

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MAY 23 2018

Ms. Holly B. Houghten
 Tribal Historic Preservation Officer
 NAGPRA Coordinator
 PO Box 507
 Mescalero, NM 88340

SUBJECT: IHS Mescalero Service Unit, Renovation and Expansion Project

Dear Ms. Houghten:

Albuquerque Area Indian Health Services (AAIHS) as a subdivision of the U.S. Department of Health and Human Services, is directing the project at this federally-owned facility using federal grant funds, and thus the proposed project qualifies as an "undertaking" under Section 106 of the *National Historic Preservation Act* (54 U.S.C. § 300101 et seq.) and its implementing regulations at 36 CFR Part 800.16(y). AAIHS is designing an addition for the Mescalero Indian Hospital, which was constructed in 1968 and in 2016 was determined individually eligible for the National Register of Historic Places under Criteria A and C. AAIHS, has determined that the undertaking has the potential to cause effects to the historic property and is writing to you to initiate Section 106 consultation. The area of potential effects (APE) for the undertaking is the Mescalero Indian Hospital site, bounded by the driveway and parking lot (see enclosure).

In 2013, AAIHS determined that the hospital required an addition to provide necessary services to the tribe. Towards that end, AAIHS completed the report, "Preservation Plan for Mescalero Hospital," July 2017, which recommended an addition avoid the south elevation and project from the east end of the historic building. The original intent was to meet the recommended design parameters of the preservation plan; however, the square footage requirements are much greater than anticipated during the development of the plan. As such the undertaking will include an addition that extends to the south and east of the original building.

A standardized design and planning method, Health System Planning was applied to the project to meet the requirements for new facilities. As a result, the addition was required to be one story with 8,100 square feet. Given the site constraints, with an access road that curves around the rear of the structure, in order to obtain the necessary square footage, the addition extends to the south and east. This requires removal several character-defining features from the historic building: the view window, the entrance canopy, original mosaic, and the planter and flagpole (see enclosure). To minimize the effects, the design team is

Prepared by RPederson:OEHE:AAIHS:5-24-18:505-256-6737

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incorporating in the new south elevation a new view window that replicates the scale and rhythm of the original view window; introducing a new entrance canopy that extends outward from the façade; moving the original mosaic to a new location within the lobby, which will be more visible to patients than the current position; and incorporating the stone retaining wall that extends from the planter. Stones from the original design will be salvaged during selective demolition and incorporated into the new building.

Although the intent is to minimize the effect on the historic property, the scale, massing, and loss of character-defining features caused by the addition will result in an adverse effect. To mitigate the adverse effect, AAIHS recommends Historic American Building Survey Level II documentation. AAIHS requests THPO's review of this determination of adverse effect for the proposed undertaking. If you concur, the AAIHS recommends that the two agencies continue consultation to develop a memorandum of agreement per 36 CFR Part 800.6 that includes measures to avoid, minimize, or mitigate the adverse effect.

AAIHS looks forward to your review and input on our determination of the effect of the undertaking on historic properties, and further consultation to develop a memorandum of agreement. If you have any questions, please contact Sandra Bitsie, General Engineer/Project Manager, AAIHS, at (505) 248-4109 or Sandra.Bitsie@ihs.gov.

Sincerely,

/s/ Russel D. Pederson. P.E.

Russel D. Pederson, Director
Office of Environment, Health and Engineering
Albuquerque Area Office
Indian Health Service

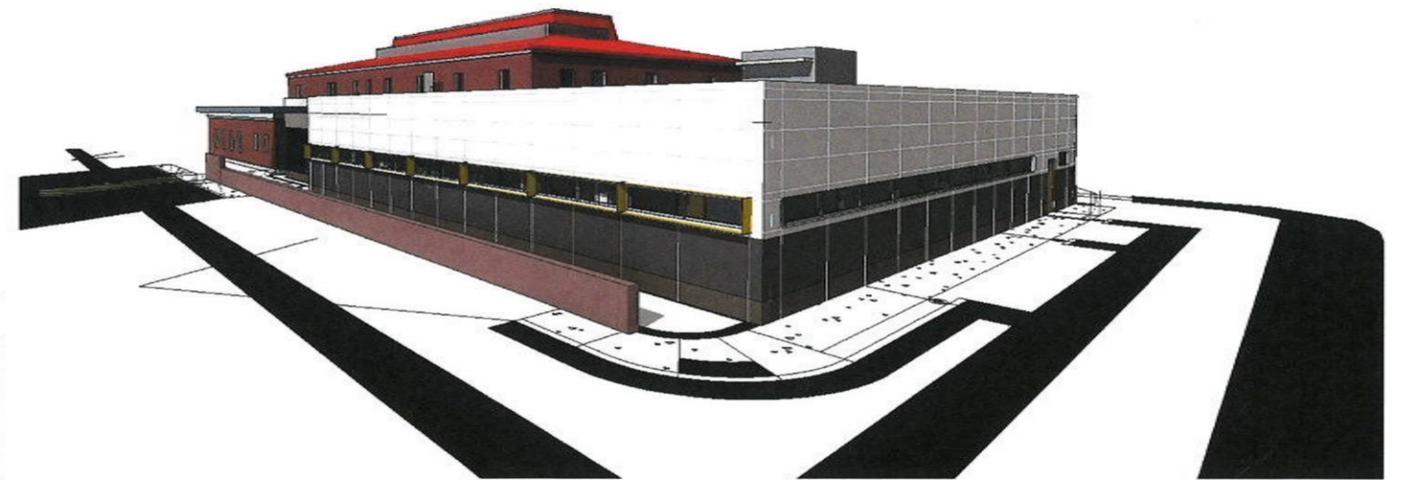
Enclosure - 2



PERSPECTIVE LOOKING NORTH - OVERALL



PERSPECTIVE LOOKING NORTHEAST AT ENTRY



PERSPECTIVE LOOKING NORTHWEST



MESCALERO INDIAN HOSPITAL
Mescalero Indian Reservation
Otero County
New Mexico

HABS No. NM-233

PHOTOGRAPHS
WRITTEN HISTORICAL AND DESCRIPTIVE DATA
REDUCED COPIES OF MEASURED DRAWINGS

HISTORIC AMERICAN BUILDING SURVEY
National Park Service
U.S. Department of Interior
1849 C Street, NW, Room 7408
Washington, DC 20240

**HISTORIC AMERICAN BUILDING SURVEY
MESALERO INDIAN HOSPITAL
HABS NO. NM-233**

Location: 318 Abalone Loop at Mescalero Indian Reservation in Otero County, New Mexico. It is located at latitude: 33.158812°, longitude: -105.772457°, which represents the center of the building. The coordinates were obtained in 2018 by plotting its location in Google Earth. Coordinates are based on North American Datum 1983.

Present Owner/Occupant: Indian Health Service, Mescalero Service Unit

Present Use: The Mescalero Hospital was constructed as a full-service hospital and is now being used primarily for outpatient care.

Significance: Mescalero Indian Hospital is significant as a representative example of Indian hospitals that were constructed during the 1960s to improve Indian health care. It is also significant for its architectural design that skillfully blended New Formalism with Brutalism, and responded to design requests from Mescalero, including a connection with and view of the Mescalero landscape, as well as using stone from the reservation that was quarried and set in place by tribal members.

Historian: Karen Van Citters, Van Citters: Historic Preservation, LLC (VCHP), 2018.

Project Information: This project is a result of the need for additional square footage to provide health services to the community. In 2013, the Albuquerque Area Indian Health Service determined that the Mescalero Indian Hospital required an addition to modernize the facility and provide necessary services to the tribe. A standardized design and planning method, called Health System Planning, was applied to the project to meet the requirements for new facilities. Based on the requirements, the addition was required to be one story with approximately 8,000 square feet. Given the site constraints, with an access road that curves around the rear of the structure, in order to obtain the necessary square footage, the addition extends to the south and east, covering the entrance façade. This resulted in the loss of several character-defining features from the historic building: the view window, the entrance canopy, original mosaic, and the planter and flagpole. It was determined that the addition would have an adverse effect and this Historic American Building Survey documentation was required. The report was prepared by Karen Van Citters, VCHP. Martin Stupich completed the photography.

