DESIGN BRIEF

BRIDGET MAGUIRE

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THESIS STATEMENT

Modern hospice care design is currently made up of four building typologies, including a wing within a hospital, a building connected to a hospital, an independent facility, and at home care. These current typology designs are deficient in the care of both their patients and their patients' families and caregivers. There is a current culture of silence around death that can be read in these typologies and instead of making people feel at home, they produce undue stress, anxiety, and isolation. My thesis project challenges the current hospice care building environments by using architecture and design to improve end of life care experiences. My design will seek to enable and allow patients to live their life to the fullest through the engagement of the senses, creating a sense of home and community, and creating spaces that metaphorically and physically assist and guide patients and their families through this final journey.

PRECEDENT STUDY

MANITOGA - living in communion with nature

ABOUT THE SITE

Location: Garrison, New York
Size: 75 acres

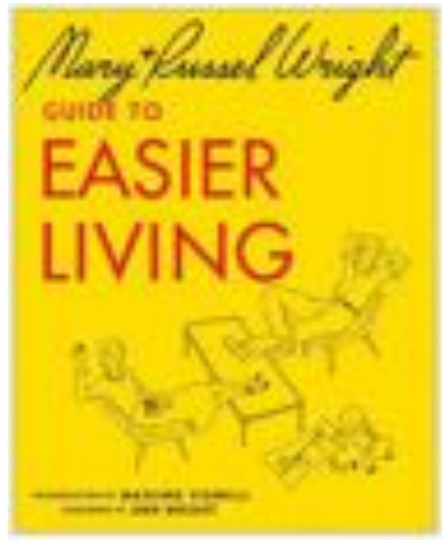
- the former home and woodland garden of American industrial designer Russel Wright
- the embodiment of Wright's design philosophy and life's work
- Celebrates good design for living in creative harmony with nature
- Wright's appreciation of Japanese architecture and landscape design, evident in the House and Studio through scale, structure, intimacy, and details
- Wright intended Manitoga to be not only a home for himself but "an exaggerated demonstration of how individual a house can be."
- In 2001 the not-for-profit Manitoga, Inc. acquired full ownership of the property

RUSSEL WRIGHT (1904-1976)

- An American industrial designer
- "Wrights shaped modern American lifestyle"
- approach to design came from the belief that the dining table was the center of the home
- designed tableware to larger furniture, architecture to landscaping, all fostering an easy, informal lifestyle
- Together Mary and Russel went on to form Wright Accessories, a home accessories design business
- best known for his colorful American Modern design, the most widely sold American ceramic dinnerware in history, manufactured between 1939 and 1959

A GUIDE TO EASIER LIVING

- Wright had always infused his popular postwar dinnerware and furniture with a reverence for nature
- Manitoga reinforced his interest in enhancing the connection of design and the outdoors
- wanted the land to service and support their need for rest and relaxation
- wanted to create a "shelter" where they could live comforably but enjoy the beauty of the land
- "Perscription for escape from automation, also my plan of creative living for retirement



TEMPLE TO ECOLOGICAL DESIGN

DESIGN AND MANAGEMENT WAS A SOPHISTICATED ENGAGEMENT WITH THE COMPLEX RELATIONSHIP BETWEEN DESIGN AND NATURE

DREAM HOUSE WAS DESIGNED TO SHAPE A PARTICUALR LIFESTYLE CLOSELY ATTUNED TO THE RHYTHMS OF NATURE AND RESPONSIVE TO THE LOCAL ENVIRONMENT

REACTION TO THE LOSS OF HUMAN CONNECTION TO THE NATURAL ENVIRONEMENT BROUGHT ABOUT MY MODERNIZATION AND INDUSTRIALIZATION

SOUGHT TO DRAW INHABITANTS INTO A CLOSER AND MORE DRAMATIC ENGAGEMENT WITH NAUTRE

MANITOGA EMBEDDED IN THE NATURE RATHER THAN STANDING APART THE VISITOR ACTIVELY ENGAGES WITH THE ENVIRONMENT IN A SIMIALR KINETIC AND TACTILE “CREATION”

WRIGHT SUGGESTED TWO KEY PRINCIPLES AS KEY TO THE DESIGN PROCESS AT DRAGON ROCK:

BLENDING AND CONTRASTING

BLENDING

CHOSE TO BUILD IT INTO THE SIDE OF A GRANITE CLIFF OVERLOOKING THE QUARRY, ENCLOSED BY ROCKS AND TREES

THE DARK GRAY TIMBER FRAME, OVERHANGING EAVES, AND FLAT ALUMINUM ROOVES WITH SEDUM WERE CONSCIOUS ATTEMPTS TO INTEGRATE THE BUILDINGS AESTHETICALLY AND MATERIALLY INTO NATURE

INTERIOR BLENDS WITH THE EXTERNAL ENVIRONMENT BY WAY OF THE GRANITE STONES EXTEDNING FROMT THE QUARRY TO CREATE THE LIVING ROOM'S FIREPLACE, STAIRS, AND FLOOR

USING MATERIALS, COLORS, TEXTURES, AND LITERAL APPROPRIATIONS FROM THE SITE HE BLENDED THE INTERIOR SPACE WITH THE EXTERNAL ENVIRONEMENT

WRIGHT'S DESIGN OF THE INTERIORS AND FURNISHINGS ENSURED THAT THE HOUSE AND STUDIO INHABITANTS WERE IN CONTINUAL DIALOGUE WITH ENVIRONMENT, ENGAGING WITH NATURAL MATERIALS, AND ADAPTING TO SEASONAL RHYTHMS

