

Our Last Home

Designing for Care at the End of Life

by
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Author's Declaration

I hereby declare that I am the sole author of this thesis.
This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

In the last fifty years, hospice palliative care has changed the modern understanding of dying. Rather than focusing on death, it promotes the facilitation of optimizing life for patients whose conditions have worsened beyond the possibility of recovery or cure. As such, this thesis is a response to the demands of architecture to support this unique stage of life. It analyzes and posits guidelines for designing spaces which must cater to the specific and vastly different needs of the palliative care specialists, family members, and the patients themselves. Also, it seeks to examine the nuanced complexities and poetics involved in a proposed architectural design for a hospice in downtown Toronto.

The typology for a hospice is one that is both complex and evolving. It must combine the domestic scale of a home with the efficiency and standardization of an institution. The contemporary hospice must also accommodate rituals and beliefs surrounding the end of life that vary greatly from the many cultures that make up the contemporary city. At the very least, the building must provide inspiration and a hope for a peaceful and dignified transition, recognizing also that this is no longer a traditional place for cure. The distinctions suggest a reconsideration of what is needed and what is expected for those involved in and affected by the dying process.

This thesis will explore the architectural possibilities inherent in a new social understanding of the end of life that defies the fatalistic view of an inevitable death, in favour of a hope for dying with dignity while embracing an opportunity to experience liminality during our final days.

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To Des: It is because of you that I became impassioned for promoting End-of-Life Care, and the only reason I have been able to explore it in depth without turning back. Thank you for your professional insights, eternal patience, and for inspiring me in your gentle, humble way.

*Dedicated in loving memory of
my grandmother Lam Choi SauYung*

December 4, 1933

December 28, 2012

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PROLOGUE

“To think of death is *penser l’impensable*, to think the unthinkable. There is utterly nothing to think about death; genius and simpleton are equally thwarted by it...For anyone who ventures into thinking the unthinkable, words at least remain; we can call them thoughts just as well as not...for no doubt the limits of my language are the limits of my world, but the limits of my world are also the limits of my language and, in the face of death that is my anti-world, the impotence of my language becomes apparent.”

Jean Amèry, *On Aging*

This is not a thesis about death, but about the joys and memories of life that re-surface when the prospect of death is near. I have been humbled by working closely with those who have dedicated themselves to this line of work, as well as those who have experienced their own loss of a loved one. The last sixteen months have hardly been enough time to delve into the depths of End-of-Life Care and I anticipate that I will spend decades more time understanding it. Along the way, I have been privy to heartfelt narratives about experiences with dying as told by the husband, wife, daughter, son, sister, brother, friend, doctor, and nurse. The emotions have been powerful, and some stories haunting. Many were told long after the grieving process was over and the sadness was less immediate. However, many noted that the environments where their loved one died were ‘unbearable’ or ‘awful’. Most recollections were of sterile hospital rooms, with poor privacy measures and intrusively loud overhead speakers, machinery, and clamour. Those whose family members had died at home or in one of the few hospices in Ontario, had far less discomforting memories of the place where they experienced the final days of a loved one.

And so, the caveat must be made that this thesis does not aim to suggest that hospice care is appropriate for every family. To those who choose, very rightly, to die at home, I will make no such claims that a hospice setting is the superior choice. The aim is to create an alternative to the hospital when home care is either not feasible or desired.

As an architect, it is interesting to discover a type of building that has so recently emerged, as in the case of palliative and hospice care. Although our species has been dying for time immemorial, it has been less than a century since medical advances to prolong death and extend life has created a tangible period of time that could be classified as ‘dying’. As a result, spaces that house the services provided by hospice and palliative care have been built and designed due to new perceptions of terminal diseases. The fact that one may choose to change the goals of care from cure-at-all-costs to comfort with support extended to the families that surround patients, reflects a completely new philosophy.

The process of dying is arguably at the crux of what defines our humanity, yet currently it is a private endeavour reserved for families, friends, and caregivers who are reacting to a patient's declining condition. Marginalized by cultural stigmas, and hidden away, the focus is almost entirely on the inevitability of death and the grief and mourning that will follow, rather than on the potential to celebrate and encourage a patient to continue living fully until such time arrives.

Death is often portrayed as an enemy and negative syntax surrounds analogies of battles and fights against a force always far superior who will undoubtedly be victorious. Discussion surround the possibilities of winning, losing, and not giving up, regardless of the realities of a patient's condition. The unintentional result is that the patient, often berated with this imagery, feels that they have simply 'not fought hard enough' or that they are unlucky. These beliefs strip them of control, direction, and ultimately hope when they need it most.

In palliative care, the focus is instead on empowering a patient at the end of life to live without fear of pain or being alone, until that time comes. This approach to alleviating fear extends beyond the patient, to all those supporting him or her through this time, so that all may move beyond the fear to allow for life to continue.

There are four groups that will be mentioned specifically in this thesis: the patient, the family members and friends, formal caregivers, and the public at large. Each have their own understandings, experiences, and attitudes towards dying, but an underlying consistency to all of them is the denial that it is happening all around the city and the world.

While it is encouraged and supported that all patients exercise their right to seek curative treatment for as long as they choose, the argument in this thesis is made only for those cases where curative medicine may no longer be the ideal course of action for providing a maximized quality of life. This juxtaposition of hope for life with the fear of death was initially difficult to resolve. However, the last several months of investigation have brought me certain insights to a topic that continues to lack the proper vocabulary, even for those who are confronted daily with the complexities of death and dying.

I humbly admit that designing under the presumption that one individual can understand those who are dying is an immense undertaking. I can only understand a fraction of their situation through observation and synthesis. The design must also include ways of providing a space that is conducive to supporting those who support the patients. If the caregivers are not properly cared for, their ability to extend complete support to the patient will be jeopardized. And lastly, at a larger scale, the proposal will also be a modest edifice to the public that aims to assuage the fear and anxiety surrounding death. It means to say to everyone that the dying process is very much still similar to living. If nothing else, those who are dying have a greater exhilaration in taking every breath and feeling every ray of sunshine. The hospice is a place that allows those at the end of life to continue living to their greatest capacity, while receiving the appropriate symptom control to allow them to do so, surrounded by friends and family whose greatest wishes are to see them comfortable and content.

Ultimately, this is a thesis about facilitating and redefining the human spirit, and providing hope at the end of life through design.

“The verb die can only be used logically in the past tense, since it does not receive its legitimization until death has already taken place. The afflicted may then say to themselves, they have to think around death, since they cannot think about death -- and constantly try this roundabout way anew even though they constantly describe only half-circles. I will die. [They] say to themselves.

When? Where? How?

Above all: How?”

Jean Amèry, *On Aging*

INTRODUCTION

Perhaps the most interesting thing about dying is that it will happen to everyone. It is at the crux of our existence and determines for certain that we are finite beings who live and consequently die. It is one of the few levelers in our known world, especially as we enter an age where all things can be selected, chosen, manipulated, outsourced, and ultimately controlled. Dying, however, is not a matter we have a choice in, insofar as when it will happen. As such, the element of time is beyond our control.

Instead, how we die and where we die, with whom we spend our last days and how we choose to react to the news that we are dying are all still ways in which we may customize and make the dying experience our own. There are, of course, social constructs in place depending on our location that may govern or suggest certain known ways in which we should behave around the topic, but ultimately it is important to allow for flexibility in these times, for people die as they have lived – uniquely.

However, it should be acknowledged that the categorization of ‘dying’ itself is relatively new. Previously, there was only the briefest moment

between living and death that was understood as such. Life and death occupied two extremes that were the only two existential options; one was either alive or not. It was the introduction of palliative and hospice nursing care that propelled the liminal state of dying as a transition between living and death. Unfortunately, this was a natural evolution of the concept that 'nothing more could be done' for a patient past a certain point, and so dying was the label given to those for whom hope was apparently meaningless. Now, more recent improvements in palliative care have brought forth a new opportunity for hope. Instead of hoping to be cured, one could hope for a good death.

A 'good death' can be categorized in many ways. In fact, it should be in as many ways as there are ways to live. The hopes and expectations for the dying range across a wide breadth. Religion, accomplishments, regrets, family dynamics, social status, ego, and fears are all contributors to the way in which a person may hope to leave this world. Fear is perhaps the most underlying factor of all. Certainly, dying is inevitable; but each person only experiences it only once. Speculations on how it happens and what it feels like are solely second-hand accounts.

Naturally, dying is surrounded by fear, for the lack of empirical wisdom around how it is done best and what one might expect when it happens. There may be fear of dying alone or dying too soon, or most commonly, dying in pain. Hollywood and popular fiction have dramatized dying as horrific and painful, often happening in the middle of the night shrouded in darkness, alone in a hospital. These painful and horrific images extend to those who survive the patients, as they are often pictured wailing and cursing in bewilderment. While this may well have been the case in the past, the percentage of deaths occurring in this way is decreasing quickly as a result of palliative care.

Palliative is derived from the Latin term *palliare*, meaning to cloak. In the context of medicine, palliation refers to the cloaking or masking of pain. By providing relief and management, pain can be controlled and virtually eliminated from the end of life. By targeting the to alleviation of pain, the chances of suffering diminishes and both patients and families are able to focus on different aspects such as reconciliation and closure. As a result, the concept of 'dying with dignity' has arisen. While dignity for a person manifests in many forms, a primary goal of care is to ensure that the end of life is without pain and with the ability to die peacefully.

It should be mentioned that palliative care is not only limited to end-of-life care and extends to patients in all stages of morbidity who are in need of pain control and alleviation, as well as symptom management. Palliative care in the context of this thesis will be limited to pain relief and symptom management at the end of life. Hospice care will be the term surrounding all aspects of counseling, bereavement, and support at the end of life provided by inter-disciplinary professionals such as nurses, social workers, counsellors, and nutritionists. The residential hospice, or simply hospice, will refer to the physical building in which these services are made available to the patients and their families.

Palliative care has changed the hopes and expectations around dying, presenting a new art of dying in the modern age. **Part I: Ars Moriendi** will explore the Art of Dying prior to the introduction of hospice palliative care. It will address the evolution of death rituals and acceptance in Western society, and track the social changes that occurred as a result of tradition or ceremony. This will lead into a discussion about the architectural responses to human innovation in healthcare and medicine, and the control it afforded over prolonging life and delaying death. The effects of medical developments and institutionalized hospitals are then described in terms of their effect on shifting the emphasis away from historic idea of holistic care in Ancient Greece and towards unwavering desires to cure in the modern era.

When this mentality of cure-at-all-cost first gained momentum, the designs for health facilities were efficient, sterile, and controlled. Hospitals seemed intentionally designed to confuse patients and family members. Way-finding was based completely on signage and the number of restricted areas leaves many feeling trapped or at the mercy of such an institutional set-up. Familiarity with these labyrinthian hospitals was not comforting either, for it may have resulted from countless visits and hospitalizations due to endless treatment. Whether one had spent some or no time in a hospital, it was certainly no place to be experiencing grief or loss. Section 1.3 explores the institutional typology of healthcare facilities in terms of their appropriateness for facilitating patients in their journey for a dignified death.

Including hospitalization, the options currently available to patients at the end of life are:

- 1) Hospitalization in a palliative care unit (PCU)
- 2) Complete assisted home care
- 3) Home care with in-patient visits to a hospital
- 4) Residential hospice care.

As introduced in section 1.4, this thesis will be focused on the fourth option of residential hospice care, while acknowledging that there are advantages and preferences for the other three options. It will put forth the argument for the improvement of and greater availability for hospice care only for those who choose it or may not know that it is an option. Home care, especially, has its own merits in providing the familiarity and comforts of the home for the patient. However, some homes may not be equipped for higher levels of care due to size or location. Furthermore, those who survive the dying patient may not want the memory of death to be in the home and may choose hospitalization or hospice care for this reason alone. Regardless of the reasons for choosing a residential hospice for the end of life, this thesis aims to provide examples for, and suggestions on, what the ideal circumstances are for providing a separate home to the dying.

Part II: A Home at the End of Life will explore the challenge of designing a residential hospice that aligns the services provided to the design of spaces that support them. Generally, the shift is moving away from ‘quantity of life’ in the desire to extend it in terms of time, and towards ‘quality, of life’ in order to enjoy every moment of it. While a high and acceptable quality of life varies from patient to patient, the hospice can symbolize the shift in expectations from extension to enjoyment. The emphasis in program or space can be given to ‘softer’ elements such as communal gathering space or quiet reflection space, as opposed to the hospital model of giving the most priority to operating or imaging rooms. The place for healing is therefore returned to the patient and the person, as opposed to the machinery to sustain or ‘fix them.

Here, architecture has the opportunity to address the needs of each individual who is affected by the hospice. Due to the much smaller scale and shorter list of requirements for supporting spaces and back-of-house, which will be elaborated on in Section 2.1. The hospice typology

far more resembles that of the domestic home than the institutional hospital. The challenge is therefore to design for the services provided, while balancing the expectations and generally more sensitive nature of those using the space. On one hand, the hospice must still effectively deliver the medical support for patients at the end of life; but on the other hand, it must maintain a level of domesticity and familiarity so as not to bear reminder of a potentially grim memory associated with the hospital.

