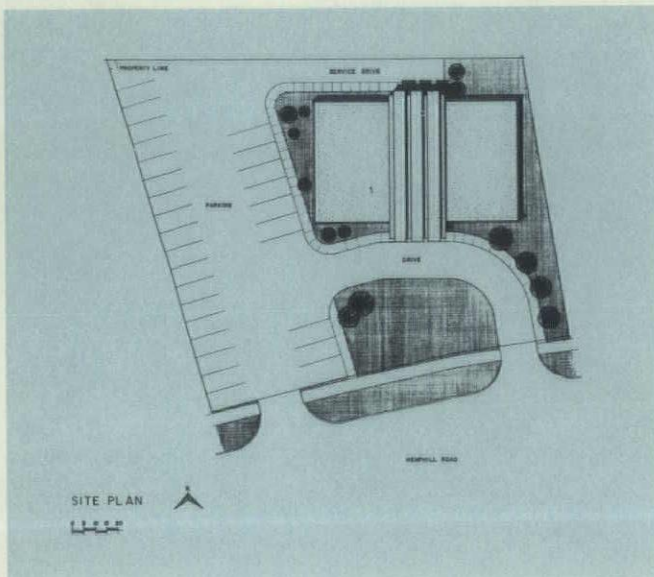




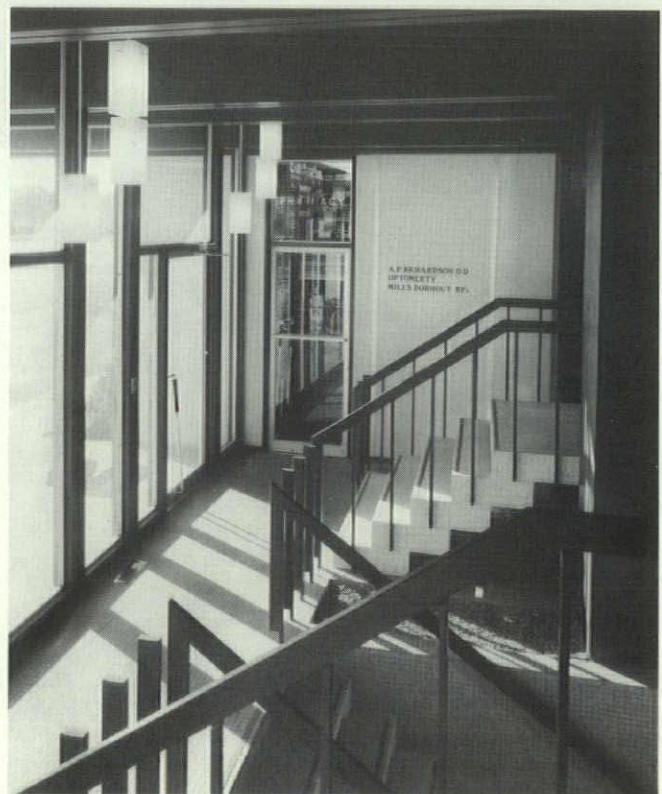
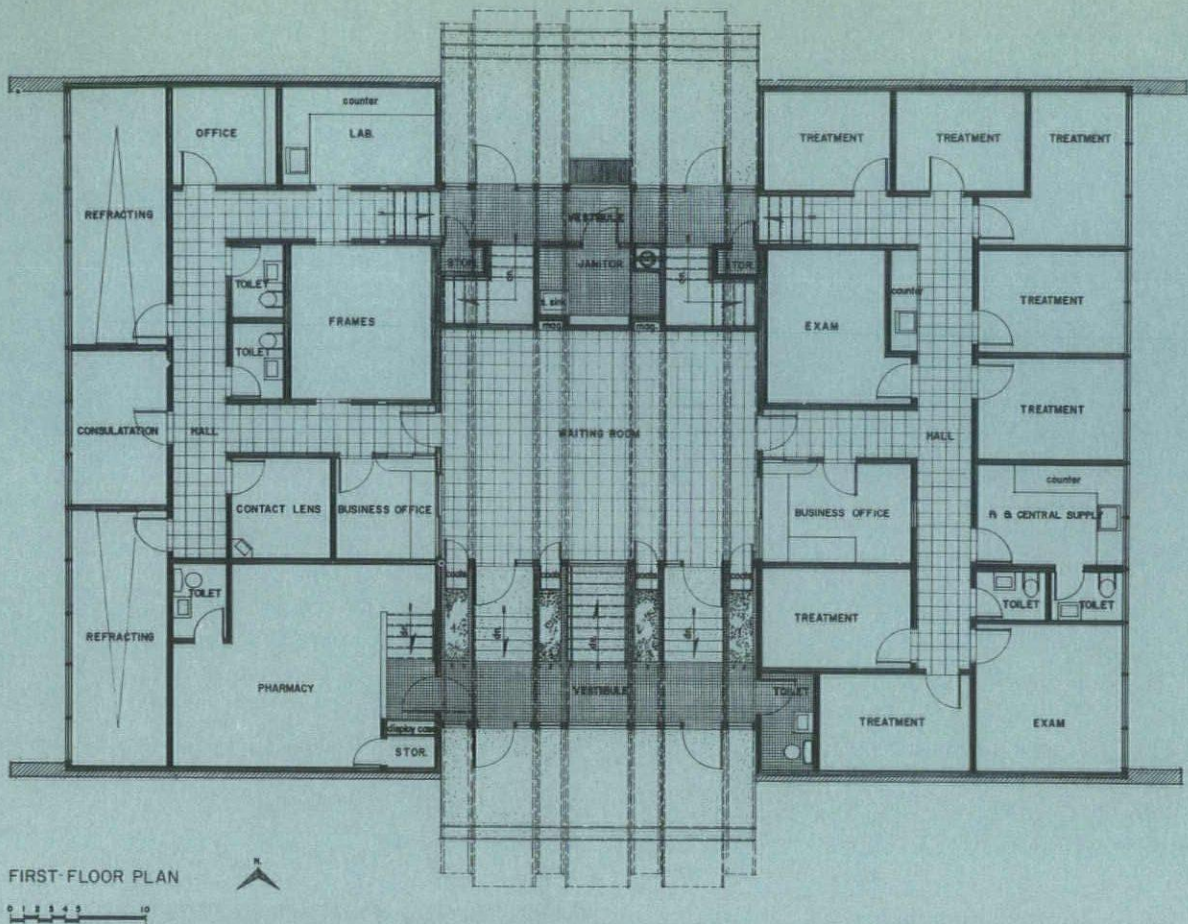