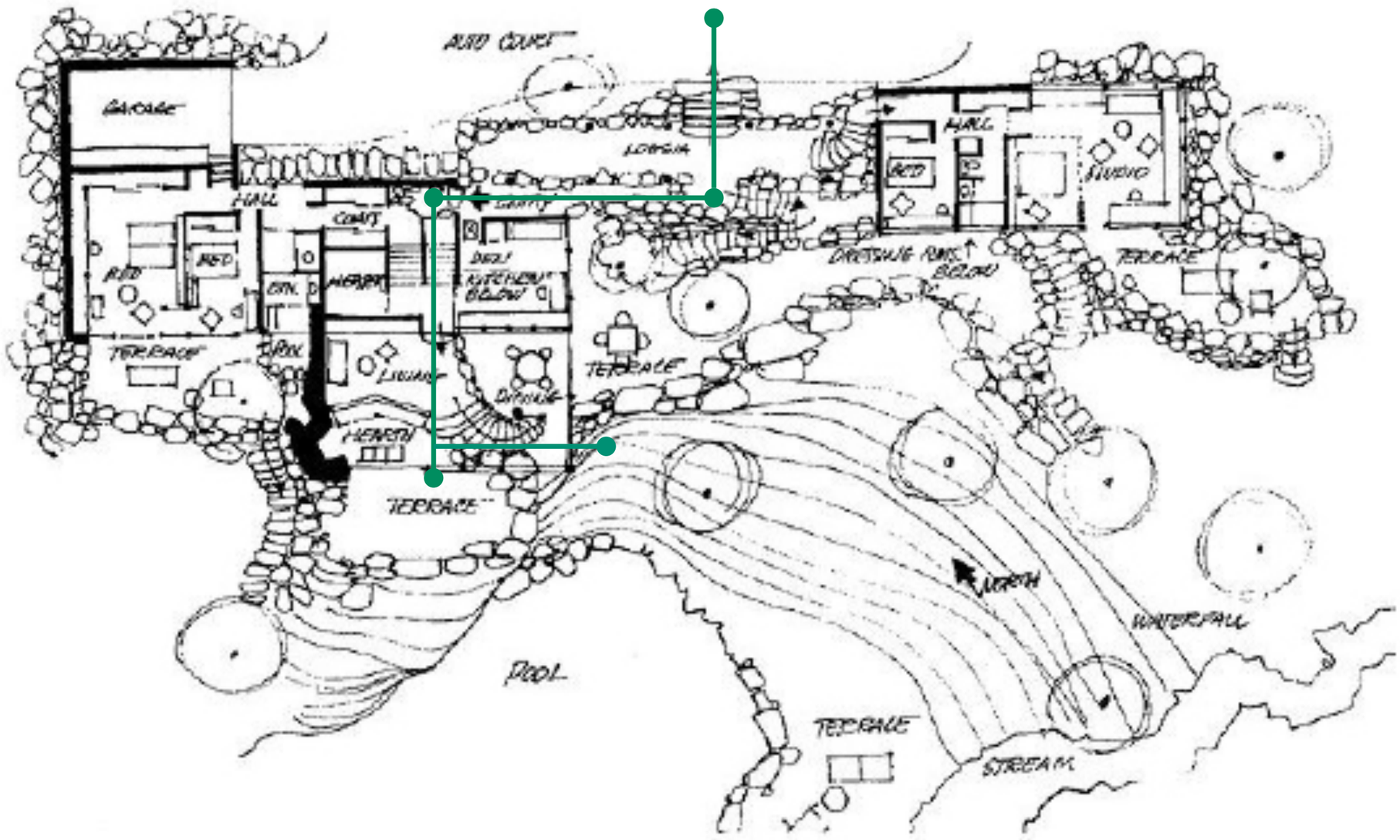
CONTRASTING

CONSCIOUSLY JUXTAPOSED LOCAL, NATURAL MATERIALS WITH MODERN FURNITURE, HIGH TECH PLASTICS, AND TEXTILES TO PROVIDE VISUAL AND SENSORY CONTRAST INCORPORATED INNOVATIVE MATERIALS SUCH AS, FORMICA, STYROFOAM, AND FIBERGLASS INTO THE INTERIOR FITTINGS AND FIXTURES

DYNAMIC AND PROVOCATIVE INTERACTION BETWEEN THE NATURAL AND ARTIFICIAL

JUXTAPOSED NATURAL MATERIALS WITH PLASTIC FURNITURE, PANELS, AND PARTITIONS

FRAMED PICTURESQUE VIEWS TO THE EXTERIOR THROUGH REGUALR, GEOMETRIC WINDOW FRAMES



SEQUENCING OF SPACES

WRIGHT CAREFULLY CONSIDERED THE HOUSE UNFOLDING SPATIALLY AND TEMPORALLY

VISITNG THE HOME

A VISITOR WOULD ARRIVE VIA THE CIRCULAR DRIVEWAY AND BE CONFRONTED WITH THE VINE DRAPED PERGOLA CONNECTING THE HOUSE AND STUDIO

INTENTION WAS TO HEIGHTEN ANTICIPATION AS THE VISITOR COULD HEAR THE WATERFALL BEYOND THE VINES BUT COULD NOT SEE IT

ENTERING THE HOUSE THROUGH THE ENTRANCE HALL THE VISITOR WOULD DESCEND A FEW GRANITE STEPS INTO THE LIVING AND DINING SPACE, WHERE THE WATERFALL WAS FINALLY REVEALED THROUGH THE LARGE GLASS WINDOWS

CAREFULLY CHOREOGRAPHED PATH SERVED TO HEIGHTEN SENSORY AWARENESS WITH THE CHANGES IN LEVELS, MATERIALS UNDERFOOT, AND AURAL AND VISUAL STIMULATION CONTRINUTING TO A RICH PHENOMOLOGICAL EXPERIENCE