The users of the hospice are three-fold. Primarily, the hospice is built to serve patients at their end of life. However, due to their frailty – in many cases – most patients are completely bed-ridden by this point and may not leave their rooms, despite a desire to. This thesis will be focused on adult or elderly demographics, as the needs and requirements for children’s hospices differ slightly. For the adult patient, the average length of stay for a patient in a residential hospice is approximately twenty-one days, according to the Hospice Association of Ontario. This means that patient rooms are turned over more than once a month. Herein lies the crux of the design challenge: designing for liminality and temporality, which will be discussed in length in Section 2.2.

The hospice needs to be, at once, the most monumental building that will contain the lasting memories of an individual, as well as a transient place that is equally ready to be the stage for the next patient with an altogether different life’s worth of memories to hold and bear witness to. As such, the space needs to have enough flexibility to allow for personalization, without being stark and bare. All the while, it must provide a familiarity that harkens back to the domesticity of home while still being an effective space to provide medical assistance. How can the patient room set the stage for memories to be shared, made, and immortalized for one patient, and yet be prepared and reset for the next within hours? Furthermore, if a patient is mostly bed-ridden, the architectural focus shifts from the walls and ground to the ceiling, where little attention is usually paid. This is where a person may spend their remaining days. The challenge is to make the room relevant to patients of all ages, races, cultures, and backgrounds who all come with unique experiences, likes, dislikes, hopes, fears, and expectations. For some, this may be the first time they are receiving regulated medical treatment. For others, this may be the culmination of years or decades

of hospitalization. For all, the patient room is where they will likely spend the last of their days, surrounded by family and friends, or in the presence of dedicated medical personnel.

The remainder of the building serves to provide support for the caregivers of these patients, who can be divided into two categories – informal and formal. The former refers to family members or friends of the patients who are there to support them. This may include husbands, wives, mothers, fathers, daughters, sons, sisters, brothers, and/or other family members. Regardless, these informal caregivers may be there for days on end, keeping vigil by bedsides or rushing in daily before and after work. The hospice needs to provide for those who choose to be a part of the dying patient's end of life, who have either temporarily put their own lives on hold or who have adjusted to make hospice visitation a part of their daily routine. This means providing a space that is familiar and flexible for the informal caregivers as well.

The formal caregivers in a hospice include, but are not limited to, doctors, nurses, religious personnel, personal support workers, social workers, psychologists, counsellors, nutritionists, pharmacists, and therapists. These professionals are there to provide the best End-of-Life Care possible to families who elect hospice care. They are a unique group of individuals in the medical and healthcare field. While other specialties are driven to aid and cure those who are sick – with the eventual goal to restore them to health – these particular caregivers have chosen a field where the measure of success is a paradox to that typical model of care. Practically speaking, this model of care requires calibrating both their professional and emotional selves to the acceptance that most of their patient will die under their care. The existential topics discussed on a daily basis and the constant reminder of life's finitude often result in burnout, so a hospice must respond sympathetically to their delicate psychological balance. Those who work in End-Of-Life Care strive to support patients and their families towards a good death. This shifts the scope of care away from the traditional mindset of curing a patient, to accepting and embracing the fact that a cure may not provide the means to the highest quality of life for an individual. As such, the mindset of each practitioner who enters the door is that of a healthcare provider whose goals of care revolve completely around what a patient wants and needs. There the hierarchy of power is restored to its historical levels where the doctor and patient relationship was drastically different from how it is commonly interpreted in most current healthcare models.

Historically, the doctor was regarded as a public servant, bid on to serve the elite. Care of the poor or very sick was often a role reserved for the church or nurses. With the evolution of medical knowledge came power. Pharmaceutical drugs and complex operations, coupled with insurance and healthcare taxation models, put great power in the doctors' hands and patient-centred care took a backseat to billing codes and specialist designations. The cure-driven medical model contributed to the perceived ego of the cure-driven doctor who 'pulled out all the stops' and was convinced 'there is always something he/she can do'. Here is where holistic patient care disappeared and focused approaches to specific organs and ailments arose. Of course, this is inarguably important and all patients have the right to seeking life-enhancing treatment. The observation is simply that palliative care physicians are among the few specialists who seemingly forgo their professional drive to cure unreservedly and allow the patient and patient's family to dictate, primarily on their own terms, how care should be delivered at the end of life.

Imagine, then, the practitioner who enters the hospice daily, knowing that their patients are dying and will die under their care. The hospice needs to reflect the extra care and fatigue involved with entering this line of work. During medical training, they promised to 'first do no harm' when taking the Hippocratic oath. How then is it possible to accept that their patients will die under their watch? Is death not viewed as the most harmful thing to happen to a patient? The role of the practitioner here is to 'do no harm' by assuaging the fear and doubt surrounding the topic. Because they cannot guarantee against it, and certainly cannot avoid it at this point, the least harmful thing to do is provide reprieve and comfort to the patient until it happens. Hopefully, but not always, the patient and their family will have accepted the eventuality of death and the transition is without conflict. However, this is not always the case and often the family, in fact, continues to push and deny that the patient is dying long after the patient has come to terms with it. Many family members continue to believe, with good intentions, that more can be done to elongate their loved one's life through curative methods. While this may be true in some cases, often intervention at this stage could have the opposite effect and result in accelerating death or heightening pain levels.

Here, the physician's role is to balance the expectations and wishes of both the patient and the family. This is certainly a difficult job with just one patient. However, in a hospice, this role is multiplied over five to ten patients, each of whom is convinced – with every right – that their situation ought to receive the most attention. As such, this job can cause fatigue and emotional burnout, so the hospice must serve to alleviate that whenever possible, by providing protective and restorative spaces to retreat to. Further, one must keep in mind the fact that while the patients and families are constantly rotating in and out of the building, this place is their daily reality. Supporting those at the end of life is a noble duty and the hospice ought to reflect the humility and strength of those who choose to answer its calling.

The building must provide for all caregivers, and Section 2.4 explores the numerous studies that took place prior to positing a final design for the hospice, given the emotional and practical complexities of End-Of-Life Care. There was great difficulty in choosing a site, for the argument begins with an acknowledgement that there are not enough hospices in Toronto to begin with. As such, a hospice would be acceptable for many locations and sites. Similarly, the form and architectonics for the hospice were explored through several iterations on various sites, whose suitability was determined based on the requirements set forth in the previous section.

Part III: 1 Riverdale Lane represents a synthesis of many iterations and a site that was most conducive to presenting a feasible and practical built option. The site chosen is part of a master redesign of the Bridgepoint Hospital complex at Broadview Avenue and Gerrard Avenue. The specific parcel of land chosen is undesignated in the master plan and is zoned for an eight-to-ten storey mixed-use building. Further elaborations on the site will be presented in Section 3.3. The hospice is presented as a built form, which stands as a representation of how society is evolving in its treatment and acceptance of caring for those at the end of life. It serves as a stepping stone in understanding the broader implications of promoting hospice palliative care in order to embrace and support dying patients and their caregivers. After all, society builds what it values. If more hospices are built, it stands to reason that we have increased our value in those who are dying by giving them beautiful spaces purpose-built for them to receive optimal care in their final days. This is a thesis about Our Last Home.

PART 1
Ars Moriendi

1.1 FEAR: Our Death-Denying Society

While the main focus this thesis is on the joys of life and living, it seems impossible to do so without also mentioning the feared and threatening antithesis of death and dying. However, it can be argued that it is becoming evermore possible and expected in the Western world to physically live without the mention or reminder of death in our day-to-day lives, earning us the label of a ‘death-denying’ society.^{1 2}

This was not always the case and in many parts of the world, death still plays a significant role in daily life. Before the evolution of modern medicine and the ability to reverse the effects of disease to near-perfect health, death was not questioned. Death was understood as a part of daily existence. As mankind developed, so did the existential need for religious figures, spirits, and gods who were linked to death. Our early ancestors attributed the rights and powers of death to a higher being, rendering themselves at the mercy of their wishes.



Fig. 1 Beata Ludovica Albertoni; Bernini, 1671.

This image highlighted the mysticism and romanticised ideas of mystical death popular in the Baroque Era.

In his book *Western Attitudes Towards Death from the Middle Ages to the Present*, Phillipe Ariès gives an extensive overview of this evolution. Briefly, he identifies five basic understandings and attitudes towards death: tame death, death of the self, remote and imminent death, death of the other, and forbidden death.³

The 'tame death' was a reaction to the dying person's ability to understand his role in the ritual or custom surrounding death.⁴ This gave the individual a sense of purpose and reassurance that safe passage to the next world awaited upon completion of the ritual.⁵ While there are many definitions 'ritual', it can be best described as 'those acts or rites which enable one to pass through a place of time of great danger in safety'.⁶ Under this definition, it follows that these rituals were used to tame death by ridding it of its 'psychological violence'.⁷ Strength in numbers also helped to decrease its impact during the Middle Ages, when cemeteries and memorials became open and public, encouraging interactions and familiarity with the deceased. An entire community gathered to mourn the loss of a fellow member, which helped to remind and comfort all about their own eventual death.⁸

'Death of the self' suggested a shifted focus on the individual as a culmination of sins and failures, which could undoubtedly jeopardize the promise of a blissful after-life. The threat of Hell made death the portal to punishment for eternity, based on the sins committed in life.⁹ However, death was still not the enemy, but the means for judgment to occur. As such, it held extreme and eternal power as a time to be avoided in case one was not ready to account for their wrongdoings.

Over time, privatization of the grieving process and the relocation of cemeteries outside of the city led to a disconnection from death in daily life.¹⁰ 'Remote and imminent death', followed by 'death of the other' appeared to be the basis for much of the lack of communal grieving and support seen today. Evidence of this separation of death from the community could perhaps best be seen in the reaction to the carnage of World War I. Through the war, death became shameful to be associated with, as a blight on our collective consciousness. Death became forbidden and something to be hidden from others: a taboo.¹¹

Another by-product of the war was the advancement of medical technologies and treatments. Now, death appeared to be controllable – or, at the very least, temporarily avoidable. Man’s ability to control and alter his biological destiny was a turning point in the understanding of the ‘death-denying’ Western society.

Arguably, these were the medical advances that gave death its role as ‘the enemy’. Now, miraculous cures were available outside of the church and man gained control of his own destiny. With the introduction of modern medical cures, vaccinations, and operations, we developed a sense of entitlement to living beyond the natural biological progressions of our bodies. Further separation into availability of medical assistance based on income and status stratified the population, resulting in a gradient of those who could and deserved to live longer, and those who did not. Undoubtedly, these inventions and discoveries were paramount markers of human intellectual achievement. Controlling, escaping, avoiding, and prolonging the eventuality of death therefore became the central tenet of modern medicine.

As a result, our vocabulary surrounding the topic became stifled and apologetic. Physicians were expected to begin with, ‘we have bad news’ before prognostication. It, in fact, is not ‘bad news’ because it should not be a surprise to anyone – for we are all dying. This news, in fact, should have been understood as the admission on the doctor’s part that they did not believe any further treatment should be attempted. Instead, they were relinquishing any responsibility in the process, leaving death itself as the culprit upon which to blame a patient’s fate.

Instead, of looking for a suitable scapegoat, palliative care aims to give some control and empowerment back to the patient in allowing them to choose to continue living, while re-calibrating hope for a cure with hope for the best possible life before death. As such, this thesis echoes those goals, by becoming a part of the cultural shift away from viewing death as an enemy. By essentially ignoring the fear it has instilled in humans for countless generations, it can then be loosen its paralyzing grip to allow us to properly address the other, more human and immediate, aspects surrounding the end of life.



Fig. 2 Mass Graves of World War I

These were haunting and overwhelming reminders of the loss of human life and the shame surrounding war.

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1.2 CONTROL: Hospitals and Curative Medicine

Care of the sick and dying has a long history that dates back as early as 1200 B.C.¹² Before institutions of the modern sort were introduced, Greek temples were sanctuaries for the body and soul. 800 years later, in 400 B.C., the now-famous Hippocratic oath that all medical professionals take of “First, do no harm”, was introduced into the psychology of care.¹³ However, the emphasis was not on the intervention-based curative medicine that we know today, but a holistic treatment of the entire person. It was more focused on exposure to ;fresh air, sunlight, rest, baths, exercise, and a reasonable diet’.¹⁴ These places were seen more as baths and spas than a more modernized concept of an institution. The Temple of Asclepios, 400 B.C., pictured right, was a prime example of the typology of the healing temple of Hippocrates’ time.

Just 200 years after the temple was built, healers in India were advancing the standards of care well beyond the Greek and Egyptian practices, introducing intricate surgery and advanced medicinal prescriptions. The Hindu physicians worked in what is known as, ‘the most advanced hospitals of the ancient world’¹⁵ and increased the length of stay capacity to include overnight accommodations with the appropriate attendants to continue caring for the sick.



Fig. 3 The Healing Temple of Asclepios; 400 B.C.

It is heralded as one of the earliest iterations of our current definition hospital design. The Greeks were very focused on a holistic approach to healing.



Fig. 4 Hotel Dieu Hospital, Middle Ages.
The sick and dying were often housed more than two to a bed in dark and cold conditions with few windows and poor ventilation.