*Providence Hospital  
Southfield, Michigan  
Giffels & Rossetti, Architects  
Contractor Darin Armstrong Inc.*

*Family Clinic Building  
Flint, Michigan  
Gibbs & Tomblinson, Architects  
Contractor McKinsey Construction Co.*



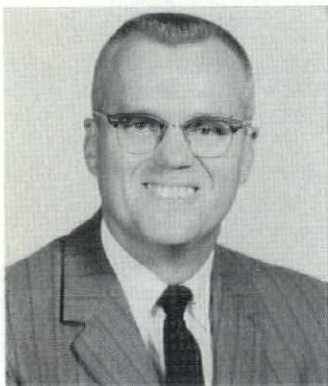








## producers council



E. L. Hambleton

E. L. "Pete" Hambleton is the district manager for Kentile, Inc., manufacturers of Kentile Floors. He attended Baltimore Polytechnic Institute before receiving his Bachelor of Science Degree in Marketing, Business and Public Administration from the University of Maryland. Now serving Producers

Council as vice president, Mr. Hambleton exemplifies many of the reasons for continued growth and interest in the Detroit Chapter of the Council.

Architectural Marbles in Kentile Vinyl Asbestos Tile consists of eight colors in 1/8-inch thickness which were designed especially with the architect in mind. It is a heavy duty tile which will stand up under the punishing wear encountered so often in institutional and commercial buildings, and at the same time, it is also suitable for highly styled residential work.