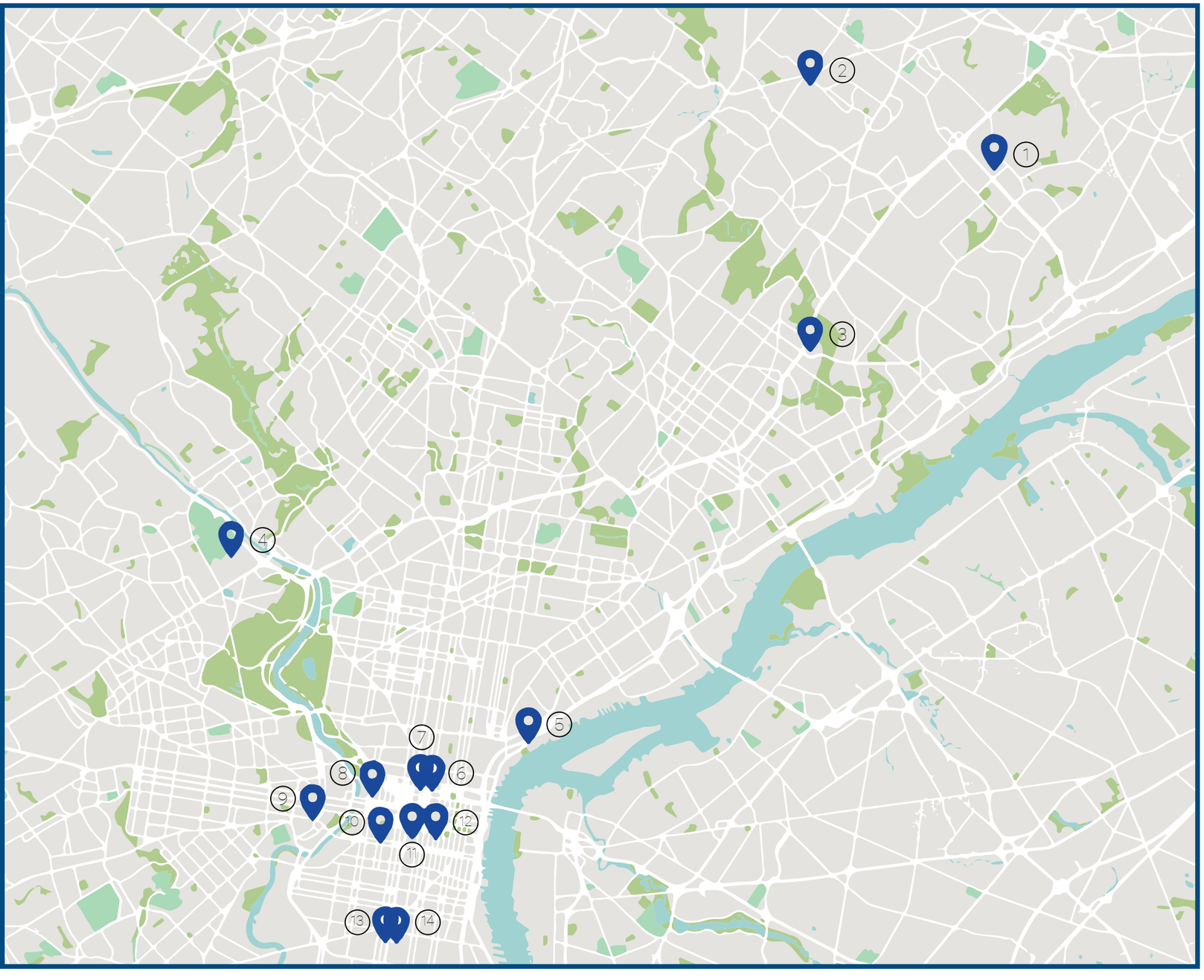



ATMOSPHERE PROBE


calming
meditative
relaxing
contemplative

SCALE PROBE

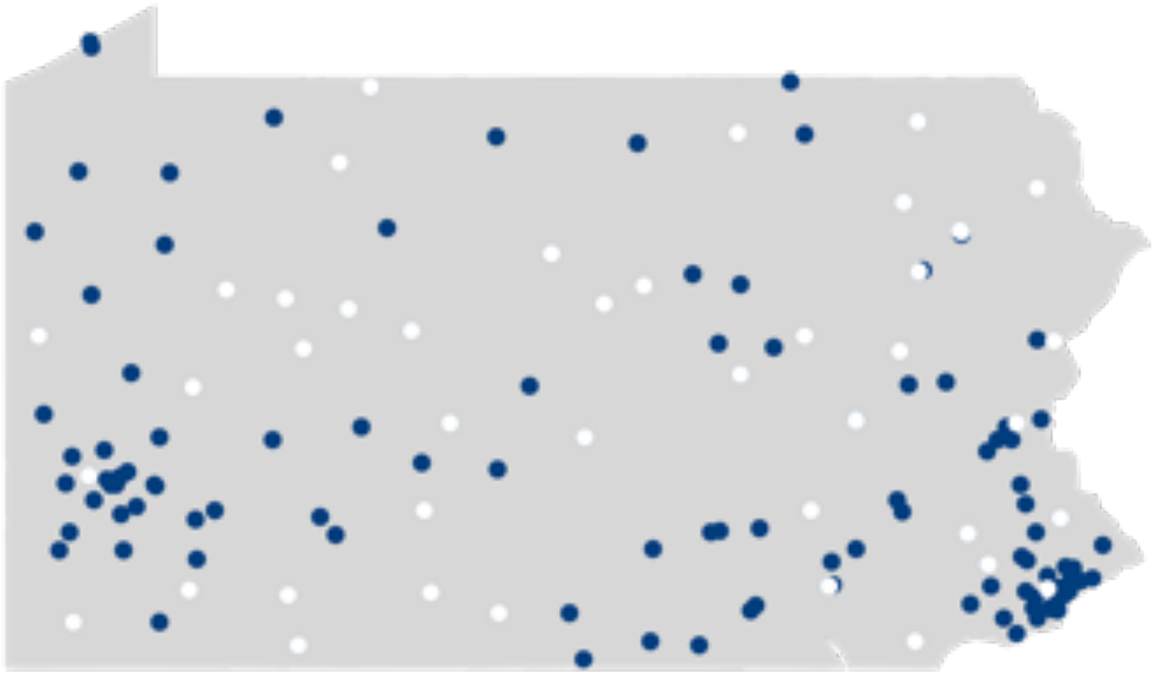
HOSPICE CENTERS IN THE GREATER PHILADELPHIA AREA



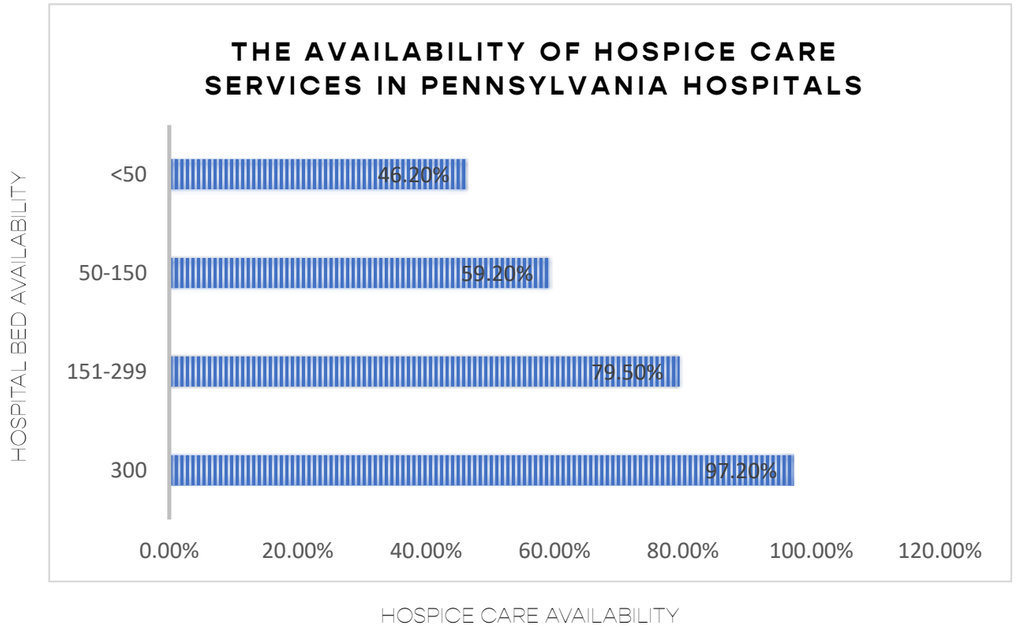
1. Redeemer Hospice
2. Philadelphia Hospice
3. VITAS Inpatient Hospice
4. Penn Medicine Hospice
5. VNA Care
6. Hospice Program Philadelphia
7. St. Johns Hospice
8. Jewish Hospice Center
9. Penn Palliative Care Inpatient- HUP
10. Wissahickon Hospice Center
11. Mercy Hospice
12. Penn Palliative Care Inpatient - Pennsylvania Hospital
13. Bridge Care Hospice
14. VITAS Inpatient Hospice

The majority of hospice care centers in the Greater Philadelphia Area are incorporated or a wing within a hospital system. This means that there is a complete lack of positive sensory or natural elements within these centers. This type of center is not conducive to provide a stress free and comfortable environment for patients, their families and loved ones, as well as staff.