Part I. Historical Information

A. Physical History

1. **Date of Erection:** 1968 (building plaque states 1967, when design was begun)
2. **Architects/Engineers:** Ferguson, Stevens, Mallory, Pearl
3. **Original and subsequent owners, occupants, uses:** The building was designed as a hospital for the Mescalero Tribe and is still being used by tribal members, but for regular visits and outpatient care.
4. **Original plans and construction:** The hospital was designed in 1967 by the firm Ferguson, Stevens, Mallory, Pearl using the architectural vocabularies of New Formalism and Brutalism. The aspects of New Formalism that are part of the building design included light colored precast concrete columns, entablatures, the View Window at the waiting room, and the site placement, as though on a pedestal. The aspects of Brutalism include the dark stone walls, massing, and window surrounds that extended one foot from the wall.

The Albuquerque architectural firm had been winning awards and applying current architectural philosophies to their architectural work when they were hired to design the Mescalero Indian Hospital. For the hospital project they brought in the vocabulary of New Formalism, but used the local Mescalero stone and kept the architectural elements restrained and at the appropriate scale for the community hospital. The entrance includes a shade structure with columns that meld into the canopy, an aluminum framed glass wall with concrete columns and a geometrical entablature. The entablature circumscribes the building at the first floor and a smaller entablature does the same at the top of the second floor.

5. Alterations and additions:

No date: Remodel of dishwasher area and nursery; Dean & Hunt, Associates, Inc., Albuquerque.

1975: Sprinkler system; William H. Ladew, Inc. El Paso, Texas.

1975: Interior renovation for Dental.

1975: Mechanical, electrical, plumbing, and structural upgrades; Department of Health Education and Welfare, Dallas.

1981: Minor repairs, roofing, repaint; Browne & Seales, AIA, Albuquerque.

1984: Replaced window units, kept cast frames, new fixed wood windows and one unit with awning below, in same place as original. Updating roof flashing and HVAC upgrades; Glynn Browne, AIA and Allison Engineering.

1989: Addition of canopy at service entrance; Dean Krueger & Associates, Inc., Albuquerque.

1994: Repavement and exams room renovation; Weller Architects, P.C., Albuquerque.

1998: Fire Protection replacement; Martell & Associates, P.A., Dallas.

1990s: Estimated date of window replacement and setting them flush with the wall plane.

2005: Plumbing upgrades; DCSW and Bridgers Paxton, Albuquerque.

2010: Electrical upgrades; Towner Services, Inc., Albuquerque.

2008: Mechanical & Electrical upgrades; DCSW and Bridgers Paxton consulting engineers.

2014: Window surrounds cut to 4" and new windows installed in 1990s location.

B. Historical Context

The history of the United States government's involvement in Indian health care policy dates back to 1824 when the Indian Office (forerunner to the Bureau of Indian Affairs or BIA) was organized under the War Department and sent Army doctors to communities in Indian Country to provide health care to indigenous populations.¹ In 1849, the Indian Office, also known as the "Indian Service," was transferred to the newly created Department of Interior and continued this policy. At that time, health care for Indian people was not a high federal priority, and as a result, the care that was provided was generally substandard. In reality, this lack of interest in health care by the federal government was acceptable to most Native peoples since they had little interest in the "white man's medicine," and had little need for the government doctors.

Much of this changed with implementation of government boarding schools for Indian children. Boarding schools began with the opening of the Carlisle Indian School in 1879, and by 1900, the number of off-reservation and on-reservation boarding schools totaled 106.² This interest in Indian education coincided with the creation of a Medical and Education Division within the Indian Office in 1873. Thus, by the late nineteenth century, the federal government associated health care with education, and it is not surprising that most boarding schools had an infirmary or small hospital on their campus. In most cases, for Indian students attending boarding school, this was their first exposure to Western medical practices. And for on-reservation boarding schools,

¹ J.G. Townsend, "Indian Health – Past, Present, Future," in *The Changing Indian*, edited by Oliver LaFarge, (Norman: University of Oklahoma Press, 1942), 31.

² Margaret Connell-Szasz and Carmelita S. Ryan, "American Indian Education," in *Handbook of North American Indians, Volume 4, History of Indian-White Relations*, edited by Wilcomb E. Washburn, (Washington: Smithsonian Institution, 1988), 291.

this combination health care/education policy resulted in the first structured contact between doctors and nurses and the people of that Indian community.

By the turn of the twentieth century, the percentage of Indian children and young adults receiving the benefits of a Western health care system was still very small. As a result, Indian people continued to be ravaged by European diseases. In the 1920s, cases of tuberculosis and trachoma were particularly rampant. Indian reform organizations, such as the American Indian Defense Association, called for immediate federal action to correct this failing, and as a response a Division of Health was created within the Indian Bureau in 1924.³ Although it had been formally established, the new division was hampered in its efforts to improve Indian health care in large part because Congress was reluctant to appropriate sufficient funds for building new facilities and hiring additional medical personnel.

In 1928, the Institute for Government Research issued the Meriam Report that severely criticized United States Indian policies that fostered poverty and unhealthy living conditions among Indian communities.⁴ With regard to health care, the report categorized the general health of Indian people as poor. The report documented the unsanitary living conditions in Indian communities and described the high infant mortality rates for Indian people. Although the recommendations offered by the Meriam Report resulted in some new programs and facilities, many projects languished in the federal bureaucracy until 1933 when President Franklin Roosevelt appointed the well-known Indian reformer, John Collier, as Commissioner of Indian Affairs. Collier immediately went to work convincing Congress to appropriate sufficient funds for new health and education facilities. His success is evident in the fact that by 1942 there were 78 general hospitals and 12 sanatoriums built exclusively to serve Indian people.⁵

Federal Indian policy changed directions again following World War II. The government advocated a policy of termination that not only attempted to desegregate Indian communities and dismantle tribal specific programs, but attempted to formally end the traditional federal/tribal political relationship as well.⁶ The federal government hoped to once-and-for-all assimilate Indian people into mainstream American culture. As a part of this termination policy, Congress attempted to have Indian and non-Indian populations share public facilities, such as health care clinics and hospitals.

³ Townsend, "Indian Health," 31.

⁴ Lewis Meriam, *The Problem of Indian Administration*. Baltimore: Johns Hopkins Press, 1928, (Reprinted: Johnson Reprint, New York, 1971).

⁵ Townsend, "Indian Health," 32.

⁶ Donald L. Fixico, "Termination and Relocation," *Federal Indian Policy, 1945-1960*, (Albuquerque: University of New Mexico Press, 1986), 92.

An offshoot of this policy was Public Law 83-568, passed on August 4, 1954, which transferred health services from the Bureau of Indian Affairs to the Public Health Service (PHS) and created the Indian Health Service (IHS) within the Department of Health, Education, and Welfare (now the Department of Health and Human Services).⁷ This act meant that all health care facilities, such as Indian hospitals and clinics, and medical and environmental health programs were now under the general umbrella of the IHS. It was anticipated that this would streamline health care services provided to Indian people, but many Indian leaders initially saw the transfer as just another part of terminating the government's responsibilities for Indian specific programs and incorporating them into general public health policies.

BIA Commissioner Glenn Emmons hoped that the transfer of health services from BIA would improve Indian health care; however, the statistics did not bear this out. By the late 1950s, the policy of termination was on its way out and President Dwight Eisenhower was calling for increased funding of Indian-specific health care programs, particularly in the area of sanitation facilities constructed to improve the environmental health of tribal members living on reservations. Two acts that passed in the 1970s re-emphasized health care under the new federal policy of Indian Self-Determination. In 1975, the Indian Self-Determination Act (P.L. 93-638) offered tribes the option to manage their own health care programs. A year later, the Indian Health Care Improvement Act (P.L. 94-537, amended in 1980) had a stated goal of elevating the health status of the American Indian to that of the general population.⁸ The role of IHS, and federal government, was thus evolving as many tribes begin to assume more responsibility for meeting their own health care needs.⁹

As part of the increased funding for Indian health care, the government constructed state-of-the-art hospitals on reservations to support the local community. As a result, a hospital and quarters buildings were constructed at Mescalero. The Mescalero hospital project was designed in 1967 and completed under Serial No. BIA 0150-67-20 with all construction documents in one package: the hospital was completed under Project No. K56-PH-80 and the six quarter buildings and garage were completed under Project No. K56-OH-830. The project was developed through a partnership between the two entities 1) the Department of Health, Education, and Welfare, Public Health Service, Bureau of Medical Services, Division of Indian Health and 2) the Department of Interior, Bureau of Indian Affairs, Branch of Plant Design and Construction in Albuquerque, New Mexico. The architectural firm that was hired to design the buildings was Ferguson, Stevens, Mallory, Pearl (later known as SMPC Architects) also located in Albuquerque, New Mexico.