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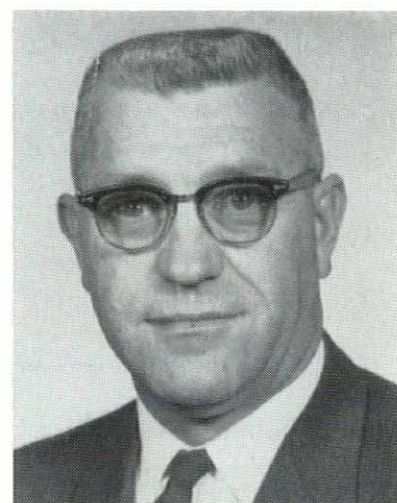
## OFFICERS INSTALLED BY BUILDERS AND TRADERS

Highlighting the annual meeting of the Builders and Traders Exchange of Lansing was the installation of new officers for 1963. The program, held January 15 at the Lansing Civic Center, also featured a presentation of Ideas for Downtown Lansing by William Black and Angelo Lucia, members of the Mid-Michigan Chapter of AIA. Presiding at the meeting was the Builders and Traders out-going president, Bill E. Hanel, who conducted the installation proceedings.

New officers are: president, Donald A. Simon, Dard, Inc.; vice president, William Hausman, Capital Steel Div.; treasurer, Lawrence Hunt, Barker Fowler Electric Co.; secretary, J. Revell

Hopkins. Builders and Traders Exchange. Directors are: Robert Andersen, Andersen Excavating Co.; Robert Warren, Michigan Electric Supply Co.; Harold Neumann, Payne-Rosso Co.; Donald M. Stillwell, Michigan Supply Co.; Frank D. Hayes, Hayes Electric Co.; and Kenneth L. Granger, Granger Brothers, Inc. William Kane of Manson, Jackson & Kane is the professional associate.

Guests honored at the meeting were: Lloyd Hanel, Sr., Otis M. Granum, R. C. Brenner, Andrew Andersen, Frank McConnell and Merle Cowan. Special honor was also paid to E. W. Schermerhorn who died recently. Robert Rosso was in charge of this program segment.



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Donald Goldsmith

Donald H. Goldsmith, Detroit Chapter member, has been elected to the board of directors of the Fred Sanders Co., Detroit confectioners, it was announced by Chairman Fred W. Sanders. A 1926 graduate of the University of Michigan School of Architecture, Mr. Goldsmith joined Sanders in 1931 as resident architect. Election to the board has not influenced his other functions within the Sanders organization. He designs all new and remodeled store and factory facilities, is responsible for their maintenance and the acquisition and disposal of real estate in addition to directing the activities of the purchasing department.

## BAUER & BLACK DEDICATES NEW RESEARCH CENTER

A \$1½ million dollar research center, designed by Giffels & Rossetti, Architects-Engineers, has been dedicated in Barrington, Illinois by the Bauer & Black Division of the Kendall Company. The one-story, 40,000 square foot laboratory building contains complete facilities for medical, industrial, and mechanical research, an adhesive laboratory equipped with small scale production machinery, and administrative offices. Among its exterior features are wall panels of aluminum and black solar glass, movable all-metal interior walls, and an outdoor patio for employees.

Designed as a self-contained, multi-purpose unit, the new center is capable of developing an idea from theory into the finished marketable product,

within its own walls. The building is generally divided into two sections, the medical research division, and the industrial research area. Both sections contain single and double modules which can accommodate either two or four researchers.

Special-purpose laboratories are also included, such as a synthetic organic chemistry laboratory, a pathological laboratory for tissue culture and analysis, a photographic darkroom, and a bacteriological laboratory.

## ROCKEFELLER GRANT FOR PLANNING CENTER

Pratt Institute in Brooklyn has announced the receipt of a \$94,000 grant from the Rockefeller Brothers Fund to be used over a two-year period for establishment of an experimental Adult Planning and Urban Renewal Education Center. The proposed center is intended to make available factual information on urban renewal and housing theory and practice to grassroots citizens' organizations. The program will offer extension courses dealing with urban renewal and planning to community groups concerned with such problems and prospects.