In Europe, the focus on ‘treatment’ was generally waived, in favour of providing accommodation and spiritual healing for the sick instead. Hotel-like places were often erected in close proximity to churches, to allow for shelter as well as care provided by the priest on-site. The emphasis on spiritual healing was consistent throughout the design of most modern European hospital wards. Often, the large open wards featured chapels and an altar, enabling patients to be spectators during the religious services that took place.¹⁶

One of the greatest turning points in the history of modern hospital philosophy happened during the Renaissance when the term ‘hospital’ was first introduced.¹⁷ Derived from the Latin term *hospes*, meaning “host” or “guest”, the hospital began to separate itself philosophically and physically from the Church. The first hospital to closely resemble today’s institutions was the Hotel Dieu in Paris, founded by Saint Landry in 651 A.D. Its accomplishments were many, as it established a new standard of space in which to practice medicine. It was the first to separate and classify patients based on illness, severity, and gender, as well as organize medicine into various departments. However, its shortcomings could not be overlooked, as every ward was not created equal. As seen left in the painting by Jean Henry in *Livre de la Vie Active*, we can see that those who were dying or of poorer economic status were confined to dungeon-like quarters, often sharing two to a bed.¹⁸ French philosopher Michel Foucault later perpetuated this bleak picture of the hospital, describing the Hôpital Général de Paris as ‘the great confinement’.¹⁹

Still, the Hotel Dieu model was so successful that few changes were seen for an entire century in Europe, until the Protestant Reformation in the 16th Century when privatized institutions were favoured over Catholic, religiously-affiliated accommodations.²⁰ Meanwhile, in England, designs were becoming more Palladian,²¹ re-introducing the symmetrical and Classical orders of Greek and Roman temples. Also important to the Palladian design was a connection to nature and sunlight, a vast departure from the dark monastic quarters of earlier centuries.

The next factor to noticeably affect the hospital was war. Military and navy manpower resulted in a surge of English hospitals. Simultaneously, ground-breaking medical theory gave way to the re-introduction of the need for fresh and clean air in the institution. While this was intuitive for the Greek baths, air quality and the eventual spread of *malaria* (the Latin terms literally describing ‘bad air’), saw the development of a series of detached pavilions connected by an open arcade as exemplified by the Admiralty Hospital. ²² Maximum exposure to natural ventilation and thus sunlight were re-instated as important design features.

The 18th century was not only a turning point for the physical hospital, but also saw a change in the whole profession of medicine, in that the role of the doctor changed from being a beckoned tradesman for servicing the elite at their homes, to a sovereign profession in the treatment of patients in the institution of a hospital. ²³ With an increase in control over the patient, their symptoms, and their treatment, medical advances progressed rapidly towards empirical (evidence-based) medicine.

Inevitably, developments in modern medicine resulted in a new philosophy of dying. While the physicians and medical practitioners improved their craft by curing and thus ‘saving’ an increasing number of patients, death was inevitably viewed as a failure. This idea ultimately extended from failure on the part of the physician to properly treat and cure, to a failure on the part of the patient to pay for appropriate services, to failure on the part of the institution to provide an adequate environment for treatment.

Before curative medicine was developed, the sick and dying were one in the same, and care followed suite in terms of caring for the whole person and providing comfort. However, as hospitals gained hold and the classification of patients became more prevalent, the term of ‘dying’ applied to those for which ‘no more could be done’. This was a devastating by-product that was both foreseeable and unfortunate. Medicine and medical advances represented hope. By logical contrast, dying represented a loss thereof, and suddenly the physicians’ roles changed from being a clinician focused on holistic treatment, to a results-driven technician.

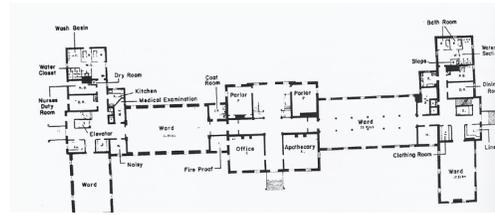


Fig. 5 Pennsylvania Hospital, First Floor Plan; Not To Scale
An example of Palladian control and authority in design. This model stood as much for regulation and correction as it did for health.

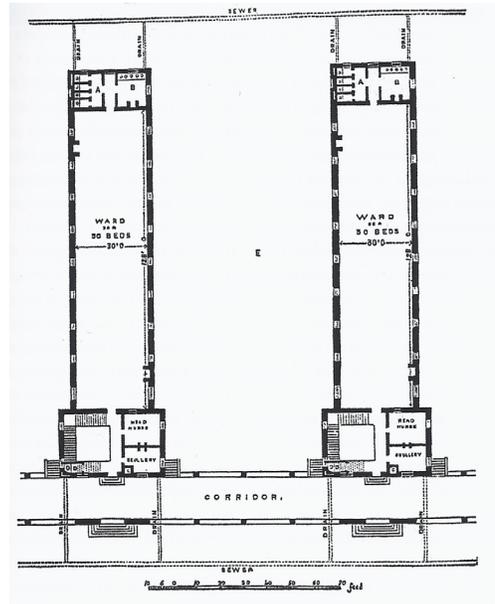


Fig. 6 The Nightingale Ward in Plan; Not To Scale
A long rectangular corridor of 15 beds per side for a total of 30 beds per ward, preferring nursing efficiency to patient privacy.

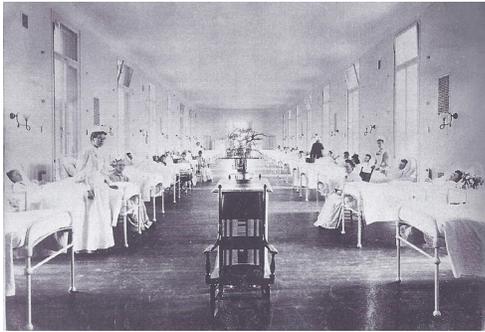


Fig. 7 Women's Ward, Royal Victoria Hospital.
This was an example of the Nightingale concept of an open ward with a focus on observing and regulating the patients, instead of preventing infection or the spread of disease.

It was then, just as this attitude began to cement itself, in the 19th century, that the concept of 'hospice' came into being. In 1879, a hospice, stemming from the Latin word *hospitum* meaning guesthouse, was opened by the Irish Sisters of Charity at Harold's Cross in Dublin. In this facility, care of the sick and dying once again became a religious and charitable endeavour.

"No one comes here expecting to be cured, nor is it a home for incurables, as the patients do not look forward to spending years in the place. It is simply a 'hospice' where those are received who have very soon to die, and who know not where to lay their weary heads"²⁴

Since the late 1800's, Florence Nightingale was celebrated for her contributions to the profession of nursing. Her uncompromising view of accessibility to patients for the best nursing practices resulted in similar open wards to the pavilion design. Her vision led to another layer of design sensitivity, where "the design of an ideal hospital for Nightingale was bound up with notions of cleanliness, order, observation, and education."²⁵ Her legacy also included the new and prominent role carved out for the nurse as a professional, integral to the personalized and more routine care for patients in the hospital.

Nightingale's insistence on an open ward to encourage visibility and accessibility to all patients also extended to other institutions, especially "domestic architecture and other female workspaces, such as schools and libraries".²⁶ It has followed that nursing has always demanded an approach that valued relationships, psychological and emotional presence, and routine care reminiscent of a domestic home. In the 1900's, there was an "idea of a separate, seemingly domestic structure situated in a romantic landscape [that] was essential to the experience of the first nurses' residence."²⁷ Further to this, the domestic feel was thought to improve performance and thus patient care. Architects were, in fact, briefed on the merits for designing to this effect: "The more attractive and homelike this building can be made and the more alluring it can be made to the young woman who is taking up nursing, the better will be the class of women who will come to it and, in the end, the better will be the care that the patient will receive."²⁸ This mention of domesticity in nursing was paramount in drawing distinctions between the doctors and their associations with curative treatment and the institution of the hospital, and nurses with their associations to domesticity.

Later in the 20th Century, medical achievements were in full swing and the United States gained much international attention. The joint discoveries of penicillin by Alexander Fleming and streptomycin by Selman Waksman in the 1920's saw the celebrated introduction of antibiotics,²⁹ which caused another massive shift in the philosophy of hospitalization. Where natural air and ventilation were once viewed as improvements for health care, the influenza pandemic challenged and quashed this idea. Respiratory illnesses and airborne viruses led to the segregation and further control of patients within the hospital. Quarantine and isolation were now seen as necessities.

Once health care became efficient at stopping the spread of disease, it inevitably departed from treating the person as a 'whole' and began to classify patients in terms of body parts or identifying a person in terms of their illness. Thus, the hospital and the concept of institution took on a depressing and controlling raison d'être. Hospital design was ceremoniously stark and sterile for the greater part of the twentieth and twenty-first centuries.³⁰ Concepts such as 'de-humanization'³¹ and simple being a 'number' on a hospital conveyor belt³², began to emerge from these 'factories of health'.³² Above all, one thing was certain: the hospital had its own mythology. "The needs of patients – once perceived as primarily emotional, now seem as psychosomatic, tightly bound to overall well-being – have come to coexist (often uneasily) with the design demands of technology.", write Richard Miller and Earl Swensson, architects and authors of *Hospital and Healthcare Facility Design*. Another architect, Ian Clarke, described hospitals as "exercises in sensory deprivation...singled out for contributing so much to feelings of despair and hopelessness".³³ Finally, attention was being brought to the emotional effects of healthcare facilities, as equally important compared to the practical efficacy.

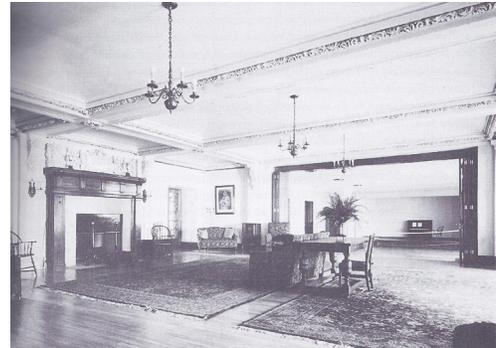


Fig. 8 Nurse's Residence, Living Room

This generous area promoted socialization and a more feminine touch., highlighting the distinction between doctors and nurses at the time.



Fig. 9 1918 Flu Epidemic Emergency Hospital Camp Funston, KA. The open warehouse concept of housing the sick in these times became part of the mythology of institutionalization and dehumanization of patients.

In his award-winning book ‘Facing Death’, medical author Dr. Howard Spiro wrote this on dying in the hospital:

“Few can turn quietly to the wall and go peacefully. For one thing, hospitals are too expensive a place to await a quiet death. For another, we doctors and nurses are not good at waiting. Our house staff are young and confident, eager to prove their mettle. In intensive care units the dying find no rest, but are kept in motion by machines blowing up their lungs and beating their hearts; electrical connections sometimes seem more important than the bodies they serve. There are few words from dying patients because most have tubes in their throats; the staff are too busy shouting orders to hear them anyway.”

-Appears as cited in *Modern Hospice Design*, 93.

Given such a negative collective memory surrounding the hospital, how could we think that it is an adequate or appropriate place to die?

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 33. *ibid*

1.3 BATTLE: The War on Cancer

One of the most significant influences on hospital design has been the focus of Western society on the ‘fight’ against cancer. Due to its increasing pervasiveness that claimed the lives of a reported 7.6 million in 2008, according to the World Health Organization ³⁴, fighting it at all costs has become the most important goal in its reduction.

Since, 1971 when former U.S. President Richard Nixon announced that we are fighting ‘the war on cancer’, we have accepted a metaphor that invokes negative connotations of waging battles against one’s own body. In the February edition of the New Yorker, Dr. Atul Gawande wrote an article on the difference between palliative care and curative medicine. It provided rare insights on when the ‘fighting’ is too much. As a surgeon, he epitomizes curative medicine where “the goal is to extend life, [sacrificing] the quality of your existence now – for the chance of gaining time later.” ³⁶ He goes on to say. “We imagine that we can wait until the doctors tell us that there is nothing more they can do. But rarely is there nothing more that doctors can do. There’s always something. We want these choices. We don’t want anyone to limit them.” ³⁷



Figs. 10 & 11 Hope and Loss in the War Against Cancer
 TIME and Fortune Magazine Covers portraying the War on Cancer. This type of editorial slant is at once inspiring for those who choose to fight, but creates a sense of shame for those who do not.



Fig. 12 These are the Bullets in the War Against Cancer
 The overt metaphor of fighting, battling, and wining or losing a war is never far away when describing our efforts with Cancer treatment.



Fig. 13 No Matter What: Fight On
 This billboard ad sends the message that a cure should be sought after at all costs. While this is a hopeful message promoting human innovation and medical expertise, it marginalizes those who no longer seek curative treatment.

The desire to have choices is certainly understandable and palliative care still provides a stage where many choices are still necessary to be made; end-of-life care simply proposes different goals. Palliative care encourages the idea that quality of life should not be sacrificed for quantity of life, despite the fact that quantity may appear limited.