⁷ Fixico, "Termination and Relocation," 92; Bruce G. Trigger, "The Native American Renaissance, 1960-1995," in *The Cambridge History of the Native Peoples of the Americas: Volume 1, North America, Part 2*, edited by Bruce G. Trigger and Wilcomb E. Washburn, (New York: Cambridge University Press, 1996), 408.

⁸ Trigger, "The Native American Renaissance, 1960-1995," 408.

⁹ This section was written by William A. Dodge for a previous historic building survey completed for AAIHS.

Ferguson, Stevens, Mallory, Pearl

The architectural firm that designed the Mescalero Indian Hospital is the oldest architectural firm in New Mexico that has been in continuous business. The firm began as a sole proprietorship called Gordon Ferguson, Architect. Ferguson, who had a B.S. in Architectural Engineering from the University of Southern California (1929), originally designed projects from his home, taught at the University of New Mexico, and drove a taxi to make ends meet. Because one of his early projects was so large, he sought help and hired Donald P. Stevens for the renovations at the Albuquerque Indian Hospital. Stevens, had an M.S. in Architecture from the University of Illinois and had taught architecture at the University of Texas. In 1944, Ferguson moved the practice to an office at the 100 block of Amherst Drive at Nob Hill in Albuquerque, New Mexico where it remained until 2018. Four years after the firm settled in Nob Hill, Gordon Ferguson and Don Stevens became partners. A year later, the firm name changed to Ferguson, Stevens and Associates—Stevens stayed with the firm for 35 years.¹⁰

The Albuquerque architectural firm was adept at using Modernism in their designs. Modernism was developed at the end of World War I when Europeans were anxious for a fresh start. As a result, artistic and architectural movements were created. In 1919, Walter Gropius opened the Bauhaus in Weimar, Germany, where architects and artists explored “new architecture.” The Bauhaus goals were to create architecture for the “workers” and to reject anything that was considered bourgeois. The modernists considered design that was not born of the bourgeois to be pure and they sought to develop an architecture that was pure. Regardless of the architectural or artistic movement, in general these movements were working toward what the architects described as a cleaner and more direct, yet profound, interpretation of the world. The result was a penchant for flat roofs, clean right angles, and expressed structure; there were to be no more cornices, overhanging eaves, false fronts, pilasters, entablatures, pediments, anthropomorphic features, spires, corbels or other “grandiose” architectural elements. The new Modernist architecture was to be simple, where the exterior expressed what was occurring on the interior, using steel, glass, and concrete to create the modern expression. Some of the leaders of the modernist movement, Walter Gropius, Le Corbusier, and Mies van der Rohe embraced surface texture, color, and precise geometrical shapes as the primary artistic expression in their architecture.

Being skilled at using modern architectural vocabularies, Ferguson, Stevens and Associates won the design contract for Albuquerque’s Presbyterian Hospital in 1950. The hospital was originally just two floors, but the administrator, Ray Woodard, had the architects design the building for expansion up to seven floors. The Presbyterian project was the impetus for Stevens to specialize

¹⁰ Interview with Bob Campbell, May 16, 2016; *Ferguson, Stevens, Mallory, Pearl an Albuquerque based partnership, devoted to planning and the practice of architecture*, brochure published 1968, on file University of New Mexico, Fine Arts Library; and <http://rmoa.unm.edu/docviewer.php?docId=nmuswasmpc.xml>, “SMPC Biography,” accessed 4/27/2016.

in medical architecture. He joined national medical groups and focused on how to integrate new health care technologies into the medical facilities his firm was designing. Also, around this time, the partners realized they needed additional staff. Stevens hired several young Texas architects who had been his former students, including George Pearl, Bob Mallory, and Van Dorn Hooker. Van Dorn Hooker went on to lead a long and influential career as the campus architect for the University of New Mexico. George Pearl eventually became the chief designer at the Albuquerque architectural firm, won regional and national acclaim for his work, and became a Fellow in the American Institute of Architects.¹¹ As Pearl became the lead designer, Stevens focused more on medical design, Mallory became a managing partner, and Ferguson focused on marketing.¹²

George Pearl was also the lead designer for the Albuquerque Civic Auditorium, which included a cutting-edge dome that was 62 feet high by 218 feet in diameter and varied in thickness from five inches at the center to two feet at the edges. It was the “largest thin shell post-tensioned concrete dome on the North American Continent” and it took ten days to pour the concrete.¹³ The design firm used the natural rolling sand hills in Albuquerque as an earthen form, rather than the standard wood: an existing hill on the site was built up and shaped to the proper dimensions, the concrete was poured, and once it had cured, the earth was excavated to create the arena space. The pioneering technique was mentioned in *Life* magazine and was also praised by Frank Lloyd Wright when he lectured at the University of New Mexico in 1956. According to Bob Campbell—who drove Frank Lloyd Wright from the airport to the Hilton Hotel downtown prior to the lecture—when Wright saw the auditorium he said, “That’s the way architecture should be done, it fits into its environment, the rolling hills.”¹⁴

After construction of the highly praised auditorium, the firm continued to obtain health care contracts including, the Bataan Memorial Methodist Hospital, additions to the Presbyterian Hospital, and the Lovelace Clinic. As such, the firm had ongoing relationships with many New Mexico hospitals, including those under the purview of the BIA. Throughout his career and being ahead of his time, George Pearl worked closely with New Mexico tribes and was known for being able to respond to local cultures, client needs, and the environment. He also became known as an architect who was adept at incorporating regional architecture into a modernist vocabulary.¹⁵

¹¹ Bob Campbell interview; “Albuquerque Based Partnership” brochure.

¹² Bob Campbell interview.

¹³ “Albuquerque Based Partnership” brochure.

¹⁴ “Mound-Made Auditorium,” *Life*, Volume 42, Number 23, June 10, 1957, 58; Jane Mahoney, “The First 60 Years,” *Albuquerque Journal*, November 29, 2004; Bob Campbell interview.

¹⁵ Bob Campbell interview.

In 1959, Mallory and Pearl became partners and the firm's name was changed to Ferguson, Stevens, Mallory, Pearl.¹⁶ This is the iteration of the firm that designed the Mescalero Indian Hospital, and Donald Stevens took the lead as the medical specialist, with design support from George Pearl, who integrated a bold application of modern architectural vocabularies.¹⁷ Bob Campbell, Chief Draftsman—who had been hired as an architectural student in 1955 to run the blueprint machine, obtained his license in 1964, and made partner in 1968—drafted the hospital drawings for Mescalero and oversaw the team of drafters at the firm for all projects.

From the 1950s into the 1970s, New Formalism and Brutalism were two prevalent architectural design philosophies used throughout the United States, and George Pearl drew from them for his work at the hospital and generally on projects at the Albuquerque firm. New Formalism developed in the mid-1950s as a reaction against the rigid rules of the post-war International Style. Three famous architects that used the new style were: Edward Durrell Stone (National Geographic Center, Washington, D.C.), Philip Johnson (Seagram Building, New York), and Minoru Yamasaki (World Trade Center, New York). All had previously worked with the International Style, but were looking for a fresh way to express modern materials—the resulting design approach of New Formalism combined the established architectural concepts of classicism with modern materials. Character defining features of the style include: the building being set upon a “pedestal;” colonnades or regularly spaced arches; classical architectural precedents (such as entablatures); delicate details, rich materials such as travertine, marble, or granite; light colors with dark accents; and exposed stone. Most buildings designed in this style had a strong institutional monumentality and formality.

Brutalism was also used for monumental institutional architecture during the same period, and arose as a reaction to and a need to break away from Modernism. Architects who used Brutalism worked to express architectural materials in a “raw” and unadulterated way—concrete in particular. Famous architects that designed using this style include Le Corbusier, I.M. Pei, Marcel Breuer, and Paul Rudolph. While New Formalism had a formal and regular pattern in the use of colonnades and fenestration, Brutalism focused more on expressing materials in their “pure” form, defying classical features and formulae, and focusing on massing and breaking wall planes.