Development of such an educational effort is considered essential in view of the difficulty in achieving meaningful citizen participation in city planning, despite the increasing commitment of city governments to undertake planning and renewal projects with such participation. The center is expected to begin providing services to citizen groups in September 1963.

## THEME SELECTED FOR AIA CONVENTION

"The Quest for Quality in Architecture" will be the theme of the professional program of The American Institute of Architects' 1963 Convention May 5-9 in Miami, President Henry L. Wright, FAIA, has announced.

In describing the program subject, Mr. Wright said: "At its 1962 convention in Dallas, the Institute discussed the expansion of architects' services,

both to the community and the individual client. In 1961 in Philadelphia, the convention theme centered on extension of the scope of architects' practice into the field of urban design.

"AIA's current major programs also are concerned with a broadening of the architect's function to meet the requirements of a rapidly changing society. The 1963 convention seems an appropriate time to pause in this period of expansion and again explore the concept of architectural quality, to perform the re-examination of 'basic doctrine' in architecture."



Samuel D. Popkin, assistant chief architectural draftsman for Albert Kahn Associated Architects and Engineers, Inc., Detroit, has been appointed to the Hospital Architects Committee of the American Institute of Architects. His appointment follows service as the 1962 chairman of the Committee on Hospitals and Health for the Detroit Chapter. Since joining the Kahn organization in 1945, Mr. Popkin has specialized in institutional and commercial buildings and is staff architect for the new Children's Hospital which is planned as the first hospital unit in Detroit's proposed Medical Center.

## NEW LOCATION

William A. McKinnon Co., member firm of the Detroit Builders and Traders Exchange, has announced the new location of offices at 13931 Hamilton Ave., Detroit 3. The telephone number, TOWnsend 8-3800, remains the same.



# SCHOOL FOOD STORAGE FACILITIES MUST MEET FEDERAL STANDARDS

Importance of meeting federal requirements for food storage facilities in schools conducting lunch programs has been emphasized in a report to the Michigan Society of Architects from H. J. Rigterink, supervisor of the commodities distribution section of the Michigan State Department of Social Welfare.

"These schools must meet at least minimum federal requirements in order to receive the commodities which the U.S. Department of Agriculture makes available to them," Mr. Rigterink states. "The amount and value of these commodities is so great that schools go to great lengths to comply with regulations to obtain them. Inadequate storage facilities cause delays in cafeteria operation, cost added funds to meet regulations, and often create problems for the school administrator, the architect, and the Department of Social Welfare."

Pointing out that the U.S. Department of Agriculture requirements apply to all types of foods, not just those supplied by the U.S.D.A., Mr. Rigterink suggests that architects who work with schools and other institutions using stored foods write to him for a copy of "Food Storage Guide for Schools and Institutions." Requests should be addressed to:

H. J. Rigterink, Supervisor  
Commodities Distribution Section  
State Dept. of Social Welfare  
Lewis Cass Building—4th Floor  
Lansing 13, Michigan

The guide, published by the Agricultural Marketing Service of the Department of Agriculture, cites all requirements for both dry and refrigerated

storage. Mr. Rigterink underscores a number of especially important standards.

The dry food storage area is for food only, not soaps, detergent or janitor supplies. It should provide protection of the foods from the elements, fire, insects, rodents, spoilage organisms or other causes, and safeguard foods from theft. At least one-half square foot (up to one square foot) of floor space per meal served daily should be allowed, based upon two weeks' supply of food. The dry food storage area should be conveniently located to the receiving area and adjacent to the food preparation center. Handwashing facilities for all personnel should be located near the storeroom.

General construction features should include exterior walls and sub-floors that are tightly constructed, vapor-sealed below ground, and should be rodent- and insect-proof. A heavy-duty door is needed, at least 36 or 40 inches wide. The door should lock from the outside, but should always open from the inside without a key. Lighting should provide about 2 watts per square foot of floor area.