AVAILABILITY OF HOSPITAL PALLIATIVE CARE IN PENNSYLVANIA



YES NO



INTERIOR OR EXTERIOR
PLANTER WITH WATER FEATURE

THIS FEATURE CAN BE MADE IN VARIOUS SCALES AND IN VARIOUS MATERIALS. IT COULD BE INTEGRATED INTO THE ENVIRONMENT THROUGH WALL MOUNTING OR PLACED ON THE GROUND OR FLOOR AT VARIOUS SIZES AND SHAPES

SOUND OF WATER IS HEALING

BRINGING EXTERIOR ELEMENTS TO THE INTERIOR

AESTHETICALLY PLEASING

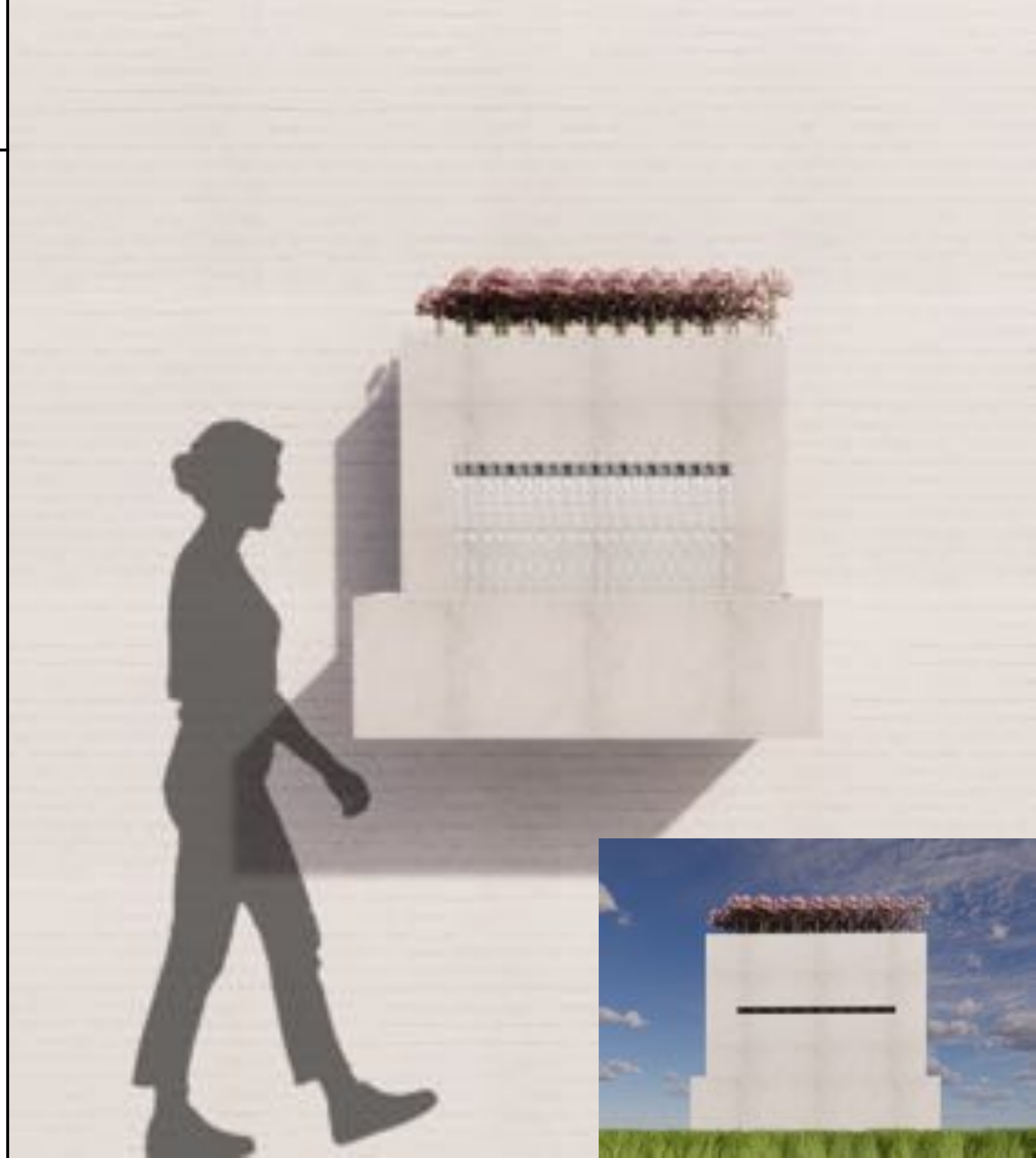
CAN CREATE A MOMENT FOR REFLEXTION AND MEDITATION