Ferguson, Stevens, Mallory, Pearl had been in partnership for eight years when they were hired to design the Mescalero Indian Hospital. By then, Stevens and Pearl had a well-established working relationship, although it wasn't always as Pearl would have liked. Often Stevens would develop a floor plan and then ask Pearl to put an elevation on it.¹⁸ As the lead designer, this would exasperate the architect, but in the end, the two men would work out the programmatic

¹⁶ The name changed again in 1972 to Stevens, Mallory, Pearl and Campbell and in 1993 to SMPC; interview with Glenn Fellow, April 26, 2016.

¹⁷ The drafter for the project was Bob Campbell, who later became a partner of the firm.

¹⁸ Bob Campbell interview.

requirements that drove the floor plan and integrate it into an overall architectural design. By the mid-1960s, the firm had produced a number of buildings in the New Formalism and Brutalist styles.

The firm was responsive to the requirements of the client and was adept at using their “imagination to create a pleasant...building using economical materials.”¹⁹ The architects worked within constraints when necessary, but were enthusiastic to go out-of-the-box to create cutting edge architecture. Their New Formalism precast concrete building for the Ideal Cement Company in Tijeras, New Mexico won an American Institute of Architects (AIA) award and a national award from *Factory Magazine* as one of the best factories in 1960.²⁰ Fred Fricke, the firm’s structural engineer originally showed up at the office with a steel design for the building and Gordon Ferguson told him, “What the [heck] are you thinking? This is a cement plant and you want steel?”²¹ The architects changed the design to concrete and included a curving roof to respond to the hills in Tijeras Canyon. It was in the modern architectural vocabulary of New Formalism, but rendered in a manner that responded to the local environment and client. This was the underlying philosophy of Ferguson, Stevens, Mallory, Pearl: to use cutting edge architectural design principles, but respond to the local environment and culture. Their approach also won a regional award from the AIA won for Pearl’s Brutalist Madison Junior High in Albuquerque.²²

Construction of Mescalero Indian Hospital

The new 1968 hospital at Mescalero was constructed to the north of an existing hospital that had been situated on the north side of Sage Avenue. Once construction was complete, the previous hospital was razed and the parking lot put in its place. Three duplexes and one single family unit were constructed on the south side of Sage Avenue, just to the east. Two duplexes flanking a garage were constructed on the south side of Mescal Loop, just to the south of Sage Avenue.

During the project, the design team encountered challenges as 1) the BIA and the Mescalero Apache tribe did not always see eye-to-eye; 2) the soil at the proposed site was not optimal (there were many soils tests and the northwest corner caused many issues during construction); and 3) the site (on a hill) required considerable grading to accommodate the new hospital. Whatever difficulties, the design team was positive about the inclusion of Mescalero Apache tribal representatives in the design process. The tribe, the Division of Indian Health, and the BIA attended a number of meetings at the architectural offices in Albuquerque during design development.²³

¹⁹ “Albuquerque Based Partnership” brochure.

²⁰ Ibid.

²¹ Bob Campbell interview.

²² “Albuquerque Based Partnership” brochure.

²³ Bob Campbell interview.

The hospital was constructed with a concrete foundation; concrete masonry unit and steel I-beams; locally-mined stone veneer; a terne plate, standing seam metal roof; and precast concrete details. The roof extends from the middle of the building to enclose a penthouse with the elevator and mechanical equipment.

The building is two stories and the original floor plan includes a primary rectangle running east/west with an extension on the south and west elevations. Stevens' typical medical facility floor plan included a service core with patient rooms on the exterior, so service areas were close to all rooms, and nurses and other staff could easily access patient rooms.²⁴ Each floor at Mescalero included a service core: the first floor core included medical records, storage, locker rooms, restrooms, and a nurses' work area and the second floor core has nurses' station, locker rooms, storage, and a day room. The stairs and elevator were part of the service core on both floors. The first floor perimeter comprised of the waiting area, exam rooms, an emergency treatment area (adjacent to the east door), X-ray, pharmacy, dental clinic, offices, mechanical room, and a carport on the west end. The second floor perimeter included a delivery room, nursery, 1-, 2-, and 4-bed rooms, and a kitchen and dining area. The hospital included a locally designed mosaic in the lobby that had been incorporated in the original plans.²⁵

As previously noted, the Mescalero Indian Hospital was designed in a combined architectural vocabulary of New Formalism and Brutalism: in this building, the two architectural styles worked together and create a balanced asymmetry. New Formalism was expressed in the entrance canopy and glass wall with modern portal. This lighter side of the building contrasted with the massive stone walls that include boxed windows protruding from the wall plane. Aspects of Brutalism include the stone walls that express the penchant for raw materials and the deep window protrusion that expresses the Brutalist need to break planes.

The primary details of the design—the New Formalism entrance with glass wall and the Brutalist massive stone walls—were the result of requests made by the Mescalero Apache tribe. During the design process, the tribe stated that, “They didn’t want to be in an enclosed space, they wanted to see their land.”²⁶ Responding to the need, George Pearl designed a glass wall to the east of the entrance and called it the “View Window.” This window was in the waiting area and allowed for patients to take in the southern vista afforded by the site. Because the view is to the south, there was a potentially large issue with overheating from solar gain. To alleviate the issue Pearl added a modern precast concrete “portal” shading structure and entrance canopy, which fit perfectly within the New Formalism vocabulary.

²⁴ Bob Campbell interview.

²⁵ Bob Campbell did not have recollection of the mosaic or any requests by the tribe to include it in the building.

²⁶ Bob Campbell interview.

In addition to the entrance canopy, precast columns, and shade structure at the View Window, precast concrete details include the entablature at the top of the first and second floors, and the window surrounds that protrude from the stone wall surface. The entablatures include a geometric design on the portion of the cast concrete that angles downward.

While the tribal representatives felt it was important to have a view of the Mescalero Apache land, they were also adamant about using local stone and tribal labor. The stone for the new hospital was mined at Mescalero and incorporated as a veneer on a reinforced concrete masonry unit structure with steel bond beams at the top of the walls. The use of stone lent itself to the massing and forms of Brutalism. The stone wall design included precast window surrounds that extended from the wall plane in patient rooms and offices. The placement and extension of the windows from the primary building façade are characteristic of Brutalism, in which windows are often tall and rectangular, and the designers compose elevations with changes in planes. If the entire building were a New Formalism structure, the windows would have been placed close together and at regularly spaced intervals, which would have resulted in little or no space in which to include the local stone. The tribal requests seem to have led directly to the blending of the two modern styles that were popular during the 1960s.

Part II. Architectural Information

A. General Statement

As noted in the history above, this building is a combination of the New Formalism and Brutalist styles that were popular during the late 1950s into the mid-1980s. The architect for Mescalero Indian Hospital, George Pearl, was adept at adapting the styles to the Indian reservation site, incorporating prevailing architectural theories, tribal design requests, and incorporating tribal labor to quarry and lay local stone during construction.

1. Architectural Character:

The Mescalero Indian Hospital was designed in a combined vocabulary that was a reaction to the Modernist architectural principles that relied upon standardization, removing historical references or ornamentation, and using the materials of glass, steel and concrete as the primary architectural expression.

New Formalism developed as a reaction to Modernism, however, it did incorporate some of the Modernist principles, but it based them on historical references, so the result was a sort of modern temple, with regularly spaced columns, pure geometric forms, and a grandiose scale. Brutalism rejected both the precision of Modernism and the historical expression of New Formalism with a resulting architecture that focused on massing, stone or concrete, modularity, and broken planes to create a sculptural ruggedness that rejected the lightness of Modernism or

New Formalism. George Pearl blended New Formalism with Brutalism to create the hospital at Mescalero.

2. Condition of Fabric:

The hospital is in excellent condition. However, paint is stained and peeling from the concrete entablatures; the entrance canopy roof is leaking; the sidewalks are spalling; and there is some lichen growing on the south stone wall under the east canopy (the area is in constant shade).

B. Description of Exterior:

The Mescalero Indian Hospital is an asymmetrical, two-story stone building, set into a sloping site with concrete architectural elements, and a metal, terne plate roof. There are two entry levels to the building: one off the parking lot at that includes the main, south entry with a canopy and a second floor entry on the north at the top of the site slope. In plan, the building is a rectangle with a service extension to the west and an office area that protrudes to the south, adjacent to the entrance canopy. The entrance doors are wide, sliding anodized aluminum units. The entrance canopy extends from the south elevation and the roof is angled down toward the building. It is constructed of poured concrete that has been painted white and consists of three evenly spaced square columns with concrete supports that extend from each face of the column, tapering to the edge of the canopy. The outside edge of the canopy angles upward and includes an indented, trapezoidal design (a New Formalist version of dentils on the entablature of a temple). The north end of the canopy tucks under the concrete band of the main structure that divides the first floor from the second on the south elevation.