While a balanced position would seek curative methods to every extent possible, for some, there is a comfort in seeking an alternative where suffering is minimized and the agony of ‘being a burden’ on one’s family can be released. The difficulty here is that “arriving at an acceptance of one’s mortality and a clear understanding of limits and the possibilities of medicine is a process not an epiphany”³⁸ and as such, time is of the greatest importance, yet in shortest supply. Certain dangers arise when we are racing against the clock, because “when we imagine ourselves as having much more time than we do, our every impulse is to fight, to die with chemo in our veins or a tube in our throats or fresh sutures in our flesh.”³⁹ This is not an ideal way to see a family member’s final moments. Important questions should be asked at the beginning of treatment, to help clarify the clashes in opinions that family members or powers of attorney have with the patient and the physician, in terms of continuing to ‘fight’.

The answer to “What level of being alive is tolerable to you?”⁴⁰ should determine the courses of medical action. In fact, often it is the patient’s families or loved ones who encourage all forms of treatments to be pursued, even when the patient themselves have adjusted to a new set of hopes and expectations for their remaining days that may not include treatment.⁴¹ This brings to light the well-intentioned, though often conflicting points of view that patients have with their family members. For the family, their desire is to spend as much time with their loved one as possible. Prolonging life, for them, results in an increase in time spent with the patient. To the family, more treatment is synonymous with more time. This is especially true with families who are faced with death for the first time. Often, it is easier to allow the natural courses of illness to continue if and when a ‘full life’ has been lived. In the example of older adults who have reached or surpassed the natural life expectancy of seventy-nine for men and eighty-three for women in Canada,⁴² electing to discontinue curative medicine, when it is no longer beneficial to the current well-being of the patient, appears easier to do.

According to “A Guide to Advance Care Planning”, Advanced Care Planning is about “making choices now, while [the patient is] capable, about how [they] wish to be cared for in the future if [they] become incapable of making decisions”.⁴³ Determining some courses of action in advance, before the stress and crisis of facing death is immediately at hand, helps to alleviate some of the conflict that arises where a patient’s family may raise concern over their loved one’s ability to make coherent decisions and step in to inadvertently make undesirable decisions on their behalf. During these discussions, the use of jargon can strongly skew the direction of a conversation and must be carefully considered. Since 2000, much debate has arisen over changing the protocol from assigning “Do Not Resuscitate” or “DNR” to a patient’s advance care directives to the alternative phrase of “Allow Natural Death” or “AND”. According to an article appearing in the Journal of Emergency Nursing written by Crissy Knox titled “Allow Natural Death: A More Humane Approach to Discussing End-of-Life Directives”, the AND status is presented in a way that is ‘more suitable for patients and families’ due to the focus on the positive action of *allowing* natural death instead of the negative language of *do not* resuscitate.⁴⁴

Researchers from the Departments of Psychology and Biology at the University of Houston-Victoria also conducted a study highlighting the different attitudes resulting from changing the DNR status to AND, reporting that “simply changing the title of the medical order from DNR to AND increased the probability of [its] endorsement”.⁴⁵ This is due to the association of family members that giving consent to DNR is synonymous with giving consent to terminate a loved one’s life. Changing the order from “Do Not Resuscitate” to “Allow Natural Death” makes the order less threatening and more descriptive during a highly emotional situation, which aids in ensuring the desired care for the patient.⁴⁶ According to Knox, “[The] patient’s family will spend a lifetime remembering and regretting the conversations and decisions of that day”.⁴⁷ It is therefore invaluable to have an environment both of open communication and design that decreases the levels of stress and confusion that already surround the discussions of end-of-life care. In fact, this environment should also encourage discussions pertaining to end-of-life care, whether they are questions, fears, stories, or open denial of the situation.



Fig. 14 Maggie's Centre Dundee

Designed by Frank Gehry, this particular Centre has become somewhat of an icon for the movement where the cause has attracted the attention and talent of many celebrity architects.

Maggie's Cancer Care Centres in the United Kingdom have risen to the occasion by providing places for those who find themselves faced with the prospect of 'battling' any form of cancer. The first Centre was built in loving memory of Maggie Keswick, the late wife of British architect Charles Jencks. He described the evolution of these buildings in the book *The Architecture of Hope* as beginning with a response to the hospital's 'cramped cell' and its negative association with her 'affliction and the chemotherapy'.⁴⁸ Both graduates of the Architectural Association in London, they embarked on their shared vision of a new built environment specifically for cancer patients that would "acknowledge their plight and affirm their worth, [especially] in a culture where cancer is usually hidden."⁴⁹ The results were all sorts of forms that took into account countless metaphors about illness, life, death, and depression, who "mixed in functions and moods [as] a cross between several existing [building] types."⁵⁰

This new and unique building type was described by Charles Jencks, in fact, as a "non-type...a house which is not a home, a collective hospital which is not an institution, a church which is not religious, and an art gallery which is not a museum". Instead, he referred to the Maggie's Centres as a combinatory hybrid of all these existing types.⁵¹ Regardless of their lack of specific building type classification, they were successful in helping those afflicted to simply forget about the turbulent and uncertain waters of being affected by cancer that the "borrowed fluorescent place"⁵² of a hospital bed served as a reminder of, in so many hospitals around the world. To be exact, the architectural brief for the first Centre read as such:

"We need our buildings to feel safe and welcoming. They need to be small and domestic in scale. On the other hand these little buildings should not pat you on the head, patronize you by being too cosy. They should rise to the occasion, just as you, the person needing help, is having to rise to the occasion of one of the most difficult challenges any of us is likely to have to face."⁵³

Their design request was answered by architect Richard Murphy, whose response was “a set of intimate spaces, with light and views penetrating in unexpected places...[like] the tight-layered space of a Chinese garden crossed with high-tech jewelry.”⁵⁴ This was an optimistic image, that spoke to the fussy and idiosyncratic ways of individual human beings. It seemed most appropriate in a place that supports such a multi-dimensional, multi-faceted disease such as cancer, to share the same characteristics as a late-Victorian house with its ‘tight, surprising corners and ambiguous overlapping spaces.’⁵⁵ This addressed the need for informal breakout spaces and quiet nooks to have private thoughts, appearing as a building within a building with many little niches and intimate places.⁵⁶ Here, family and friends could gather and share information and experiences around the process of cancer treatment continuing to lead social lives during a time when time alone is often welcomed.⁵⁷ The interesting design challenges and hope-inspiring cause attracted the design talents of many celebrity architects such as Frank Gehry, Daniel Libeskind, Zaha Hadid, Rem Koolhaas, and Kisho Kurokawa, who all contributed designs for centres in other parts of England. Maggie’s Cancer Care Centres were now synonymous with good design, which is a notable feat for a building that did not provide treatment facilities or living accommodations.

Maggie’s Centres provided a new, architecturally whimsical answer to the question plaguing many hospital architects who were challenged with the new rising concept of ‘evidence-based design’ in whether or not buildings could contribute, measurably, to a patient’s recovery. Jencks mused on the topic that “Architecture is never as clear-cut as a clinical outcome, yet it is surely pure common sense that a pleasant environment is conducive to recovery.”⁵⁸ Jencks suggests that a Maggie’s Centre is comparable to an ‘architectural placebo’⁵⁹ where the psychological benefit is greater than any measurable physiological effects.



Fig. 15 Maggie's Centre Glasgow

The warmth created by providing spaces for people to gather for informal chats and have a cup of tea were great contributors to the successes of this centre.

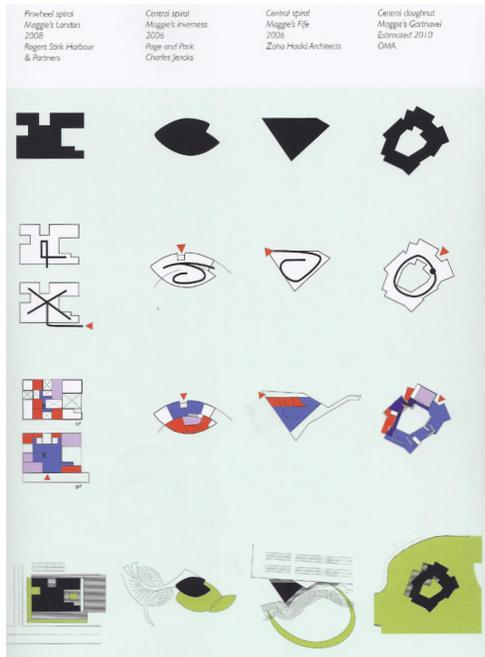


Fig. 16 Maggie's Centres in Plan
 Above are dissected plans of some Maggie's Centres, done by Lily Jencks. They are categorized, from top to bottom, by formal type, circulation, programming, and situation on site.

Lessons to be learned from Maggie's Centres:

- 1) Central locations in major cities such as London and Edinburgh that allow the centres provide a good range of accessibility around the country and visibility within the community
- 2) Allowance for a multitude of functions without appearing fragmented or lacking inner logic by having plans that encourage continuous circulation with varied programs surrounding it
- 3) The importance of having central gathering spaces for impromptu sharing and discussion
- 4) The description or suggestion of a new building typology referred to as 'the hybrid building'

Maggie's Centres are a slight departure, however, from the hospice typology in one fundamental way: the emphasis on 'fighting' the disease. While curative cancer treatment should almost always be explored, it must be re-clarified that the hospice is for patients who have already decided – for their own reasons – to stop fighting. Therefore, the hospice does not serve as a battleground or as the 'trenches' to "look for allies in the war" with an 'army of doctors'.⁶⁰

Instead, the building must communicate the right message of empowerment rather than stand as edifice to a community-in-arms relentlessly fighting against the mortal enemy of cancer. The hospice should be a subtler place for those who have laid down their arms and, after countless battles, irreversible fatigue, and physical deterioration, must find a place rest their heads and allow their overworked cavalry to stop and replenish because their own fights are far from over. After intense hospitalization, it was architect Alvar Aalto who said that "Architecture should defend man at his weakest".⁶¹ The hospice is a sympathetic and nurturing building that protects the patients and their families during a time when they have made an overwhelming decision that defies the main drives of society, modern medicine, and human logic, in electing to stop all measures of countering a fatal disease. It must therefore provide this protection, extend its sympathy, and hand control back to the patient who has long been at the mercy of disease, by saying, "It's OK to let go. You don't have to fight anymore."⁶²

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 35. Jencks, C and Heathcote, E. *The Architecture of Hope* (London: Francis Lincoln Ltd. 2010) p. 7
 36. Gawande, A. "Letting Go" *New Yorker* Aug 2, 2010. p. 41
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 38. *ibid* p. 47
 39. *ibid* p. 45
 40. *ibid* p. 47
 41. *ibid* p. 48
 42. "Life Expectancy at Birth" *World Health Organization*. http://www.who.int/gho/mortality_burden_disease/life_tables/en/ (accessed October, 2012)
 43. "A Guide to Advanced Care Planning" *Government of Ontario* <http://www.seniors.gov.on.ca/en/advancedcare/docs/AdvancedCare.Guide.pdf> (accessed October, 2012)
 44. Knox, C. et al. "Allow Natural Death: More Humane Approach to Discussing End-of-Life Directives" *Journal of Emergency Nursing* December, 2005. p. 560
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 46. *ibid*
 47. Knox, C. et al. "Allow Natural Death: More Humane Approach to Discussing End-of-Life Directives" *Journal of Emergency Nursing* December, 2005. p. 561
 48. Jencks, C and Heathcote, E. *The Architecture of Hope* (London: Francis Lincoln Ltd. 2010) p. 6
 49. *ibid*
 50. *ibid* p. 13
 51. *ibid* p. 14
 52. Gawande, A. "Letting Go" *New Yorker* Aug 2, 2010. p. 39
 53. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 41
 54. Jencks, C and Heathcote, E. *The Architecture of Hope* (London: Francis Lincoln Ltd. 2010) p. 27
 55. *ibid*
 56. *ibid* p. 97
 57. *ibid* p. 21
 58. *ibid* p. 80
 59. *ibid* p. 91
 60. *ibid* p. 20
 61. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. i
 62. Gawande, A. "Letting Go" *New Yorker* Aug 2, 2010. p. 49

1.4 RIGHTS: Dame Cicely Saunders

Prior to the creation of the first modern hospice as we know it today, two important pre-cursors were established in England. The first was Harold's Cross, which was the first hospice to actively make efforts to counter the 'cold and impersonal' feel of the hospital.⁶³ Its roots were humble, with meager funds raised by donations predominantly from the poor, hoping that one day they would lay their heads to rest there. For them, a stay in the hospice was likely regarded as luxurious, and something to be coveted at the end of life. The hospice was set up, and consequently run by the Religious Sisters of Charity around the time of a Tuberculosis epidemic in the late nineteenth century and was established as a place that took no issue to admitting patients with imminent mortality.⁶⁴

Harold's Cross was followed by Trinity Hospice, established in 1891 with the help of notable royalty such as Queen Alexandra, Princess of Wales. With her help, the hospice grew and thrived and expanded its community presence. By the 1900's, the hospice as a specialized building type in terms of its services, was becoming widely accepted

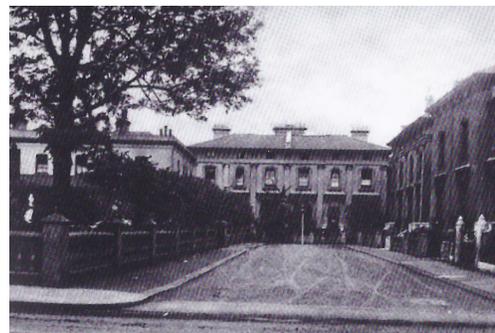


Fig. 17 St. Joseph's Hospice, London; 1907.