SOUND OF WATER CAN ACT AS A TYPE OF WHITE NOISE

POSITIVE AND APPEALING SMELLS REDUCE STRESS AND CAN BE TRANSPORTATIVE

CAN CREATE CONVERSATION AND COMMUNITY ENGAGEMENT

PROVIDES OPPORTUNITY FOR TEXTURE AND COLOR

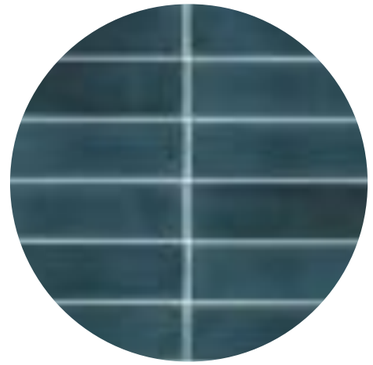


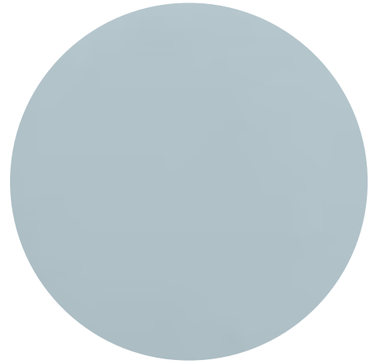
MATERIAL PROBE

DESIGN PROBE: MATERIAL

MATERIAL PALETTE

TEXTURE - NATURAL - LIGHT - MINIMAL





CONNECTION

PROXIMITY

INTERTWOVEN

ADJACENCY

FLUIDITY

LINK

STUDY MODEL #1

CONNECTION

PROXIMITY

INTERTWOVEN

ADJACENCY

FLUIDITY

LINK

STUDY MODEL #2

NATURE

BIOPHILIA

INSIDE OUTSIDE

NOSTALGIC

TEXTURE

STUDY MODEL #3/4

PODIUM SLIDES

A House at the End of Life

Bridget Maguire

HOSPICE CARE
BUILDING TYPOLOGIES

Hospice Care

McGill University Health Centre

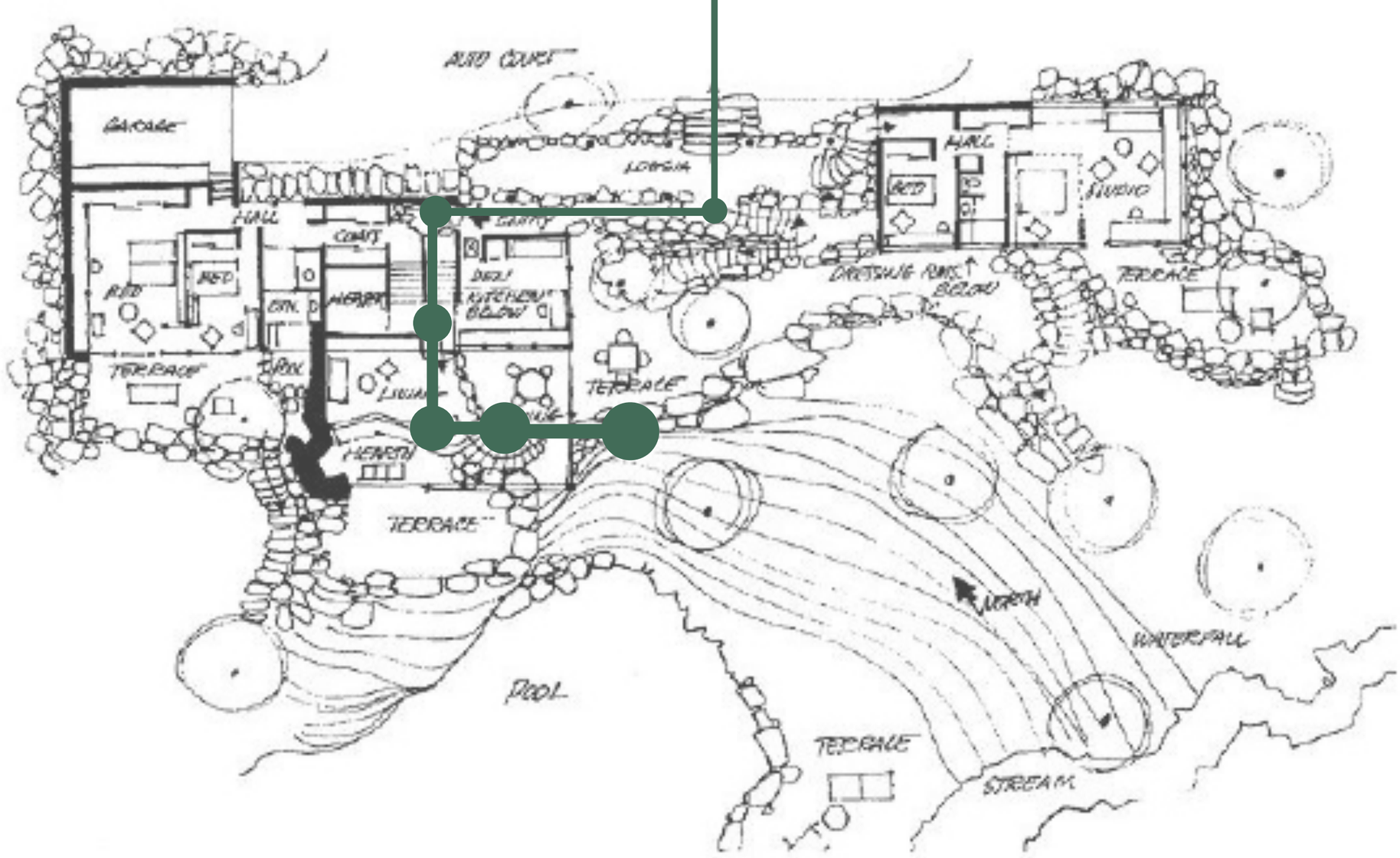
accomodations

sightlines

‘An architecture that rises to
the occasion’

- Maggie’s Centre Design Manifesto

MANITOGA
Garrison, New York



HOMELINESS AND CONNECTION

MANITOGA
Living Room

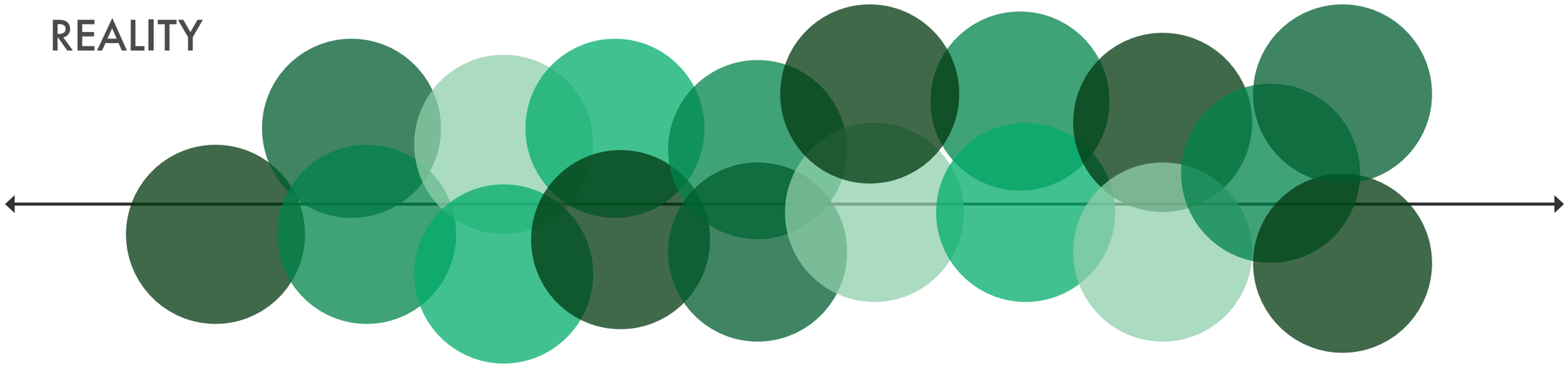
SENSORY EXPERIENCE

MANITOGA
Kitchen and Door Detail

HARMONIOUS SEQUENCING OF SPACES

MANITOGA
Pathway

THE FIVE STAGES OF DEATH AND GRIEF



"BILL OF PATIENT'S RIGHTS"
Caregiving: Hospice-proven techniques for healing body and soul By: D.C. Smith