Good ventilation is essential to proper storage of any type of food. Generally four air changes per hour are adequate. Temperatures of 50 to 70 degrees are recommended for the dry food area, which should be free of uninsulated steam and water pipes, water heaters, refrigeration condensing units or other heat-producing devices.

In the refrigerated storage space, two types of refrigeration are needed—normal refrigeration, maintained at 32 to 50 degrees F., and frozen food storage, maintained at 0 degrees F. or below. The refrigerated storage space should be convenient to the receiving area

and adjacent to the food preparation center in the kitchen. Reach-in refrigerators and freezers or frozen food cabinets with built-in motors and compressors operate best when placed away from walls. If motor and compressor units are not built into the refrigeration equipment, separate units should be placed where they, too, can have a good flow of air around them. Do not put them in a room where food is stored because of the heat they give.

Reach-in refrigerators must allow approximately 1/2 to 1/3 cu. ft. of space for 100-350 meals served daily. Freezer space must allow 1 cu. ft. for every 30 to 35 pounds. Locking hardware is required on freezers and refrigerator units.

## SENATOR LAUNCHES ANTI-UGLY CAMPAIGN

Senator Harrison A. Williams, Jr. (Dem., New Jersey) has launched what he described as "the beginning of a long-term program to combat urban ugliness." As a first step, he introduced a bill in the Senate to establish a National Council on Architecture and Urban Design, which would be composed of 25 representative members known to be concerned with the problems of community appearance and livability.

Senator Williams said he planned to discuss the legislation with a variety of organizations and individuals and reintroduce a revised bill early next session, along with several other measures. The Institute is now studying the bill, at Senator Williams request. The Senator said the objective of the bill and other forthcoming measures would be: 1—to encourage a positive architectural and design responsibility on the part of the Federal government



with respect to those programs it enacts and administers, and 2—to promote greater understanding and leadership on the part of public officials and private citizens and organizations throughout the country. The Council would be authorized to appraise the level of architectural and design attainments of the nation, formulate goals for the future, study the financial and other impediments to good architecture and design, and study the effect of government programs and laws on community appearance and livability.

The Council would have authority to hold public hearings, sponsor conferences and make awards for outstanding effort and accomplishment in the field. It would terminate activities three years after enactment.

#### **STICKEL FIRM DESIGNS NORTHLAND ADDITION**

Two new tenant buildings under construction at Northland Center, Detroit, since August of last year will be opened for Spring shopping according to Horace Carpenter, Jr., vice president and general manager. Architect for the project is Frederick Stickel Associates of Birmingham, Michigan. Fourteen stores will occupy the almost 100,000 square feet of space with Best & Co., women's and children's apparel store taking over one entire building for their occupancy. The buildings, designated as "G" and "H," are located at the south end of the Center and are designed to blend with the six other buildings that make up the world's largest shopping center.

#### **CONFERENCE ON "THEATRE" PLANNED AT ANN ARBOR**

Scheduling of the Ann Arbor Conference on "Theatre," to be held in Ann Arbor, March 21 and 22, is announced by the College of Architecture and De-

sign of the University of Michigan. Tentatively entitled "Art and Architecture of the Theatre," the four sessions are designed to examine the role of theater in any society and make recommendations for the programming of future requirements.

In the first session, an objective review will cover the cultural factors which create theater in any society as the logical expression of a **need**, rather than as an **existence** which demands extension. An anthropologist, a philosopher and a theater critic will present papers for discussion. The mutual support, economically and culturally, of the theater and urban centers, and their contribution to urban revitalization will be discussed in the second session by a planner, an investor and a representative of a community-oriented professional theater. The third session will explore the technological advances which contribute to the "total environment of the theatre" and allow the theater building to become a laboratory for architectural design. At this session, architect and critic, together with engineer and artist will exchange information and viewpoints on "means of expanding the performance, in time and space," and "The performance's relation to reality."

A fourth session on programming growth patterns of the theater and supplying recommendations for the construction of facilities will be discussed by playwright and producer, architect and designer.

Featured concurrently with the conference will be the American Federation of Arts exhibition "The Ideal Theater," sponsored by the Ford Foundation in the Museum of Art.