This particular building was a pre-cursor to the modern hospice. Here, patients could walk around the gardens and receive end-of-life care.

in London's urban fabric. The ideology surrounding care for the dying was also improving as a result. At the time, Trinity Hospice was one of the first places designated for end-of-life care that had accessible gardens for the patients.⁶⁵ It represented a place that held its patients in such high regard as to provide them with gardens -- a commodity that many did not receive in hospital. Shortly after, St Luke's Home for the Dying hosted a young social worker named Cicely Saunders who would single-handedly change the conditions for dying patients and begin the Modern Hospice Movement.

While pursuing medical school in order to gain recognition and professional clout when speaking to colleagues, Ms. Saunders befriended a particularly influential patient, whose comments inspired her to finally act on years' worth of observations on the insufficient care for dying patients. His name was David Tasma, a Polish refugee who spent much time talking to his benevolent social worker, Ms. Saunders. He often spoke of his isolation and pain, lamenting the inhumanity of dying in this state. Together, they imagined "a house where people could find relief from pain, where they could meet with encouragement for self-awareness and socialization, and where the setting with be uplifting, not depressing."⁶⁶

After other experiences with patients complaining of pain at the end of life, Saunders devoted herself to researching pain control at St. Joseph's. Here, she met another memorable patient whose death coincided with that of her own father, which launched her into a grieving state that was only ended when Saunders opened her own institution. She was driven to build a place devoted to the care of cancer and terminally-ill patients, calling it St. Christopher's Hospice. It officially opened its doors in 1967.⁶⁷ Located in the small suburb of Sydenham, St. Christopher's Hospice quickly set in motion a 'major new international hospice initiative'⁶⁸ after a wealthy businessman was so touched and impressed by the treatment his father received under the care of Ms. Saunders that he became involved in the inception of another hospice close by in Dartford. After that, he took his inspiration abroad to mainland Europe as well, spreading the philosophy of care beyond England's borders to Moldavia, Serbia, and Romania.⁶⁹

St. Christopher's Hospice was the first purpose-built hospice and it stood as a representation of a new type of holistic treatment for the dying. Its saw-tooth façade became an iconic image of a new direction for building spaces that suited the needs of those at the end of life. The design allowed for daylight to enter a patient's room from various directions. However, beyond the architectural techniques used to create a better environment for dying patients' last days, St. Christopher's was an edifice to a new philosophy of care that focused on dignity and comfort. This was a paradigm shift from the centuries of neglect that dying patients experienced before. Instead of relegation to back, unused hospital rooms or crypts of churches, the dying now had a place to go for care that was specially catered to their needs. Saunders' work was so revolutionary that twelve years after the inception of St. Christopher's, she was honoured with the title of Dame and the prestigious Templeton Prize for founding the hospice and palliative care movement.

The philosophies of care could simply be described as services or goals of care for the dying, but Dame Cicely Saunders enlivened the cause with a building that stood as a symbol and landmark for this radical new way of approaching death and dying. Her humanity, personified in her hospice, set the example for all hospices to follow. Her message was simple and powerful: "You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but to live until you die."⁷⁰



Figs. 18&19 St. Christopher's, Sydenham
This iconic saw-tooth façade allowed natural light to enter the patient rooms from two directions. The inviting front entrance also helped to ease anxieties surrounding the end of life.



Fig. 20 Not Enough Hospice Beds in Ottawa

Rosa Loranger, 98, was moved from hospital to a long-term-care facility in Ottawa without palliative care available to her. With only nine beds available at the May Court Hospice and thirty-five at the Bruyère Palliative Care unit, it is unlikely that she would receive the care necessary to ensure a comfortable and dignified death.

GOALS OF CARE FOR THE DYING

Assistance in developing and finalizing documents pertaining to terminal care information that will be accurate, timely, and reliable.

Communication that is timely, honest, and open with family, friends, and caregivers; people who will listen. Opportunity to discuss their impending death (if desired) with selected family and caregivers.

Excellence in delivery of physical care, comfort, privacy, intimacy, sleep, rest, and management of pain and other symptoms that is responsive to changing conditions.

Permission to express feelings, both positive and negative; to say “Thank you, I love you, I forgive you”, as well as to express dissatisfaction, anger, resentment.

Opportunity to explore their finiteness and spiritual dimensions of life, opportunity to discuss preferences about funeral arrangements as well as the impact of dying on survivors.

Time to reflect on the implications of the diagnosis and prognosis, to identify and attend to thoughts, feelings, and needs, time to tell their story, to re-affirm their identity and value in their life. Time to reflect on and to grieve prior as well as current losses. Time with selected family and friends. Time to attend to unfinished personal business. Time to plan for distribution of assets and to address their financial responsibilities.

These have been adapted from
The Hospice Foundation of America
“The Dying Process: A Guide for Caregivers”⁷¹

63. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 12

64. Verderber, S. and Refuerzo, B.J. *Innovations in Hospice Architecture*. (New York: Taylor & Francis Inc., 2006) p. 12

65. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 12

66. *ibid* p.15

67. *ibid*

68. *ibid* p. 8

69. Verderber, S. and Refuerzo, B.J. *Innovations in Hospice Architecture*. (New York: Taylor & Francis Inc., 2006) p. 8

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71. “The Dying Process: A Guide for Caregivers” *Hospice Foundation of America*. http://www.optionsforelder-care.com/elder-care-books-and-articles/hospice_end_of_life_manual.pdf (accessed June, 2012)

1.5 LEGACY: Lives Lived, Stories Told

These next two narratives are based on patients whose stories were collected over the last year as part of this thesis research. They serve to illuminate the unique perspectives of patients and their families regarding the end of life. They briefly describe the lives of two patients who would have benefited greatly from the care and environment of a residential hospice. The story of Jackie portrays a young family where one of the parents is enduring a life-limiting illness who now has a shortened life expectancy and experiences debilitating pain. The story of David paints a picture of an elderly man in a retirement home who has a slow-reacting cancer, but has lost the emotional support of a deceased spouse, and who has no children to visit while he slowly dies in isolation. Unfortunately, both of these stories are heard and experienced many times by palliative care physicians treating patients at home or in the hospital, when a hospice is the better alternative. The end of life should be as much a part of a person's legacy as the rest of their life. Hospices provide the opportunity to facilitate that and more.

JACKIE

Jackie came to Canada in 1994 as a refugee after fleeing the genocide that was happening in Rwanda. She and her husband spent some time apart before reuniting in Canada, as he took a more complicated route through Germany as a student before his immigration was completed. Jackie was an accountant and her husband Derrick was a professor. Many of their family members died in the war and the two promised to make the most of their good fortune of finding refuge in Canada to start their lives anew. Though each were in their late-thirty's, Derrick found work at a factory producing automotive parts and Jackie abandoned all her professional training to start anew as a nursing student. In this time, their own family grew to include two twin boys and a younger girl. They moved to a small house, close to the twins' school and with access to decent public transportation. Derrick would take the boys to school, while Jackie looked after their daughter Abby on the days she did not have clinical training.

One January morning, last winter, Jackie was having consistent lower-back pain. Relying on her training, she quickly came up with an explanation based on having strained her back carrying groceries on the bus the week earlier. However, the nagging pain soon could no longer be ignored and Derrick convinced her to finally go see her family doctor. She diligently reported the lack of any other symptoms that would result in anything beyond the need for some mild painkillers. Having successfully convinced her family doctor that there was nothing to be overly concerned with, Jackie went back home and started to take a controlled regiment of pain-killers.

Not even a week later, Jackie was unable to get out of bed without wincing and Derrick brought her to the Emergency Room of the local hospital. Upon admission, Jackie was wheeled to the oncology floor on suspicion of cancer. Jackie assured all involved parties that there were no other signs pointing to this diagnosis. She was not experiencing any weight loss or a decrease in appetite – it was only pain. After all, she was a nurse and who knew her body better than herself? After a CAT scan revealing large metastatic tumours and an inconclusive biopsy of her lower-back tissue, the oncologist voiced his strong suspicion that Jackie had pancreatic cancer. To Jackie, this diagnosis made no sense, due to a lack of other symptoms, but the active treatment suggestion was to proceed with targeted chemotherapy towards pancreatic cancer

while keeping her under surveillance for further symptoms for the next week. Still without a definitive biopsy, the tumours appeared to respond to the chemo and began to shrink. The oncologist called a Family Meeting with Derrick and Jackie to explain the treatment plan for her pancreatic cancer, consisting of chemotherapy sessions every three weeks, with follow-ups and check-ups.

During this week, Derrick visited Jackie often in her shared hospital room and told her repeatedly that they would get through this. Not wanting to concern him with the severity of the diagnosis, Jackie smiled and nodded every time he suggested that she would recover. However, hours alone in the hospital bed gave her time to think and come to terms with the fact that she would succumb to the cancer and die from it sooner than Derrick would be willing to accept. She knew that pancreatic cancer was nearly always fatal and she accepted this very quickly. She simply hoped that the pain would be kept to a minimum as the disease ran its course. A week later, Jackie was discharged with an “outpatient” treatment plan and a chemotherapy schedule.

Life returned to normal for a brief while. Jackie and Derrick had agreed not to tell their children, so as not to scare or worry them about her diagnosis. Jackie was able to return to her studies for a few months while the chemotherapy was successful at stabilizing the tumour growth. She was so thankful for every morning that she awoke to see her family and smiled deeply and lovingly at her children every night before they went to sleep. Every three weeks, Jackie would take the bus to the hospital, stressing to Derrick that she was capable of taking care of herself. This gave him the peace of mind that her condition was manageable and perhaps even improving. Often he would re-assure himself of her diagnosis by commenting on the fact that they were beating the cancer and that they would be stronger together for it. He could not bear the thought that after fleeing Rwanda, he may still prematurely lose his wife to an enemy he could not fight.

In late May, a spike in Jackie’s symptoms sent her back to the hospital for another admission to control her pain and symptoms. The oncologist returned to inform her of the new treatment plan to proceed with radiation as well, to address the tumours that were no longer responding to the chemotherapy. Her body was also losing the strength to tolerate the treatment, which was beginning to do more harm to her overall strength, than good. This was the turning point in her discussions with Derrick, as

the situation became harder to ignore: the cancer was slowly killing her and it was increasingly unlikely that she would recover from it. Jackie's immediate reaction was an adamant desire to be at home with the children, while Derrick resisted in order to protect them from seeing their mother's declining state on a daily basis. While her physical appearance was not changing drastically, the cancer was manifesting as debilitating pain, which was perceived as intolerable suffering to those around her. Derrick insisted on an alternative to having Jackie at home, but there was no immediate need or treatment plan to keep her hospitalized. Instead, a hospital bed was ordered to the home so Jackie could be as comfortable as possible.

This was a stressful time for the family. While Derrick and the children tried to maintain a semblance of their old routine lives, Jackie's failing health was hard to ignore. However, Derrick was – and had been for years now – the only working adult in the house and could not afford to stop working for an undetermined amount of time. Jackie had not received a certain prognosis on how much longer she had to live, so Derrick could not put his work on hold. Concurrently, he felt guilty leaving her at home most days, alone in their house with no one to support her. While she was fiercely independent, she became confined to her physical limitations and could barely get out of bed. However, her resolve was strong and she still managed to bring herself to the hospital for radiation and was determined to relieve her family of the burden she felt that her disease had become on them.

At this point, palliative care was introduced as a means of monitoring and stabilizing her symptoms, with the option to discontinue the curative forms of radiation therapy that were slowly weakening her body, without having a similarly beneficial effect on the tumours. At the first Family Meeting with palliative care, Jackie did much of the talking and stated her preferences to cease radiation therapy and adopt a less invasive treatment plan of pain control and symptom management. She wanted to retain the strength she had left to spend time with her children and spent much time reassuring Derrick that this was her desire. Still unable to fully cope with her decision, Derrick – saying little else – simply shook his head and said, “Maybe I just hoped too much...” Even while Jackie had come to accept the course of her disease, Derrick always hoped and expected that Jackie was not dying. With no extended family to turn to and few friends, due to his busy

work schedule, he was so fearful of the loneliness that would fill his life when Jackie died. Conversely, Jackie could not bear the thought of leaving her family without a mother. She lamented the graduations and birthdays she would miss and the landmarks that her children would inevitably celebrate without her. Still, in her last weeks, she did not want to continue treatment, so that they may remember her as a strong and coherent person – not a sunken shadow of her former self, reduced to a thin frame with numerous tubes attached to her body. She moved back home with a regular schedule of follow-ups by a palliative care physician and decided to boldly face the remainder of her days with Derrick and her children.

Once Derrick understood that there was no alternative to the hospital, he reduced his work schedule to spend more time with Jackie at home, often musing about the future they had planned together. When the kids were home from school, they would gather around Jackie's bed watching TV together and reading until Jackie felt too tired. Whenever there was a crisis of pain, the palliative care physician was paged and Jackie was re-evaluated if the pain increased or changed. This happened often, and there were some days when the physician, busy with other patients, could not come for hours. This was the reality of their situation, without the convenience and constant surveillance received in the hospital, in order to fulfill Jackie's wishes to be at home.