The key to a self-directed dying experience:

1. The rights to be in control
2. Have a sense of purpose
3. Reminisce
4. Know the truth
5. Be in denial
6. Be comfortable
7. Touch and be touched
8. Laugh, cry, express anger
9. Explore the spiritual
10. Have a sense of family (i.e. the connectedness, intimacy, and interdependence that constitute "family")

LITERATURE REVIEW

A Home at the End of Life:
Creating “Healing” Spaces Through Sensory Experiences, Connection, and Harmonious Sequencing

Bridget Maguire
Literature Review
Graduate Thesis, M.S. Interior Architecture & Design
November 2022

ABSTRACT

This literature review will discuss the history and development of hospice care over the years as well as the current available hospice center types and both the negative and positive aspects they provide. It will then look at how incorporating environmental and sensory elements dealing with sight, smell, sound, and touch can improve physical and psychological states by improving mood and reducing stress for patients, families, and staff. The review will discuss the need for creating an environment of "homeliness," which can also be described or defined as connectedness. This connectedness, or current lack of connectedness, relates to the relationship between patients and staff, patients and their family, and patients and other patients. This idea directly links to the necessity for the seamless and "harmonious sequencing of spaces" in hospice care.

INTRODUCTION

Caring for patients suffering from terminal illness is extremely grueling and taxing on family, friends, and caregivers both physically and emotionally. Unfortunately, the current design of hospice centers does not provide a conducive environment for patient, and their family and caregivers, to feel at ease.[1] After discussing the history of hospice care and current types of hospice facilities, this literature review will consider how the end-of-life experience for all involved can be improved through environmental and sensory experiences, the harmonious flow and sequencing of space, and a sense of home and connectedness.

HISTORY AND DEVELOPMENT OF HOSPICE CARE

The origins of hospice care can be traced back to houses set up to care for travelers, crusaders, and the "incurably ill" in the 11th century.[2] The 18th and 19th centuries saw further developments in hospice care through continued ties to religious organizations.[3] During this period there was a shift in emphasis to caring for patients suffering from similar diagnoses in the same facility.[4] In 1879, the Irish Religious Sisters of Charity opened Our Lady's Hospice in Dublin which came to care for thousands of patients most of whom were dying from cancer or tuberculosis.[5] The sisters opened multiple different locations in other countries, such as St. Joseph's Hospice in London where Cicely Saunders got her start.[6]

Cicely Saunders was a 20th century British nurse and social worker who played an integral and predominant role in forming the principles used in hospices facilities across the globe.[7] These principles include (1) a recognition of "total pain," including physical, spiritual, and psychological discomfort; (2) the proper use of opioids to manage pain; and (3) attention to the needs of family members and friends who provide care to the dying.[8] Saunders is recognized as opening the first modern hospice in 1967, St. Christophers in London. At the time it was unique from other hospices in that it treated terminal patients with all diagnoses and had no religious affiliations and treated all social classes.[9] In 1963, Saunders introduced her principles for caring for the dying to the United States in a lecture at Yale University,

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[1] Ken Worpole, Modern Hospice Design: The Architecture of Palliative Care (London: Routledge, 2009)
[2] Stephen Lutz, "The History of Hospice and Palliative Care," *Current Problems in Cancer* 35, no. 6 (2011): pp. 304-309, https://doi.org/10.1016/j.currproblcancer.2011.10.004, 304.
[3] Ibid., p. 304
[4] Ibid., p. 304
[5] Ibid., p. 304
[6] Ibid., p. 304
[7] Ibid., p. 305
[8] Ibid., p. 305
[9] Ibid., p. 305

driving the development of hospice medicine in the United States.[10] In 1969, *Death and Dying* by Elisabeth Kubler-Ross was published and further sparked attention to this movement.[11] The book argued for the existence of five stages that a terminal patient go through while going through the end of life.[12] [put these stages in the footnote]

In the 1970s, the United States government transformed volunteer-led hospice into a fully recognized and official medical specialty.[13] From 1974 to 2009 the number of hospice facilities increased from 1 to over 5,000, and currently over a million people are in hospice annually in the US.[14] As part of the hospice program, patients have the option of receiving care at home. Research has shown that being admitted to hospice can improve a patient's quality of life, decrease health care costs, and sometimes even lengthen life.[15] Although over the years much improvement has been made, the need for quality care at the end-of-life has continued to bring attention to this issue.[16] The need for hospice care programs will only continue to increase, especially over the next 20 to 30 years.[17] With the continued aging of the "Baby Boomer" generation who are entering the prime age range for developing cancer, heart disease, and other chronic illnesses the demand for increased quantity and quality of end-of-life care is extremely pressing.[18]

CURRENT TYPES OF HOSPICE CARE FACILITIES AND BUILDING TYPOLOGIES

According to the literature, there are four primary types of facilities in which patients receive hospice care: within a hospital, adjacent to a hospital, at home, and independent facilities. Of these types, the literature suggests that independent facilities offer the best balance of adequate care and a sense of ease for patients and families.

Hospital Wing

In most hospitals there is a floor or wing designed and constructed, or modified, for hospice needs.[19] Having hospice within a hospital allows for immediate contact between a patient and their care team but as Klochko and Yaseneckaya highlight, there is a level of psychological discomfort in living one's final days in a hospital environment.[20] The scale and complexity of most hospital buildings and management does not adequately allow for a close relationship between staff and patients.[21] As Worpole highlights, mortality is regarded as a failure in the hospital system, to be dealt with quickly and swiftly away from public eyes.[22] French architect Nils Degremont argues that dying in a hospital is akin to death

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[10] Ibid., p. 305
[11] Kübler-Ross Elisabeth and Ira Byock, *On Death & Dying: What the Dying Have to Teach Doctors, Nurses, Clergy & Their Own Families* (Scribner, 2019).
[12] Ibid., p. 305; The five stages are: denial, anger, bargaining, depression, and acceptance
[13] Ibid., p. 305
[14] Ibid., p. 306
[15] Ibid., p. 306
[16] Ibid., p. 308
[17] Ibid., p. 308
[18] Ibid., p. 308
[19] Asmik Klochko and Iuliya Yaseneckaya, "Modern Trends in Architectural Design of Hospices," Stroitel Stvo Nauka i Obrazovanie [Construction Science and Education], no. 2 (May 29, 2020): pp. 10-18, https://doi.org/10.22227/2305-5502.2020.2.2, 14.
[20] Ibid, p. 14
[21] Ken Worpole, Modern Hospice Design: The Architecture of Palliative Care (London: Routledge, 2009), 6.
[22] Ibid, p. 3

outside of society because the way hospitals treat death conveys that death is something to be ashamed of.[23] Dutch architectural historian Cor Wagenar goes even further stating that hospitals are a catastrophe of institutionalized design, completely unfit for the purposes that they have been designed for.[24] Wagenar highlights their disfunction noting that instead of making people feel at home, they cause patients and their loved ones to feel stressed and anxious at their final moments.[25] Susan Sontag highlights the ugliness and neglect of hospital interiors as being key in negatively contributing to patients' feelings of loneliness and emphasizing to patients that their illness is a punishment.[26]