The concrete band that divides the façade is approximately 2 feet tall, has a slight angle up to the top edge and a steep angle down towards the stone wall that is approximately 6 inches deep and includes the same trapezoidal pattern of the entrance canopy. This band wraps around the building beginning at the roofline on the west elevation where the one-story, south extension butts into the two-story, main building and continues across the south elevation, wrapping around the parapet of the extension, continuing behind the entrance canopy, turning the corner and continuing across the east elevation, stopping where the building meets the stone retaining wall to the north. The windows on the stone walls include poured concrete surrounds that extend from the stone wall plane, contain anodized aluminum, single pane, fixed units. On the south elevation, first floor extension, there are four regularly spaced windows at the west end and two, shorter windows at the east end. On the second floor, the windows are evenly spaced at larger intervals, at the east end, with two smaller windows at the west. Adjacent to the entrance canopy, on the first floor, there is a large span glass wall, with tall, narrow panes of glazing with a shorter pane above. The mullions are aluminum, and this is the Viewing Window that the Mescaleros requested in the original design. This window is surmounted by the concrete band that separates the two floors, as well as a “portal” that extends from the elevation with four, regularly spaced,

square, poured concrete columns. Together the entrance canopy and the portal provide the New Formalism aspects of the architectural design.

The east elevation includes four irregularly spaced windows on the second floors, with two windows on the first floor that line up with the middle windows of the floor above. The north end of the elevation butts into a stone retaining wall with a concrete cap surmounted by a chain link fence extending from the building and tapering as the grade slopes to the east. A precast concrete inverted “T” canopy with square posts extends from the elevation at the corner where the building and sloped come together. Tucked under the canopy, there is a recessed, anodized aluminum, full glazing panel door surmounted by a concrete lintel that extends from the stone wall approximately 18 inches and includes the trapezoidal entablature design.

The north elevation is one story (the second floor) because it is on the high side of the sloped landscape. It includes a simple, concrete base that is the width of the decorative, angled concrete band that divides the first and second floor on the other elevations. There is a band at the roofline that is concrete and incorporates the trapezoidal design. This elevation includes an emergency entrance with a precast concrete inverted “T” canopy of the same design as the east elevation, but with a concrete ramp with steel railings leading to the anodized aluminum, full glazing panel door, and included two steps on either side leading to the sidewalk before the ramp meets the landing at the door. This door also includes a concrete lintel that extends from the elevation and uses the trapezoidal decorative entablature. There is a unit of paired windows on the east side of the ramp and two windows directly adjacent to the ramp and another unit of paired windows adjacent to the loading dock at the west end. The loading dock is concrete and extends from the elevation, flanked by concrete masonry unit walls that are surmounted by a metal, shed roof. The roofline band with the trapezoidal pattern extends across the loading dock structure and just under the metal roof. A lintel extension using the same pattern extends from the elevation and across the four, flush metal doors. The loading dock includes one personnel, flush metal door at the east end of the dock and three butting, flush metal doors for supplies at the west end.

A service extension butts into the main building on the west elevation, just under the decorative band, and dramatically angles down towards the west. The stone wall is capped with metal flashing extending from the roof and the wall incorporates a flat concrete band at the base. There is no fenestration on the north or west of this extension. On the south elevation there is a stucco inset with an office door and window, which is flanked by bollards. To the east of the office door, there are paired louvered doors into rooms with heating, ventilation, and cooling systems. A concrete ramp with steel pipe railing extends past the doors up to a concrete loading dock with an entrance into the main building. A previous entrance into the service area, on the south elevation, has been infilled with concrete masonry unit. A metal shade canopy has been added along the south wall of the service extension and above the loading dock at the intersection of the

service extension south elevation and west elevation of the main building. This is cantilevered from the south elevation and supported at the intersection by three round, poured concrete columns. At the west end of the south elevation of the extension, a stone wall extends at an angle toward the southwest and tapers down to the ground. Behind the wall is a concrete masonry unit addition with the same roof slope as the stone service extension. The west end of this, on the south elevation, includes a metal paneled door with a wood surround. Also tucked in behind the wall, just to the south and west of the extension addition, is a concrete masonry unit flammable storage building with a slightly sloped gable roof and a flush metal door with a small louver panel at the base and a wood surround.

The west elevation, north end consists of two stories without a concrete band demarcating the floors. There is one window on the second floor above the loading dock, two single windows on the first and one paired at the first, south end, just before the south extension. The south extension includes the decorative concrete band and an aluminum, full-glazed panel door with the decorative concrete lintel extending from the elevation. The remainder of the elevation to the south is stone. The roof above the extension is flat with a parapet, while the roof above the main building includes a central trapezoidal metal roof that hides the original heating, ventilation, and cooling area with a slightly sloped, hipped roof between that and the building edge.

C. Site

The building is set into a hillside with a parking lot in front, and a road that extends behind the building, with a steep grade on the north side of the road. As a result of the slope, the south, east and west elevations are two-story, and the north is one. There is a large, curved grassy area behind the tapered retaining wall that extends to the east and the parking area adjacent to the emergency entrance on the north. The road slopes down at the west side of the building

Part III. Sources of Information

Campbell, Robert. Oral history interview at Van Citters: Historic Preservation offices, May 16, 2016.

Connell-Szasz, Margaret and Carmelita S. Ryan. "American Indian Education." In *Handbook of North American Indians, Volume 4, History of Indian-White Relations*, edited by Wilcomb E. Washburn. Washington: Smithsonian Institution, 1988.

Ferguson, Stevens, Mallory, Pearl an Albuquerque based partnership, devoted to planning and the practice of architecture, brochure published 1968, on file University of New Mexico, Fine Arts Library.

Fixico, Donald L. *Termination and Relocation. Federal Indian Policy, 1945-1960*. Albuquerque: University of New Mexico Press, 1986.

Mahoney, Jane. "The First 60 Years," *Albuquerque Journal*, November 29, 2004.

Meriam, Lewis. *The Problem of Indian Administration*. Baltimore: Johns Hopkins Press, 1928. Reprinted: Johnson Reprint, New York, 1971.

"Mound-Made Auditorium," *Life*, Volume 42, Number 23, June 10, 1957, 58.

National Park Service. "How to Apply the National Register Criteria for Evaluation." *National Register Bulletin 15*. Washington DC: U.S. Department of the Interior, 1991.

National Park Service. "How to Complete the National Register Registration Form." *National Register Bulletin 16A*. Washington DC: U.S. Department of the Interior, 1997.

Townsend, J. G. "Indian Health – Past, Present, Future." In *The Changing Indian*, edited by Oliver LaFarge. Norman: University of Oklahoma Press, 1942.

Trigger, Bruce G. The Native American Renaissance, 1960-1995. In *The Cambridge History of the Native Peoples of the Americas: Volume 1, North America, Part 2*, edited by Bruce G. Trigger and Wilcomb E. Washburn, New York: Cambridge University Press, 1996.

ILLUSTRATED APPENDIX



Albuquerque Civic Auditorium



Interior: auditorium space

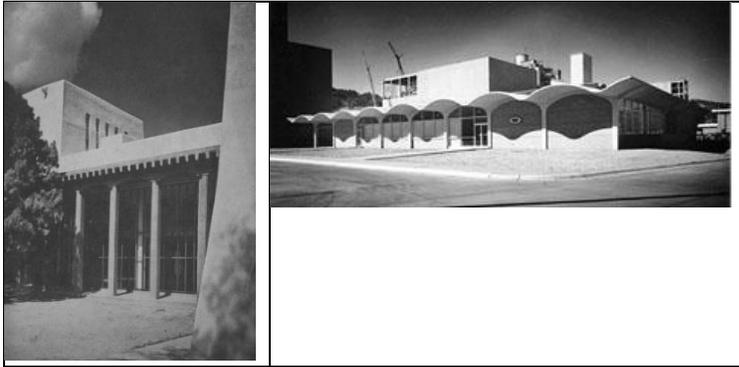
Ferguson, Stevens and Associates Civic Auditorium

Source: "Mound-Made Auditorium," *Life* 42, Number 23 (June 10, 1957): 58.