Derrick looked around their small house and imagined a life without Jackie within its walls, without her smile, and without her love. The thoughts would scare him and he would return to his present and hug his wife tighter – but not too tight, so as not to hurt her. Many evenings, they would cry at the irony and injustice of having left a war-torn country, only to be faced with premature death from cancer. Flurries of emotions filled and left his body on an hourly basis, but were repressed so as not to make Jackie feel guilty about her situation. Similarly, Jackie could not stand to see her husband's pain, but could do little else aside from assure him that this is what she wants and that she is happiest like this. This, their reality, would continue until the day that Jackie was either too weak to leave the bed at all and must be hospitalized, or until the day that Jackie's body succumbs to the cancer and she takes her last breath in their dining room, on a borrowed hospital bed, in the presence of her husband and children, whose lives would be forever changed.

DANIEL

Daniel was born in 1928 in London and has seen the world chance many times over. He began his life as an army pilot for the Royal British Air Force and fell in love with a Canadian nurse near the end of his term. Following her to Kingston, Ontario, where he continued his career at the Royal Military College of Canada. They were married at 21 and began planning their lifetime's adventures together. With their unpredictable whereabouts, Daniel and Patricia never had children, enjoying their young lives together at home and abroad. Together, they travelled and danced and sang and thrived. They were sociable and well-loved by all in the Kingston community. Forty-nine years later, in 1998, Patricia died of lung cancer, leaving Daniel distraught and directionless. His life partner, gone from his life, left him alone and depressed. With a life's worth of memories in Kingston serving as constant reminders of her life, Daniel moved to Toronto to be closer to his nephew in Windsor.

Unable to live entirely on his own anymore, he found residence in a retirement home. He still dazzled the other residents with stories of war and victory, and regaled countless stories of the adventures he and Patricia experienced. It was at this time that he met Gloria, a younger widow whose husband died in a car accident years earlier. Like Daniel, Gloria had no children and few relatives. Their companionship grew and they spent much of their time together strolling the grounds and partaking in bridge tournaments. This life suited Daniel, until Gloria became too ill for the retirement home and was transferred to a long-term care unit for better medical treatment. Daniel had lost the use of his driver's license and could not take the bus to see Gloria. He became lonely and distraught, mainly keeping to himself in his room.

It was not long after that when Daniel began experiencing back pain and a loss of appetite. The nurse on staff at the retirement home recommended him to the hospital where he was diagnosed with prostate cancer. At the age of eighty-four, the cancer was slow growing and curative treatment was not recommended. He was discharged from the hospital back to the retirement home with symptom management and pain relief.

The palliative care physician from the hospital visited him weekly, checking in on his condition. There were some weeks where little

had changed, but the doctor stayed with Daniel to provide him with company. Due to his increasing frailty, Daniel was now physically bound to his room, receiving few visitors during the day. One week, his nephew came in from Windsor, but could not promise to do so on a regular basis, for he had his own ailing father to attend to. Many days, when the doctor would come to visit Daniel, he would be alone and disoriented, making little sense and unable to sit up in bed. The isolation was overwhelming, but the doctor could think of no reasons to challenge his frail disposition by moving him to a different facility with shared accommodations, or to justify hospitalization for his relatively mild and controlled symptoms. All the doctor could do was visit diligently and whole-heartedly, doing their best to remind Daniel that he was not utterly alone in his final days.

DR. BARRY SMITH

The story of Dr. Barry Smith was compiled included in a palliative care resource package put out by Living Lessons®, a campaign developed by the GlaxoSmithKline Foundation in partnership with the Canadian Hospice Palliative Care Association (CHPCA). It is an interesting story that highlights the lessons learned by a physician upon receiving his own life-limiting diagnosis. Dr. Smith died in 2001 from ALS, but was able to write on the lessons that all caregivers ought to know about working with patients at the end of life. He taught at Harvard, was the former Dean of the Faculty of Health Sciences at Queen's University, Head of Neonatology at The Hospital for Sick Children, and sat on the Board of Governor's of both the Kingston General Hospital. Some of his most poignant messages about dying are as follows:

“[T]he end of my life is turning out to be a very rich and rewarding – even beautiful – time of life. Every life has a story, and every life must end, and what I have come to appreciate is that I know the end of my story, in a way that many people are not fortunate enough to do.”⁷²

“I have run my life through my fingers and felt satisfied with how I have lived and what I have done.”⁷³

“...ALS has given Karen and me the gift of time. We treasure what we have left; we treasure what we have had. We hold each other precious every moment. And we have found that we can talk about everything: our love, our hopes, our fears...Hers of being alone are as real as mine of not finding the courage to die with dignity.”⁷⁴



Fig. 21 Dr. Barry Smith and his Wife Karen.
Together, they learned that the end of life can be as fulfilling as ever. Dr. Smith presents a unique perspective on dying, both as a patient and a physician.

Some of his messages to doctors and practitioners working in end-of-life care:

“We became doctors so that we could help people, not so that we could keep them alive forever. Helping patients and their families deal with dying is, in fact, the very essence of good, and successful, medicine.”⁷⁵

“I am very much alive. Remember that your dying patients are very much alive, and that their lives in their final stages, can have quality and richness.”⁷⁶

“[N]othing that you tell your patients will be more frightening than the terrors they will imagine if you don’t. People can cope with reality once they know what it is. Fear stems from the unknown.”⁷⁷

“Tell your patients as much as you can about their condition and its progression. Knowledge allows them to prepare, and gives them a measure of control.”⁷⁸

“Palliative care gives a tremendous gift to those of us who include it in our work: it ensures that we reflect on our own lives, and that we live them to the fullest.”⁷⁹

“[His wife] Karen, had begun to dread asking ‘how are you’, as Barry’s physical condition could never be better and had frequently deteriorated. She finally replaced it with, ‘how are your spirits?’, which is what she really wanted to know.”⁸⁰

“You are not dealing with death. You are dealing with the quality of life of someone who is living while dying.”⁸¹

72. “Living Lessons” *Canadian Hospice Palliative Care Association* <http://www.living-lessons.org/resources/secured/PhysicianStoriesEN.pdf> (accessed June 2012) p.7

73. *ibid*

74. *ibid* p.2

75. *ibid* p.8

76. *ibid* p.11

77. *ibid* p.14

78. *ibid* p.15

79. *ibid* p.24

80. *ibid* p.12

81. *ibid* p.17

PART II

A Home at the End of Life

2.1 EXAMINED: Program and Adjacencies

A palliative care hospice is a facility wrought with adjacencies that require sensitive consideration. This chapter presents a set of precedents showing the variation in size, shape, and program that can be found in hospices around the world. While some of the following examples may have more beds or different restrictions than the proposed work, an analysis of their programmatic layouts yields some consistencies throughout.

These examples can be divided into five categories: stand-alone and connected to an existing medical campus; stand-alone with no connection to an existing medical campus, adaptive re-use; free-standing in a rural site; and free-standing in an urban site.

It is impressive to see how far some countries and regions have come in their development of architecture that responds to the needs of hospice care. The spaces reflect the cultural idiosyncracies of their locations, climate conditions, religious beliefs, and public health systems. Each produces a unique solution to suit their conditions. This adapting to place and culture bears a significant note considering the placement of the proposed hospice in the culturally mixed city of Toronto.

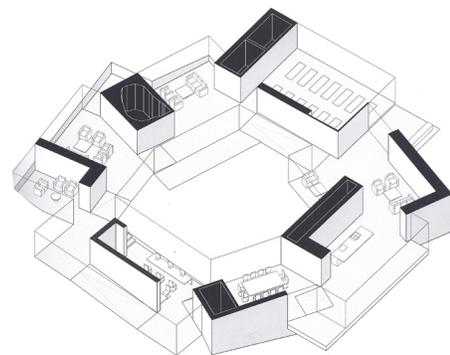


Fig. 22 OMA Proposal for Maggie's Centre Gartnavel
The program is all arranged around a central courtyard with spaces that flow seamlessly one into another.



Fig. 23 Hospice Program Breakdown; Adjacencies in a hospice require special consideration given the varied program and sensitive relationships between living and dying as a part of the cycle of life within the hospice walls.

Hospice Programming

The program elements on the left were compiled and synthesized from over twenty existing hospices. While some have more programs or fewer, those mentioned to the left are the most common. For the purposes of this thesis, these thirty-two program elements noted here will serve as the program list for the proposed hospice.

The organization of colours is in order to identify the programmatic adjacencies that were analyzed in the following five hospices, demonstrating the advantages or hindrances to each type of hospice.

The program breakdown is an interesting indicator of the hierarchy of users in the building. While it is vital to consider the patients in the design, their use of the building is quite minimal compared to that of staff or family. However, it is important to note that of the relatively few places they use frequently in the hospice, they could spend many days at a time there. For instance, a patient may be in their room for a full week without leaving the bed, let alone the room.

The family's spaces will usually be shared with many other families. As such, the programming should afford them each the abilities to branch out and share with others when desired, but also retreat to more quiet rooms. Overnight family accommodations are not necessary in every hospice, though they are particularly important for respite facilities in more rural areas. If they are included in a design, they should not be clustered too close to the shared areas to allow for privacy.

As well, the chapel and mortuary require special considerations, for they should be the quietest areas in the hospice without being too physically distant. It is also important to recognize the sensitive situation that is presented with the mortuary as a physical space set aside for those who have died in the hospice.

The staff and the staff program are appropriate buffers within the hospice. As professionals, they are trained to appropriately address the conflicts that develop during end-of-life care. Programmatically, their spaces may also provide good neutral zones between families and patients. Ultimately, the staff are there to ensure that the every transition is facilitated with grace, respect, and humanity.

Type 1: Located on Medical Campus: Autonomous

Serei-Mikatagahara Hospital Hospice

Architect: Architects' Collaborative for Public Facilities

Location: Shizouka Prefecture, Japan

Number of beds: 27

Date of Completion: 1997



The Serei-Mikatagahara Hospital Hospice is located on a medical campus, but has no direct connection to the hospital itself. The composition is similar to a Type 5, if the hospital is in an urban area, but differs in the importance of establishing a street presence. Because the hospice is already on a medical campus, there is less need to distinguish itself as a recognizable type, as its purpose can be inferred due to its proximity to medical buildings. The Serei-Mikatagahara Hospice takes advantage of this by staggering its rooms that allow for accessible courtyards. The overall plan is less cohesive or recognizable. Here, function is favoured over form, as the building is most easily understood in plan. From the exterior, it is difficult to conclude which spaces are for which programs, and appears as a generic low-rise residential block. Here, the communal space is at the centre of the building and several patient rooms branch off along corridors from this point. The main entrance has a generous overhang to receive users into the expanding and horizontally-expanding spaces within.



Fig. 24 Serei-Mikatagahara Plan; Not to Scale

The hospice is examined for its programmatic adjacencies. The staff rooms flank the entrance, leading into the central node of shared family space, and the patient rooms are all staggered for individual courtyard areas.

Fig. 25 Serei-Mikatagahara Entrance; Above left

The recessed entrance of the hospice has a long protective canopy, which allows its users to linger and adjust before entering or leaving.

Type 2: Located on Medical Campus: Connected

St. Leonard's Hospice

Architect: Allen Tod Architecture Ltd.

Location: York, United Kingdom

Number of beds: 20

Date of Completion: 1999

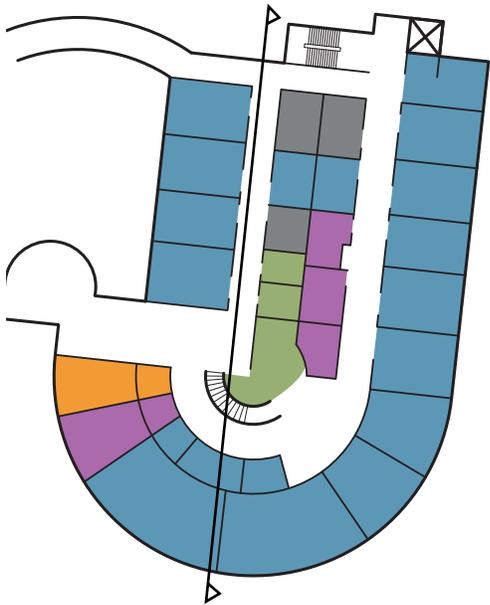


Fig. 26 St. Leonard's Hospice Plan; Not To Scale
There is a circuitous metaphor of how the cycle of life is understood here, evidenced by the loop created by having entrances at both ends. The hospice is not a destination, but a part of the cycle.

Fig. 27 Patient Rooms of St. Leonard's Hospice; Above right
The curved façade of St. Leonard's, which is visible from the quiet residential street. It is a recognizably different shape from the rectilinear hospital that it is attached to.

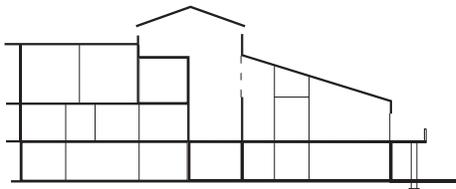


Fig. 28 St. Leonard's Hospice in Section; Not To Scale.
The skylight allows for ample sunlight to enter the entranceways to the patient rooms.