Additional program information and pre-registration data will be announced at a later date.

# 30

Dear Fellow Architects:

This letter is notification and warning that Edwin Bateman Morris, Sr. is now about to issue in book form the material in booklets formerly distributed to architects by him. Because of the pen-and-ink drawings, the book will be plastic-bound, to lie flat and show the drawings to best advantage. As may be remembered, the material is concerned with hi-fy skyscrapers, some wrong architecture, Wright architecture and the like. The title **PEN AND INKLINGS**.

May I suggest that, after due consideration, you send me, if you approve, your non-rubberized check for \$3.00. In return, when printing is complete, the book will come to you, with my best thanks. Of course, I realize many other good and valuable things may be purchased for \$3.00, and thus do not try to overpersuade you.

I hope it will not meet with incredulity if I say that many architects, in kind friendliness, have urged me to this publication. It will cause no incredulity when I state that I have the earnest support of the C.T.G.B. (the Society for Compassion for Those Who Go Broke) which asserts that they hope against hope for me.

Sincerely,

Edwin Bateman Morris, Sr.  
5517 Grosvenor Lane  
Bethesda, Maryland



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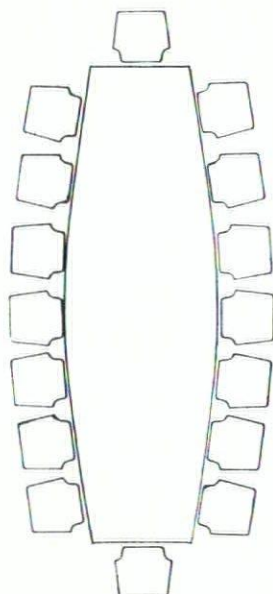
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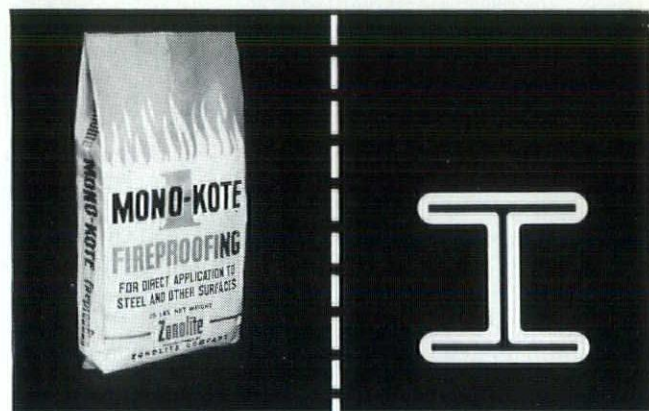
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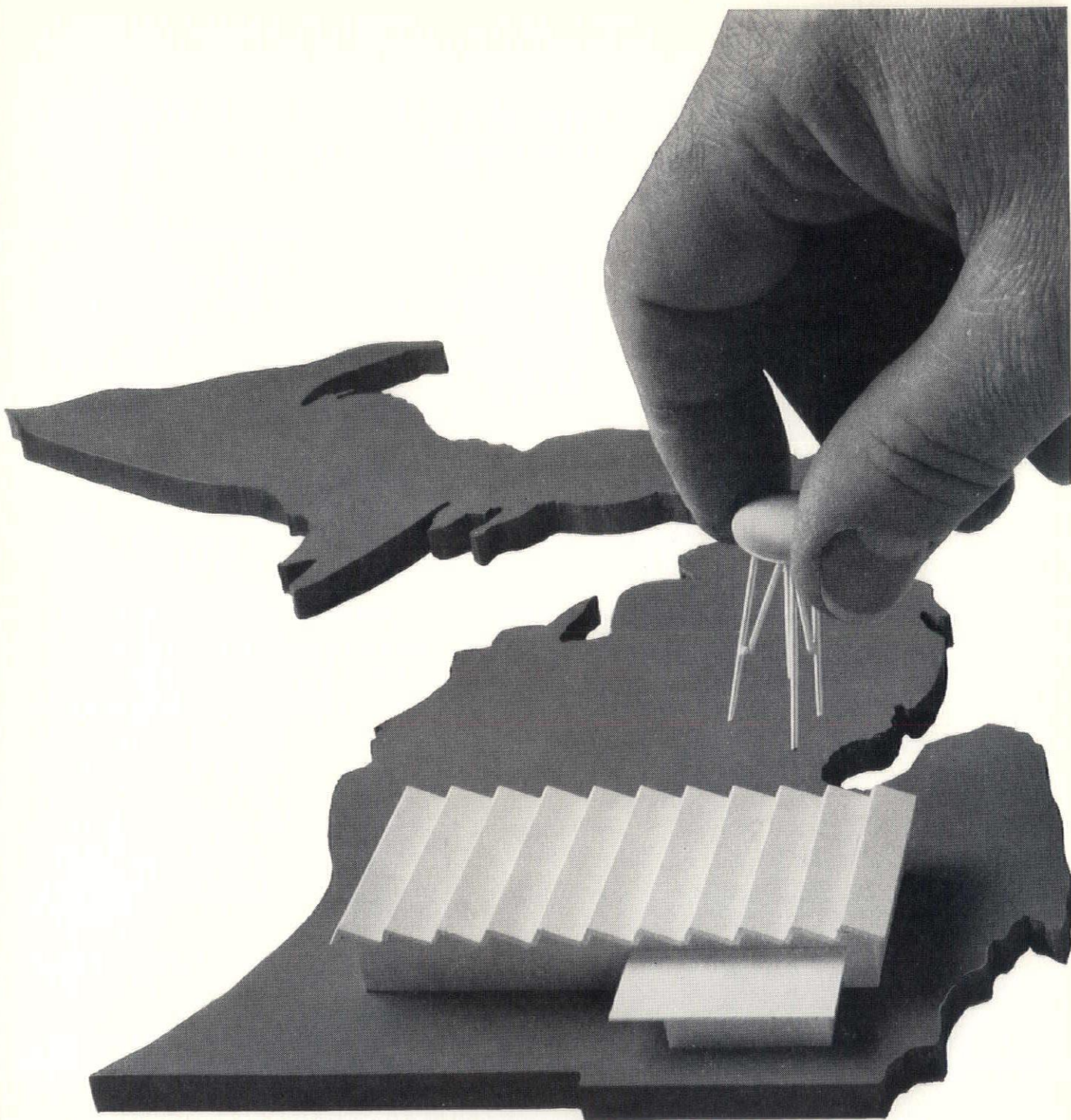
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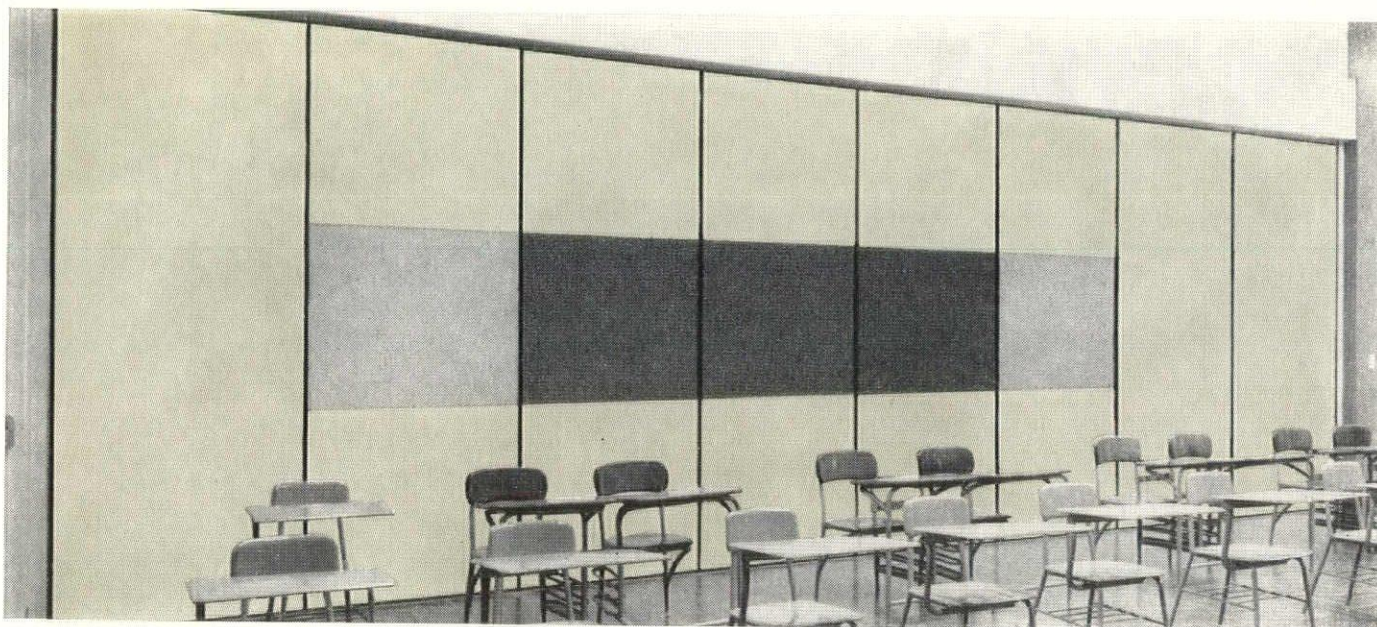
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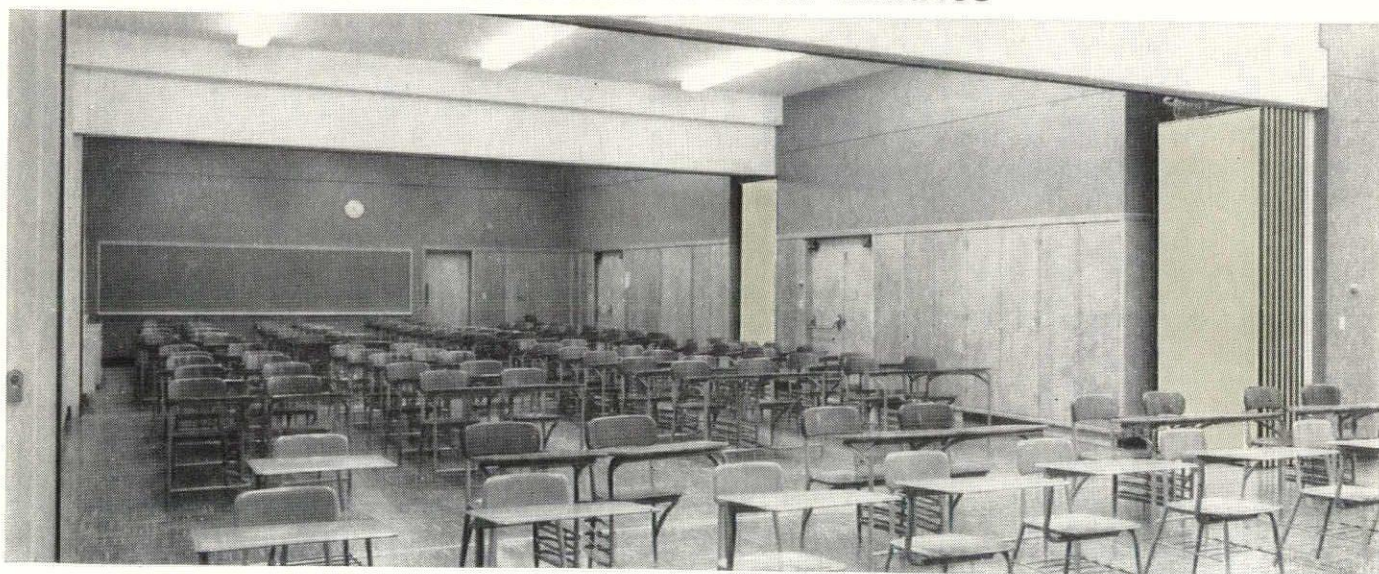
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