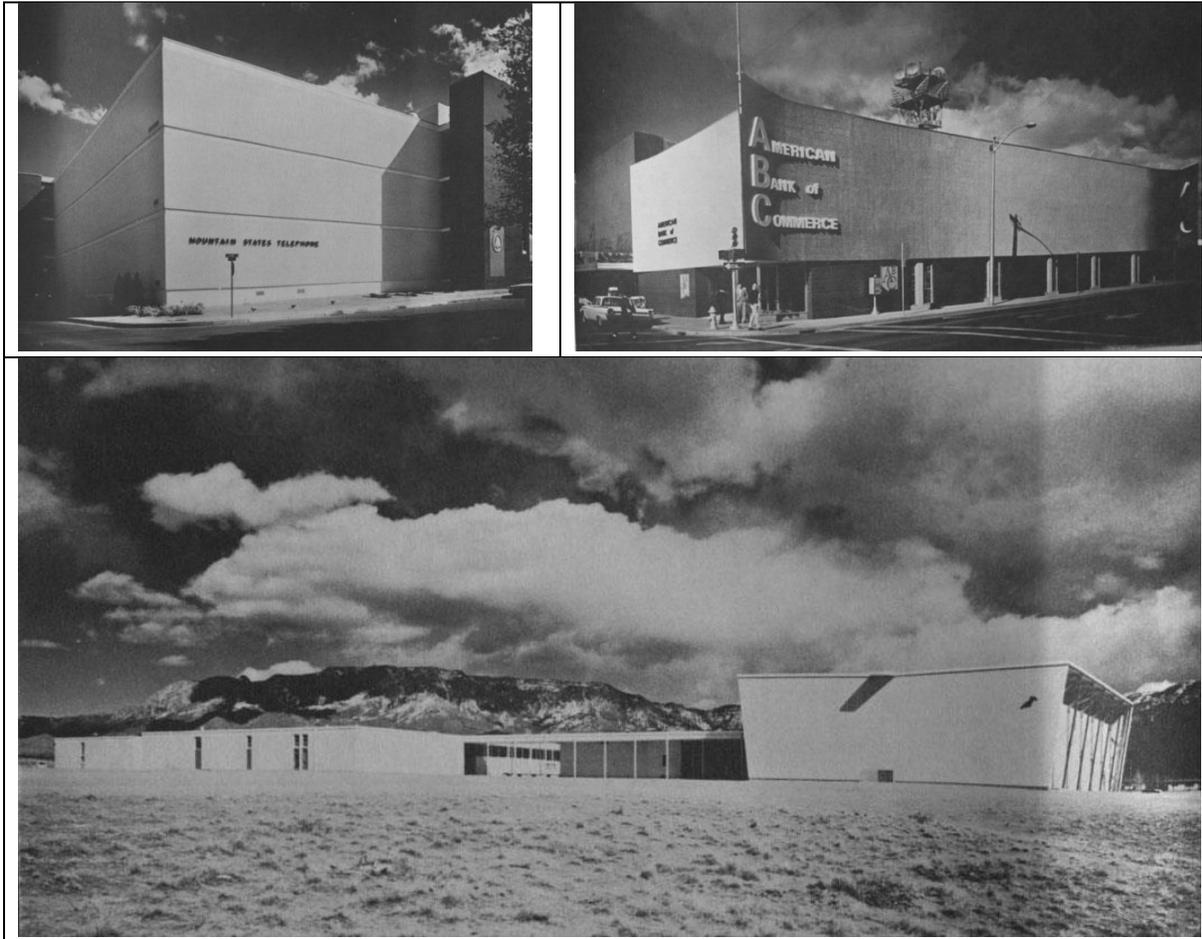
Partners at Zimmerman Library after the firm became Stevens, Mallory, Pearl, Campbell architects (Don Stevens, sitting left; George Pearl, sitting right; Bob Campbell, standing left; Robert Mallory, standing right).

Source: SMPC architects, digital files.



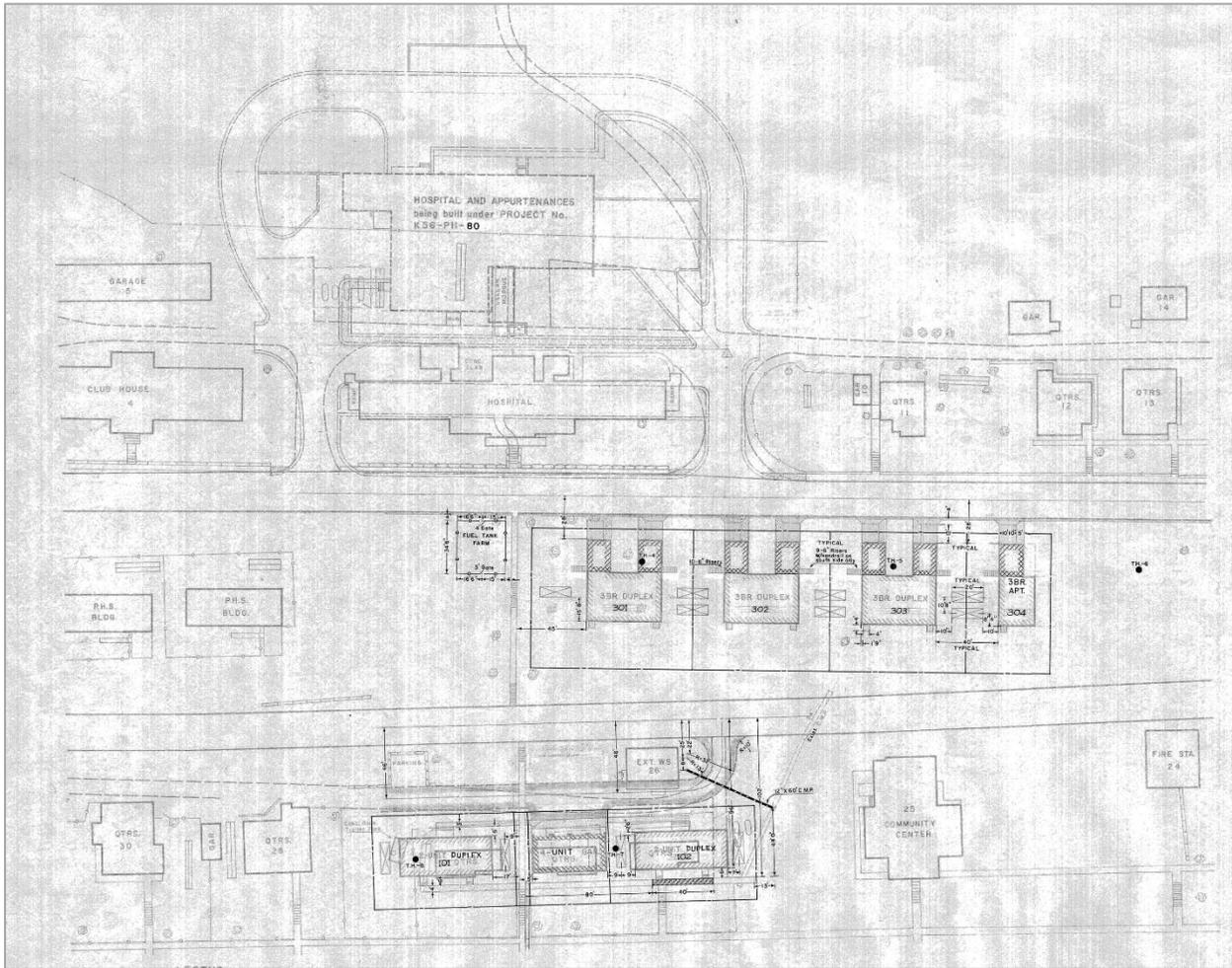
Examples of New Formalism by Ferguson, Stevens, Mallory, Pearl. Zimmerman Library addition, University of New Mexico (left); Ideal Cement Company near Tijeras, NM (right).

Source: SMPC Architects photo archive; *Ferguson, Stevens, Mallory, Pearl an Albuquerque based partnership, devoted to planning and the practice of architecture*, brochure published 1968.



Brutalism architecture by Ferguson, Stevens, Mallory, Pearl. Mountain States Telephone building (top left); American Bank of Commerce (top right); and Madison Junior High School (bottom).

Source: *Ferguson, Stevens, Mallory, Pearl an Albuquerque based partnership, devoted to planning and the practice of architecture*, brochure published 1968.