St Leonard's Hospice is connected to the main hospital at two points. Since there are fewer requirements for staff programming due to direct access to the hospital, patient treatment and programming make up much of the hospice. The horseshoe shape is conducive to this configuration with the hospital because it allows for a continuous circulation route beginning and ending with the hospital connection points. It also helps to distinguish the hospice element from the rest of the hospital, which is more rectilinear. This practice of creating a visibly different shape for the hospice portion of the hospital may be quite common. However, the hospice may appear too foreign as a result of differentiating it's form from the typical form of the hospital it is attached to. The connected hospice is easier in terms of practicalities, but presents other challenges architecturally. It is still superior to simply turning a typical hospital ward room into a palliative care room, but lacks the ability to state clearly that the hospice is meant for a wholly different time of life and different style of care from the rest of the hospital.

Type 3: Adaptive Re-use of Existing Building

Maitri AIDS Hospice

Architect: Kwan Henmi Architecture/ Planning

Location: San Francisco, California

Number of beds: 15

Date of Completion: 2000



The Maitri AIDS Hospice is part of a continuous street facade with access from the sidewalk up to a second level. The patient room windows make up the majority of the street in order to allow for street views and sunlight. The courtyard element is integral here to providing a retreat in the complex despite being in a dense urban block. This is an effective solution for an adaptive re-use, as it still provides access to the outdoors when direct use of open green space is not available. This configuration is also successful in providing that domestic familiarity, as the communal and family spaces are not separated by corridors, but instead flow naturally into one another. The corridor separates the living spaces and patient rooms from the practical, supportive program for these rooms. The typology for this type of hospice is similar to apartment or other repeated living spaces with a shared common area. The disadvantage of this Type is the lack of a recognizable form with its own distinct presence. However, this may need to be a consistent and necessary location type in dense, urban areas.

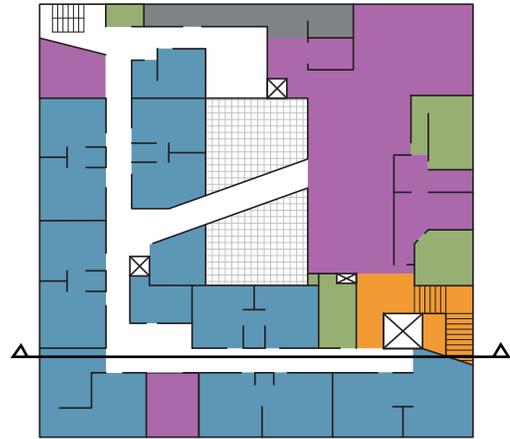


Fig 29 Maitri Hospice Plan; Not To Scale

Despite being located within a solid street block, this hospice still allowed for natural daylight to enter the core of the building with a generous courtyard.

Fig. 30 Maitri Hospice Coutyard; Left; An external courtyard encourages residents to gather at the centre of all programming.

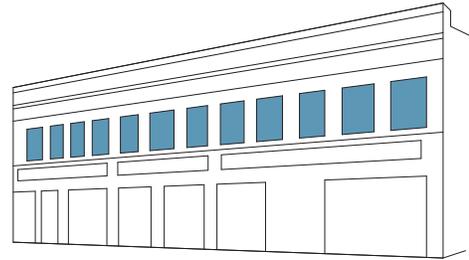


Fig 31 Maitri Hospice Street Facade; The hospice is part of a continuous streetscape in downtown San Francisco.

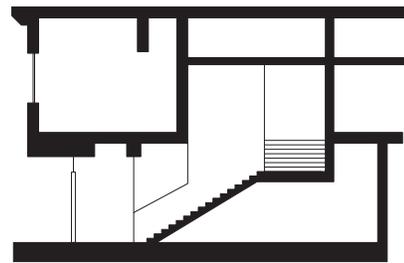


Fig 32. Maitri Hospice Section; Not To Scale

One enters from street level and is required to walk upstairs, which allows for an effective transition from one state of mind to another.

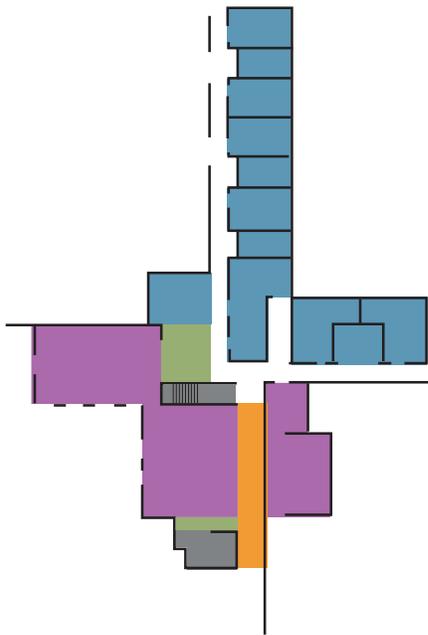


Fig 33. Darling Home for Kids Plan; Not To Scale
This cross formation differs from the Serei-Mitagahara plan due to the centralization of staff services where supervision of the children is a high priority and a clear visual path down both axes is essential.

Fig 34. Darling Home for Kids Entrance; Above right
The elongated portico provides a generous space for entering and exiting the building similar to other trellised or covered entrances for hospices. The long wall also physically separates the entrance from a healing memory garden on the other side.

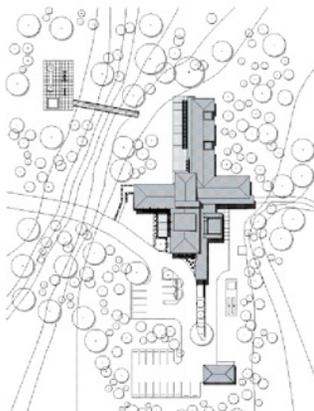


Fig 35. Darling Home for Kids Site Plan; Not To Scale
The building sits in the thick of mature trees, with sensitive wildlife and wildflowers. The architects took careful measures to disturb as little of the natural setting as possible.

Type 4: Free-Standing Autonomous: Rural

Darling Home for Kids

Architect: RED Studio Architects

Location: Milton, Ontario, Canada

Number of beds: 12

Date of Completion: 1999



While the Darling Home for Kids is a children’s hospice, where the program requirements differ slightly from an adult hospice, it can still be analyzed in terms of its location type and programmatic layout. This particular hospice is located on a United Nations Educational, Scientific, and Cultural Organization (UNESCO) World Heritage Site in Milton, Ontario. As such, extreme care was necessary in determining the effect that the hospice would have on its surrounding site. Careful attention was paid to the native natural species. With such an awe-inspiring natural setting, the hospice is afforded numerous calming and beautiful views. The architects also paid special attention to the arrival sequence by car, up a meandering path from the main road. It is easily interpreted as a retreat away from the city and provides a setting that is conducive to the much-needed reprieve for the children’s primary caregivers: their parents. Here, the program is arranged as a cross, with the nursing station is at the centre to enable visual surveillance down the two main axes. This form is well-suited for a natural setting, where the building has the opportunity to open freely and encompass more ground-level space than in an urban situation. However, separation from the city results in the necessity to include all supportive programs within the hospice that would otherwise be available within close proximity.

Type 5: Free-Standing Autonomous: Urban

Philip Aziz Hospice Centre (Emily's House)

Architect: Hilditch Architect

Location: Toronto, Ontario, Canada

Number of beds: 10

Date of Completion: 2012



The Philip Aziz Hospice Care or Emily's House is another children's hospice, but is an interesting precedent to explore due to its historical past. The existing building is deemed to be of historical significance to the City of Toronto, which has required the architect to preserve the existing building, while expanding on it in a respectful manner to accommodate the additional space required. As such, it is modifying the public's appreciation of the historical Governor's House of the Toronto Don Jail, and transforming into a place for providing end-of-life care to children. This is a prime example of the importance of maintaining a domestic feel to a hospice, especially within an urban context. It is best understood as a home, while it is larger in scale than most. With an urban site, the street presence is very important to account for and the programming will reflect this. Similar to the procession through a domestic home, much of the family and shared areas will be closer to the street, proceeding like a home towards the rear of the building. Here, view to nature are less abundant, but can be equally effective with controlled and deliberate choices for windows. Noise is also an important factor to consider, as well as privacy. Emily's House provides an appropriate precedent for 1 Riverdale Lane, as it is included in the Master Plan for Bridgpoint Health, providing a hopeful example of how hospices may soon be integrated into more hospital redesigns.

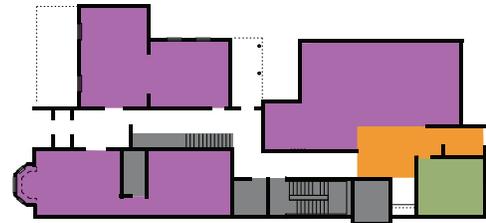


Fig. 36 Emily's House First Floor Plan; Not To Scale

The ground floor of Emily's House is not unlike a typical home of this scale. Much of the programming is shared space for families, like the kitchen, dining, sitting, and chapel areas.

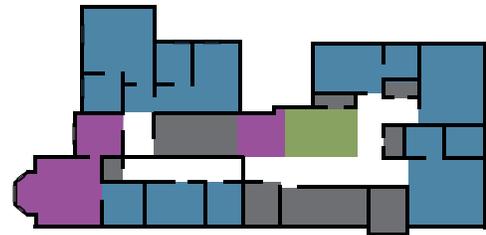


Fig. 37 Emily's House Second Floor Plan; Not To Scale

The second floor of Emily's house follows the same domestic layout of having all the accommodations on the second floor with areas for storage and a small kitchen area to make light snacks.

Fig. 38 Emily's House Proposed Rendering; Above left

The proposed Emily's House is meant to set a new standard for providing hospice services for children with life-limiting illnesses as well as respite accommodations for their families.



Fig. 39 Back Elevation; Not To Scale

There is a noticeable change in the architecture from the front to the back of the house, where the existing facade of the historic Don Jail is preserved. This hybrid allows for some flexibility in new design while drawing on the established domestic qualities of the Historic Governor's House.

2.2 PROPOSED: Design Guidelines and Strategies

As evidenced by the previous five examples of hospices around the world, there are a wide range of permutations and programs that still result in the delivery of excellent palliative care services. The following guidelines and strategies represent the broad range of design considerations that need to be considered when designing a palliative care hospice. Financial, spatial, or regulatory limitations will invariably change the design priorities, so consideration of all the following categories is not necessary. Instead, they are a systematic compilation of relevant design decisions that have appeared across numerous precedents that were studied.

However, due to the relatively small supply of successful, purpose-built precedents in Toronto, some inspiration was drawn from other building typologies such as monasteries, chapels, and residential dwellings. Still, they are only meant to inspire and aid new designers, without providing a strict recipe to follow for a flawless design. Ultimately, successful palliative care can take place in a wide range of spaces. Designing hospices to this end is merely an attempt to harness the power of space and its ability to change the moods and mindsets of those who are in it.

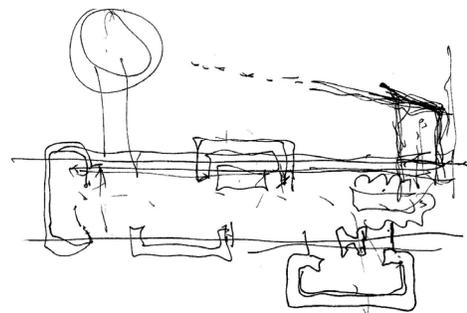


Fig. 40 Parti Drawing for Maggie's Centre Cotswolds

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LOCATION

Perhaps one of the greatest challenges in the process of this thesis was choosing a site. The difficulty lay not in the limits of having few sites to choose from, but more so the plethora of options depending on the desired design direction. Specifically, it should be noted that there are three distinct site options that need to be decided on before proceeding with further design responses.

As mentioned in Section 2.1, hospices may be categorized into one of five types:

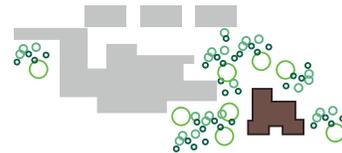
- 1) Located on medical campus: Autonomous
- 2) Located on medical campus: Attached
- 3) Adaptive re-use of existing building
- 4) Free-standing: Rural
- 5) Free-standing: Urban

Each have their own merits and each are necessary in order to serve communities with different needs and existing infrastructure. Since the proposed hospice is situated in the city (therefore type 3), it is worthwhile to expand upon some of the considerations specific to an urban site attached to an existing medical complex.

One of the greatest advantages to having a hospice physically attached to a hospital stems from a programmatic, medical point of view where the services, prescriptions, personnel, and equipment are conveniently close at hand. There are also psychological benefits to this arrangement because the hospice can borrow the reputation of the larger whole, and a certain morale is achieved by physically locating a hospice near an established medical hub within a community. By piggy-backing onto an existing hospital, there may be less friction when introducing the hospice to an existing community, shifting the focus away from death and dying, towards the healing aspect of palliative care.

