felt more satisfied with their treatment and made better progress than those who were not.

What is interesting about this study is that the improvements in the environment of the newer hospitals were really hardly at all about medical or clinical issues. Quite simply, they were more pleasant places to be in. In particular, they gave the patients better options about how to manage privacy and community than the older buildings did. In a parallel with our lecture theatre, architects should perhaps concentrate more on the patients feeling better than on the doctors and nurses treating them.

In studies of this kind we repeatedly find that it is the ordinary everyday things in buildings that make an impact on people's lives. These might include having a pleasant view rather than being in an internal room or looking onto a brick wall. Simply being warm enough and not too hot, having a reasonable degree of quiet and good lighting, are all significant factors. Beyond these, we find that people want to be able to control such things – the frustration of being in a hospital room where you cannot open the windows yourself to get a little fresh air, or turn off the light yourself when you want to rest, were described to us by quite infuriated patients. However, not only did the architects fail to see the need to provide such controls, we also found that the medics thought the patients would be incapable of operating them satisfactorily. Somehow both these professional groups had come to view patients not as ordinary human beings but as some special subhuman species with reduced capabilities and rights. In more recent work I have done on hospitals, I have also found that generally patients and the nurses who treat them every day recognize the value of good settings and good places. They fully expect that a well-designed hospital may help patients to recover more quickly. Sadly, those who are responsible for commissioning and briefing the architects are not so convinced and prefer to concentrate on the technicalities of buildings and medical facilities. Thus they concentrate on treatment rather than recovery. They concentrate on the special conditions, again tending to forget the general needs of living people.

The paradox of this, I find, is that when architects come to design specialized buildings, such as a psychiatric unit, they tend to focus on the special factors rather than the ordinary ones. This is of course entirely understandable. I have shown in my studies of the design process that all designers have an almost desperate need to identify some special factors around which they can generate design ideas in what is often a hugely complex and confusing situation (Lawson 1997). This leads designers, it seems to me, to concentrate on the identifiably purposeful activities in spaces, and neglect the less purposeful but no less important aspects of daily life. Thus we design lecture theatres with no windows as perfectly ergonomic machines for teaching, and then