Facility connected to Hospital

In newer hospitals with land available, hospice facilities can be constructed as a separate building.[27] Klochko and Yaseneckaya note that this type of arrangement provides streamlined access of a patient to their care team while also providing a more comfortable psychological state.[28] However, this requires significant planning and is only possible when space is available, a condition not always feasible in existing hospital complexes.

At Home Care

Sheila Payne, the UK's first Professor of Hospice Studies notes that "dying at home is very scary. You might think you want to do it, and you might want to support someone in your family who says they want it, but amid it happening you may feel you'd be better off elsewhere".[29] Before entering the hospice stage, people are generally adamant about wanting to die at home thinking that dying in a familiar setting will be more comfortable. What people fail to realize and soon discover is that their homes and their family members are not equipped to provide them with optimal care creating more stress and anxiety for not only them, but for their family and caregivers as well.[30] In *Home and/or Hospital,* Annmarie Adams goes even further declaring that the best place to die is at home because the house is a caring building.[31]

Independent Facility

An independent facility away from institutionalized hospital settings creates the most comfortable psychological state for patients and their families.[33] The ability to be territorially secluded in a home-like environment contributes positively to the quality of patient end of life.[34] Worpole defines this typology in his book *Modern Hospice Design* as a building or group of buildings with a connection to external gardens and grounds.[35] This type of architecture is a relatively new building typology…[since

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[23] Degrémont, Nils, 'Palliative care and architecture: from hospital to people', European Journal of Palliative Care, Vol. 5, No. 4, 1998, 127–9.
[24] Wagenaar, Cor, editor, The Architecture of Hospitals, Rotterdam, NAi Publishers, 2006.
[25] Wagenaar, Cor, editor, The Architecture of Hospitals, Rotterdam, NAi Publishers, 2006.
[26] Sontag, Susan, Illness as Metaphor, London, Penguin Books, 2002.
[27] Klochko and Yaseneckaya, p. 14
[28] Ibid, p. 14
[29] Worpole, p. 2
[30] Ibid, p. 2
[31] Annmarie Adams, "Home and/or Hospital: The Architectures of End-of-Life Care," Change Over Time 6, no. 2 (2016): pp. 248-263, https://doi.org/10.1353/cot.2016.0015, 257.
[33] Klochko and Yaseneckaya, p. 14
[34] Ibid, p. 14
[35] Worpole, p. 9

what year? What brought about this typology?] Current examples include… [are there places you can refer to? Maggie's Centers?] The priority of this building type is to alleviate symptom and pain, and to provide for the emotional and spiritual well-being of patients and their families, with the knowledge that the patient will not be leaving the premises.[36]

DESIGN FEATURES CONTRIBUTING TO A POSITIVE HOSPICE EXPERIENCE

I turn now to discuss some features that can be understood from the literature as contributing to a positive hospice experience.

ENVIRONMENTAL AND SENSORY EXPERIENCES

The concept of architecture and interiors being connected to healing dates to Rome and continued through to the Renaissance before disappearing in the 19th century with the beginning of the mega hospital.[37] As Cohen[38] and Rasmussen[39] note, the built environment can significantly affect our quality of life and make important contributions to the management and minimization of pain and discomfort. Kayser Jones further argues that environmental factors can influence a patient's ability to tolerate and control symptoms, assert a sense of control over their bodies and enhance caregivers' abilities to meet the needs and wishes of the terminally ill. [40]

In the essay "An Architecture of the Seven Senses," Juhani Pallasmaa highlights how the architecture of our time is turning into "the retinal art of the eye."[41] Pallasmaa argues that buildings are losing their connection with the visceral experience and wisdom of the body and becoming "isolated in the cool and distant realm of vision."[42] He further explains and underscores the importance of sound, touch, and scent in a persons' experience of comfort and refuge.[43] Rana Sagha Zadeh, refers to these environmental and sensory elements in this context as "positive distractions."[44] She found that contact (both physically and visually) with nature, visual art, music, sunlight, and positive sounds and scents created overall psychological and physical benefits for patients.[45]

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[36] Ibid, p. 9

[37] Terri Peters and Charles Jencks, "Maggie's Architecture: The Deep Affinities Between Architecture and Health," in Design for Health: Sustainable Approaches to Therapeutic Architecture (Oxford: John Wiley & Sons, 2017), pp. 66-75, 68.

[38] S. Robin Cohen and Anne Leis, "What Determines the Quality of Life of Terminally Ill Cancer Patients from Their Own Perspective?," *Journal of Palliative Care* 18, no. 1 (2002): pp. 48-58, https://doi.org/10.1177/082585970201800108.

[39] Birgit H. Rasmussen and David Edvardsson, "The Influence of Environment in Palliative Care: Supporting or Hindering Experiences of 'at-Homeness,'" *Contemporary Nurse* 27, no. 1 (2007): pp. 119-131, https://doi.org/10.5172/conu.2007.27.1.119.

[40] Kayser-Jones J, Schell E, Lyons W, et al. Factors that influence end-of-life care in nursing homes: the physical environment, inadequate staffing, and lack of supervision. Gerontologist 2003;43:76e84.

[41] Juhani Pallasmaa, "An Architecture of the Seven Senses," in Questions of Perception: Phenomenology of Architecture; Steven Holl, Juhani Pallasmaa, Alberto Pérez-Gómez (Tokyo: A + u Publ., 1994), 41.

[42] Ibid., p.41

[43] Ibid., p. 43-48

[44] Rana Sagha Zadeh et al., "Environmental Design for End-of-Life Care: An Integrative Review on Improving the Quality of Life and Managing Symptoms for Patients in Institutional Settings," Journal of Pain and Symptom Management 55, no. 3 (2018): pp. 1018-1034, https://doi.org/10.1016/j.jpainsymman.2017.09.011, 1023.