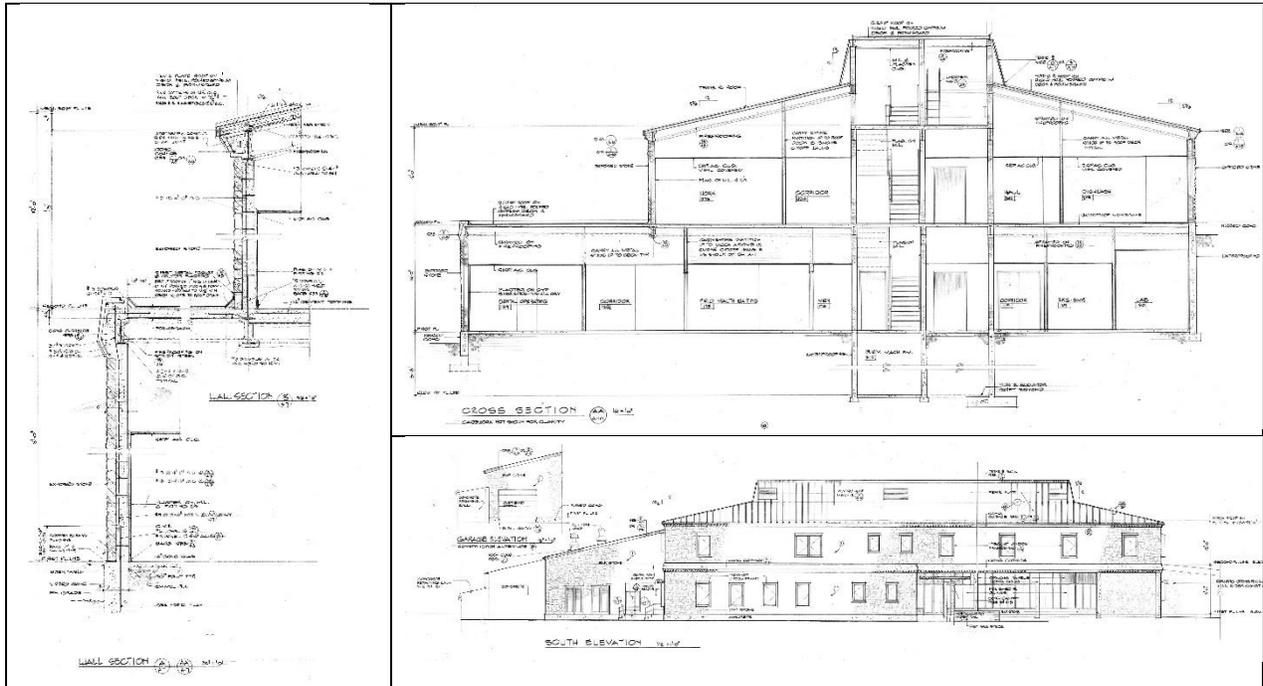
1967 Site plan showing building locations.

Source: Indian Health Service, Albuquerque Area Office, Division of Health Facilities drawing files, original construction documents.



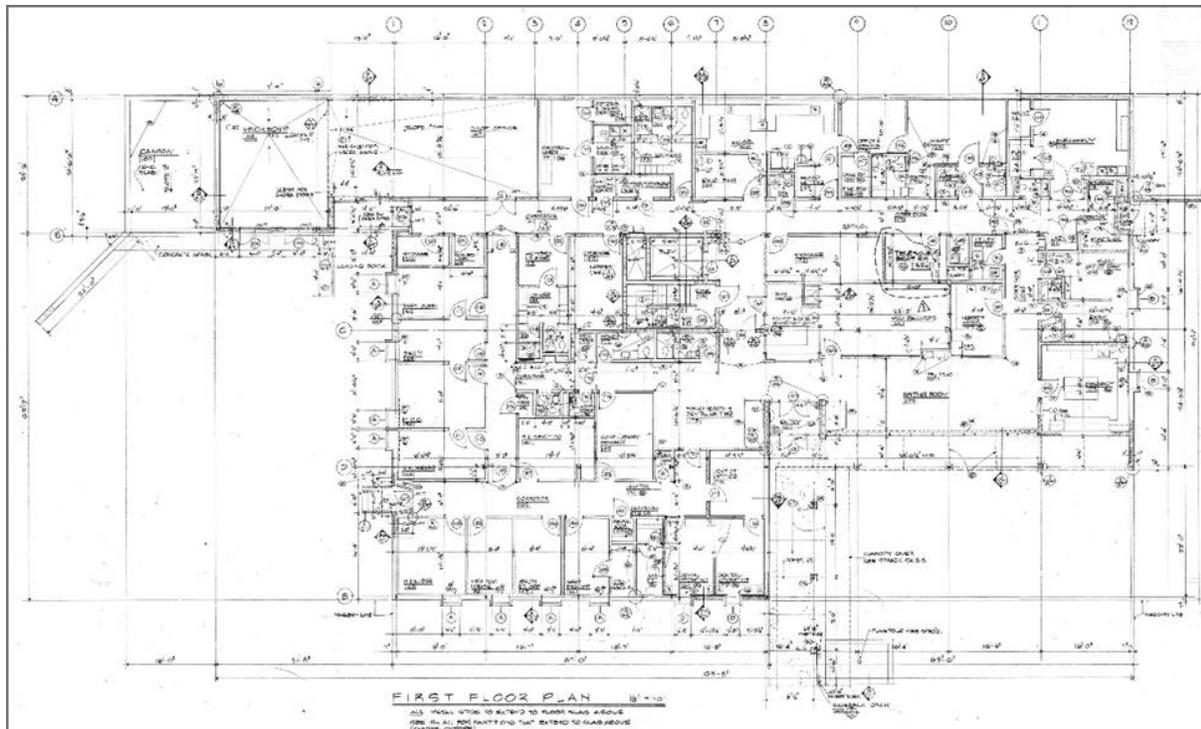
Southeast corner in 1968.

Source: Indian Health Service, Albuquerque Area Office, Division of Health Facilities real property files.



Exterior wall section, building cross section, and South Elevation, 1967.

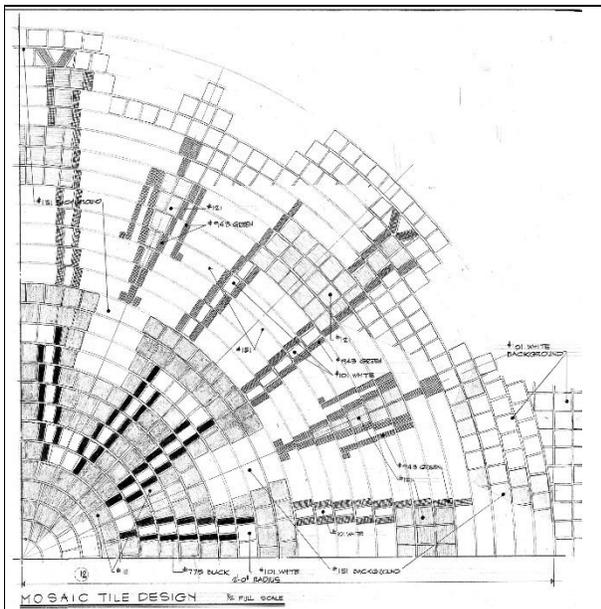
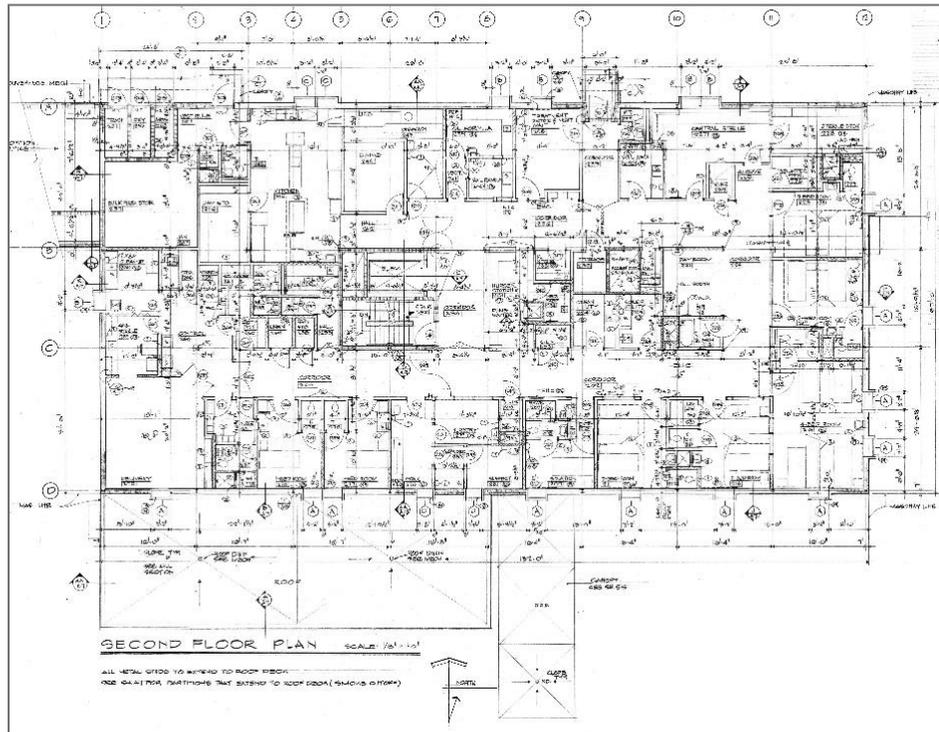
Source: Indian Health Service, Albuquerque Area Office, Division of Health Facilities drawing files, original construction documents.



First Floor, 1967.

Source: Indian Health Service, Albuquerque Area Office, Division of Health Facilities drawing files, original construction documents.

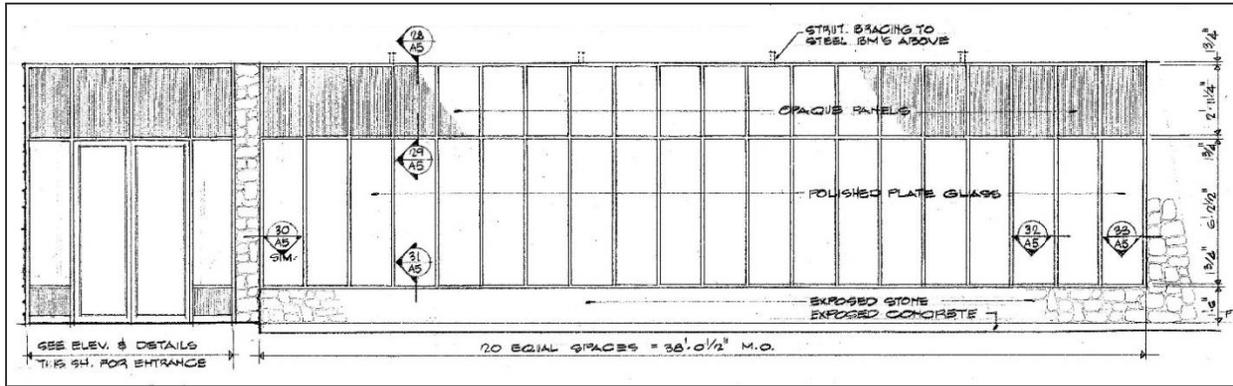
Second Floor, 1967.
Source: Indian Health Service, Albuquerque Area Office, Division of Health Facilities drawing files, original construction documents.



Design from construction drawings

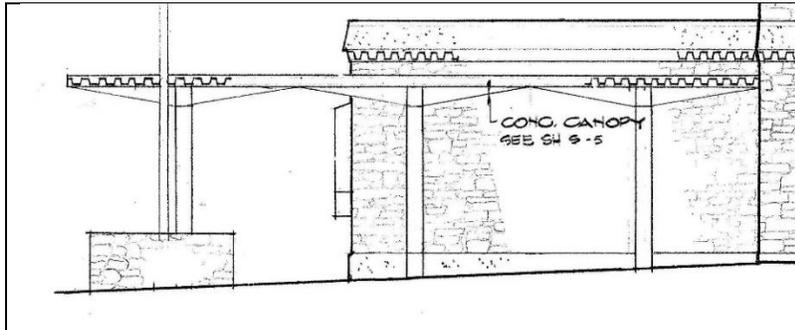
Mosaic in waiting room, 2016

Mosaic design and photograph.
Source: Indian Health Service, Albuquerque Area Office, Division of Health Facilities drawing files, original construction documents and photo by Karen Van Citters, 2016.



Elevation of the entrance doors and the "View Window."

Source: Indian Health Service, Albuquerque Area Office, Division of Health Facilities drawing files, original construction documents.



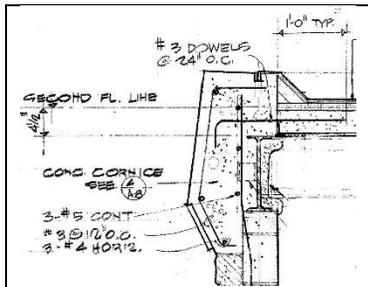
East Elevation of entrance canopy



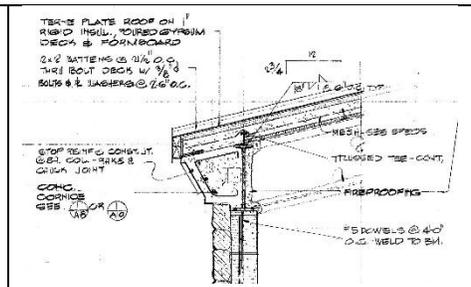
Photograph of entrance

Entrance canopy.

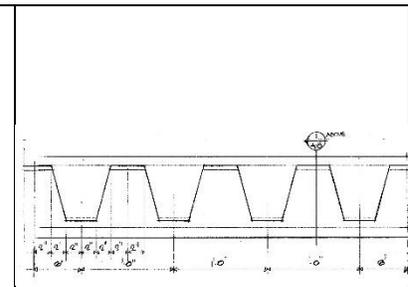
Source: Indian Health Service, Albuquerque Area Office, Division of Health Facilities drawing files, original construction documents; photo by Karen Van Citters, 2016.



First floor entablature



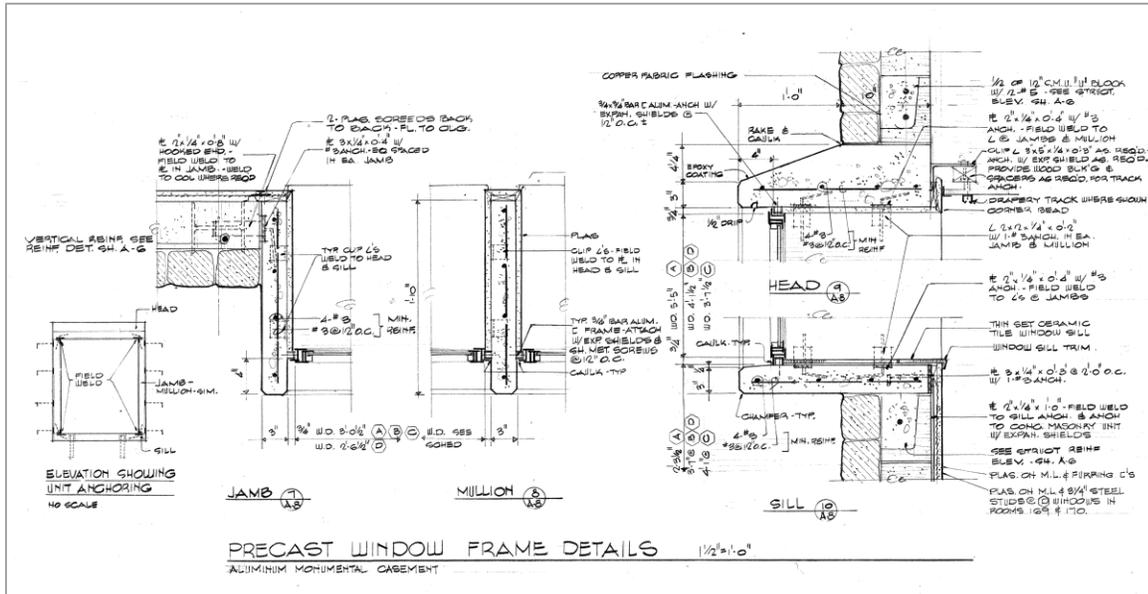
Second floor entablature



Geometric design

Sections showing building entablatures.

Source: Indian Health Service, Albuquerque Area Office, Division of Health Facilities drawing files, original construction documents.



Window details from original construction drawings, May 8, 1967.

Source: Indian Health Service, Albuquerque Area Office, Division of Health Facilities drawing files, original construction documents.