[45] Ibid., p. 1023

Worpole asserts that nature is "our ally and our ultimate home."[46] Cooper Marcus and Sachs likewise suggest that humans are a part of nature and in "surrendering" to it we in return become fortified and healed.[47] Klochko and Yaseneckaya further highlight the importance of the inclusion of sensory aspects, specifically nature, stating that situating a facility in a natural setting is an important factor for the physical and psychological well-being of not only patients, but their relatives and hospice personnel.[48] Rebecca Mclaughlin and Beth George state that these spaces can provide an enhancement of physical, psychosocial, and spiritual wellbeing.[49] They argue that this can be executed by ensuring universal access to sensory experiences through restorative spaces and access to nature; noting that this access will not only support the patient, but also the wellbeing and resilience of the medical staff and support staff.[50]

"HOMELINESS" AND COMMUNITY

Rebecca Mclaughlin and Beth George define the term "homeliness" as the de-institutionalization of healthcare facilities, instead creating areas to induce feelings of being in a domestic setting.[51] It is a term that is used to describe spaces that produce comfort while also providing an atmospheric solution to anxiety, which is palpable in hospice care facilities.[52] George and Mclaughlin further argue that it is the responsibility of the designer to free these facilities from their emotional baggage by "responding to the tension between the physical and imaginative inhabitation of space."[53] Homeliness can be designed through…. [are there specific elements?] and reinforced by creating connections and community between patients and their family, patients and other patients, and patients and staff.[54]

J. Macgregor Wise does not write about hospice facilities, but his insight from geography is helpful. He defines "home" as not the place we come from, but the place we are. Home is the organization of markers (objects) and the formation of space; these markers are not just inanimate objects but the presence, habits, and effects of spouses, children, and companions.[55] Wise presents a more open concept of home that does not tie identity to any fixed place, seeing "home's" as ever changing and social.[56] The social aspect of home highlights why, in hospice, feelings of homeliness are linked to a sense of connectedness. As the physicians Mount and Kearny note, "healing" at the end of life is defined as supporting the optimal quality of life when medical science can no longer modify or assuage the progression of the disease.[57] They see that it is possible to die healed and this is enabled and facilitated by an environment grounded in a sense of connectedness and feeling connected.[58] As Klochko and

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[46] Worpole, p. 80
[47] Clare Cooper Marcus and Naomi A. Sachs, "Hospice Gardens," in Therapeutic Landscapes: An Evidence-Based Approach to Designing Healing Gardens and Restorative Outdoor Spaces (Hoboken, NJ: Wiley, 2014), pp. 165-178, 165.
[48] Klochko and Yaseneckaya, p. 14
[49] Rebecca Mclaughlan and Beth George, "Unburdening Expectation and Operating between: Architecture in Support of Palliative Care," *Medical Humanities*, 2022, pp. 1-8, https://doi.org/10.1136/medhum-2021-012340, 3.
[50] Ibid., p. 5
[51] Ibid., p. 3
[52] Mclaughlan and George, p. 3
[53] Ibid., p. 6
[54] Ibid., p. 7
[55] Mark Taylor, Julieanna Preston, and J. Macgregor Wise, "Home: Territory and Identity," in Interior Design Theory Reader (Chichester: John Wiley, 2006), pp. 176-180, 177.
[56] Ibid., p. 178
[57] Mclaughlin and George, p. 1
[58] Ibid., p. 1

Yaseneckaya also note, a home environment has positive effects upon hospice patients and their relatives.[59]

HARMONIOUS SEQUENCING OF SPACES

In his book *Modern Hospice Design*, Worpole states that the size and complexity of most hospital buildings and management systems prevents them from being able to focus on a close relationship between staff and patients.[60] While inhibiting connectedness diminishes the experience of patients, their loved ones, and staff, better design can improve morale, self-worth, and attitudes. For this reason, hospice must be a setting where the quality and "harmonious sequencing of spaces and functions" matters more than almost any other building type.[61] Worpole argues that a "poetics of space" and a spirit to a building is as necessary as a schedule of care and accommodation.[62] He notes that hospice staff use the metaphor of "the final journey" to describe the experience of patient, so a sense of the stages and rituals involved in dying should be present throughout the design.[63] Interestingly, people have complained that newly built hospices are bland and 'ducking the issue of death.'[64] As Adams importantly notes, this is the first-time people have seriously addressed the fundamental issues of life and death, so the design should address this openly and be a place for reflection and a place to search for meaning and purpose.[65]

Some designers have highlighted the importance of the waiting room, and the issue of waiting specifically, when considering the sequencing of space. As Kaufman states in *…And a Time to Die: How American Hospitals Shape the End of Life*, the issue of waiting is a powerful reality both for those who are dying and their families who are caught between hope for life and the compassionate intention to end suffering.[66] This directly links to Worpole's argument that quality of time is of the essence, for time is clearly precious to those that know they are dying.[67] Worpole notes that the design of places for waiting or "another kind of being" can provide an opportunity of calm self-reflection and a chance to gather one's self together both for patients and their relatives and friends.[68]

CONCLUSION

It is evident that many current hospice facilities diminish patient' experience at the end of life, and negatively affect families and loved ones as well as hospice staff. As Annmarie Adams points out in *Home and/or Hospital,* there is a culture of silence around death in current hospice building types.[69] Adams argues that a healthy and evolved society confronts serious illness and death openly.[70] As

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[59] Klochko and Yaseneckaya, p. 14
[60] Ibid., p. 9
[61] Worpole, p. 9
[62] Worpole, p. 10
[63] Ibid., p. 9
[64] Worpole, p. 10
[65] Adams, p. 252
[66] Sharon R. Kaufman, *... And a Time to Die: How American Hospitals Shape the End of Life* (Chicago, IL: The University of Chicago Press, 2006), 83.
[67] Worpole, p. 9
[68] Ibid., p. 9
[69] Annmarie Adams, "Home and/or Hospital: The Architectures of End-of-Life Care," *Change Over Time* 6, no. 2 (2016): pp. 248-263, https://doi.org/10.1353/cot.2016.0015, 261.
[70] Ibid., p. 261

mortality is regarded as a failure in the hospital system, to be dealt with quickly and swiftly away from public eyes.[71] Families aren't given adequate opportunity to come to terms with death. Research has shown that incorporating environmental and sensory aspects into hospice spaces improves the psychological and physical wellbeing of those residing in these facilities. Likewise, a sense of home would counteract the complexity of contemporary hospital design, and promote connectedness between a patient and their caregiver, a patient and their family, and a patient and other patients. Harmonious sequencing of spaces, including waiting areas and the rituals and stages of dying, would also contribute to more positive end-of-life experiences. For these reasons it is essential that architects and designers continue to research and develop ways to improve hospice care facilities. As Worpole asserts, hospice spaces can inspire and provide solace even if they cannot actually heal.[72]

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[71] Worpole, p.3
[72] Ibid., p.10

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