Nestling the hospice within an established community also opens up the possibility of having children nearby, whose laughter and smiles have been noted as having a positive and cheerful effect on hospice residents. In fact, there have been several mentions of ensuring that hospice patients are reminded of life outside of their own situation.

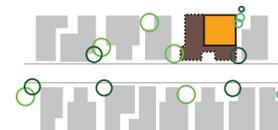
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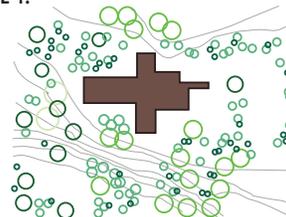
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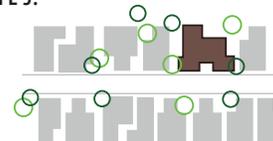
TYPE 3:



TYPE 4:



TYPE 5:



Figs. 41 - 45 Representative Site Plans for Types 1-5

Staff at several hospices often noted seeing and hearing the continuation of life outside the hospice walls provided solace and even, at times, lifted the spirits of hospice patients.⁸² Continuing the connection to and providing reminders of life outside the hospice are some of the most effective ways of taking advantage of an urban site – especially one with an established relationship with the nearby hospital.

Regardless of the exact Type of site, it is important to establish first whether a rural or urban site is preferred. Below are some ideas on why one may be favoured to the other.

RURAL

The rural site offers far greater opportunities for landscaping and fresh air, giving the hospice an inherent sense of peace and tranquility. However, there are numerous impracticalities for those who live in urban areas in terms of access for patients, families, and staff, along with the inverses of the benefits of an urban site.

URBAN

As architects, the urban site often comes with greater challenges to design a building that is site-specific, based on the complexities of its surrounding factors: public transportation, public utilities and services, familiar settings for city-dwellers, ease of attracting staff and volunteers, and the ability for it to act as a major urban landmark for the community. Urban sites do present a number of less attractive challenges, however, with the high cost of land, often minimal opportunities for extensive healing landscapes, the noise and pollution of the city, and a potentially difficult paradox to resolve of death occurring in the midst of busy lives. Sensitive design may overcome or embrace all of these, still favouring an urban site to locate a hospice meant to serve city-dwellers. Still, both sites are necessary and the frequency of either should depend on the distribution of people and what site will provide the best access to the care and services they were built to provide.

INTEGRATION

Another benefit of attaching the hospice to an existing hospital is that there may be an existing relationship of volunteerism and involvement from the community that would benefit the new program. After all, the hospice should promote, and stand as a model for, social sustainability⁸³ due to the fact that a volunteer network is integral to a hospice's operational success. While promoting volunteerism, the hospice can also become a place for teaching medical and nursing students. Regardless of the medical specialty, it stands to benefit all medical trainees to familiarize themselves with the culture of palliative and End-of-Life Care. Promoting the acceptance of palliative care among professionals who may be involved in the earlier forms of care is one of the best ways of introducing the option of palliative care, should a patient's condition deteriorate earlier than expected during curative treatment. The best place to immerse oneself in the teachings of palliative care is the hospice, where the environment is most conducive to discussions on end of life options, especially by seeing the conflict that often accompanies a family's discussion on the topic.

Programmatically, this means the inclusion of teaching and conference facilities within the hospice in close proximity to the staff rooms. This adds another layer of meaning to the building. No longer solely a place of healing, the hospice is also a place of teaching.

Besides integrating with the hospital community, the urban hospice design is uniquely positioned to provide an anchor within the community, increasing knowledge and visibility for its services. A successful hospice should seamlessly replace the fear and mystery of dying with a respect for the process and importance of end of life care. One step further in measuring the success of the hospice would be if it were perceived as a place for the public to come onto the grounds experiencing the gardens or, more successfully, by volunteering drawn in by its inviting atmosphere. The design's visibility as a symbol for community involvement in caring for those at the end of life is at the crux of the argument for a more monumental gesture than the typical house. The neighbouring community should feel the constant buzz of volunteers and families coming and going from a place rich with narratives and celebrations, rather than the tranquility and finality found in a cemetery.

DOMESTICITY & FAMILIARITY



Fig. 46 Sitting and Gathering Spaces

Maggie's Glasgow provides cosy and welcoming atmospheres for casual discussions and support.



Fig. 47 Frank Lloyd Wright Kitchen

Boundaries in program are dissolved in familiar domestic settings such as the transition between kitchen and sitting room.

As was mentioned in Section 1.3 regarding the Maggie's Centres, one of the greatest design challenges for a hospice is designing spaces to create a feeling of comfort and familiarity without simply replicating a domestic house layout. Architect Ian Clarke made the clear distinction between the danger of falling into a desire to replicate the domestic homestead in the hospice environment instead of suggesting a new typology altogether. He suggests, "Not all domestic environments promote instinctive ease, some can be oppressive, but I do agree that 'domestic' as a reflection of 'human-centred' and 'anti-institutional' motives is right."⁸⁴ Patients with terminal illnesses will only spend a short period of time as a hospice in-patient, after having lived their entire lives and the progression of their illness in a small-scale domestic environment. The hospice must offer an equally reassuring atmosphere while providing a slightly different ambience to home by offering different things – such as a good view and access to well-managed gardens, as an example. Architect Ian Clarke said this on domesticity:

"[It is] more about human experience, less about domestic visual clutter perhaps... It should promote an instinctive sense of ease on a moment-to-moment basis. [Where] it has often been presumed that the road to an instinctive sense of ease is provided by the replication of domestic character in the architecture, the deduction may not be entirely correct [as] it is more complicated than that."⁸⁵

Further, domestic architecture dissolves the need for marked way-finding, a thorn in the side of many hospital designers. Due to the intricate levels of privacy and confidentiality that exist in a hospital, it is inevitably necessary for signage and way-finding tools. The hospice, instead, should have the same ease of flow from room to room as from the living room to the dining room in a home, without having to stop and ask for directions along the way in the kitchen. While this example may have a humorous tone to it, the importance of instinctive program flow and way-finding must be taken seriously. At a time when most families are in a high stress situation, they surely do not need to be burdened with feeling like the proverbial rat in a maze. It is paramount that family members feel free to roam and wander lost in thought or able to make a tea or get a bite to eat without feeling like 'intruders at the hospital'.⁸⁶

The design focus is based heavily on the experience of the place, an item that does not necessarily affect the external massing. Ken Worpole, author of *Modern Hospice Design* suggested that there can be a distinction and perhaps even a disconnect between the interior and exterior, in which the inside could feel domestic, without that permeation of such domestic features to the exterior.⁸⁷

A greater question, may be whether or not the hospice needs to be recognizable as such. At this point in time, since there is no set typology for the hospice, the the possibilities are nearly endless. This is not to say that there are not consistencies in a hospice that can be categorized and sorted. There are many transferable design elements that should be considered for a hospice environment to be successful to the best of its abilities. However, it can be said that a hospice may not be recognizable from its massing, or materiality, or pitch of roof, or layout. In this sense, it is a true typology that is not classified by its ability to be repeated exactly, but as an accepted prototype with recognizable elements. The success of a hospice rests principally in the personal experience of each patient, family member, and caregiver, and their connections with each other. However, the importance of the architecture cannot be over-stated, for the greatest success of a hospice can be measured in its ability to provide the appropriate spaces to allow for these experiences to occur. The hospice, the principles of palliative care, and the caregivers who pass through its doors, all share a central element of sensitivity: a capable, but gentle, lending hand.

WAITING



Fig. 48 Typical Waiting Room

"Waiting in itself is not so bad - it's the circumstances in which you have to wait that count. Overhead (sometimes even neon) lighting, interior spaces with no views out and miserable seating against the walls all contribute to an extreme mental and physical enervation. Patients who arrive relatively hopeful soon start to wilt"⁹³

Henri Bergson, a 20th century French philosopher, stated that, "Most of our lives are ordered by the clock, providing a sense of onward movement that keeps us relatively positive about the direction of our lives. But there are also times, usually at great anxiety of stress, when we experience time as a form of endurance, a meaningless waiting imbued with a general sense of dread."⁸⁸ It is hard to ignore the relevance of this statement in the hospice situation, where prognosis and the exact day a patient may die is never certain. This lack of certainty generates much unease for patients and families. For a patient whose "life no longer holds any pleasure or when the ravages of disease have exhausted them and they long for an end"⁸⁹ the question, 'When will it be over?' may be asked, with no absolute answer available. At this time, the palliative care specialist aims to reassure them and their families that they will be comfortable and not suffering from pain.

At these moments, the waiting may seem endless. It is worth considering the cultural understanding of what kinds of emotions the mention of a 'waiting room' illicit among family members. Often, there are associations with uncomfortable chairs, flickering fluorescent lights, tattered magazines, the dull noise of a news channel playing on an overhead television, and a lack of eye contact around the room. There is general discomfort and anxiety surrounding most waiting areas; and for a hospice, it is important that this is alleviated.⁹⁰ In his paper "A Place for Empathy: Ethics Involving Architectural Design in Healthcare", Dr. John Lincourt accurately describes hospital waiting rooms where, "It is difficult to talk at all, and even more impossible to exchange words of intimacy. It is not a good place for prayer, or even idle chatter. It is not a good place at all."⁹¹

The focus for the patients and families should be shifted to active engagement from a sense of endless waiting. In order to achieve this, the hospice must have inviting gathering spaces that encourage interactions. The hearth or central lounge area should promote friendly discourse and a 'family kitchen table' type of atmosphere.⁹² A formal waiting area should be avoided altogether, in favour of the hearth or small nooks and alcoves that allow for private moments and small conversations off to the side of the main hallway.

The other instance where waiting may happen is when families may be waiting to meet with a physician or support worker. Due to the fact that there should not be a reception desk ⁹⁴ in keeping consistent with the more 'domestic' scale of the hospice, the waiting area attached to one should also be avoided. Re-framing this area as a 'sitting room' or 'lounge' that is in close proximity to the kitchen or hearth will promote the instinctual ease of being in a home rather than an institution.⁹⁵ Creative space planning must be harnessed to ensure security without a formal reception desk and the subsequent waiting room.



Fig. 49 Generous and Well-Lit Sitting Room

At a hospice, a designated 'waiting area' is not necessary, for it can be argued that much of the time spent in a hospice revolves around waiting. Instead, these spaces should be areas that families want to be, that allow them to centre their thoughts or engage in conversation.

RETREAT & MEDITATION

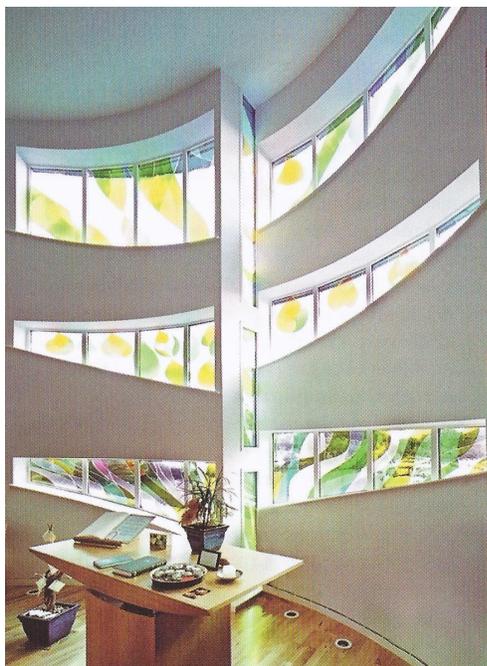


Fig. 50 Stained Glass in the Windows of the Chapel at Marie Curie Cancer Care Centre

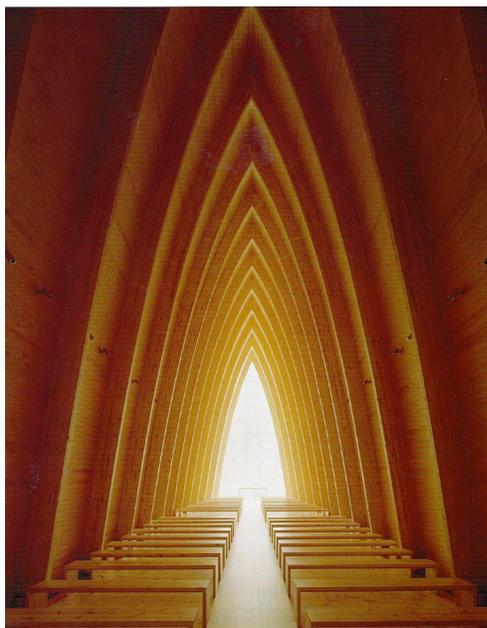


Fig. 51 St. Henry's Ecumenical Art Chapel in Turku, Finland
The chapel spaces should promote spirituality and reflection without necessarily containing religious symbols.

While the hearth or small alcoves may provide places for informal meditation and grieving, a more private and formal room must also be available. These spaces must provide 'peace and quiet', where staff and families alike may 'retreat' to at the difficult points in their day.⁹⁶ Given Toronto's cultural diversity, it is important not to focus on the religiosity of the chapel, for many different faiths will pass through. Instead, it should simply provide a safe place with enough space for viewing a body and performing simple rituals. While some natural daylighting must be afforded to this room, it may be prudent to refrain from having large windows into which passing pedestrians may look in and stare.

It is beneficial to have ground-floor accessibility for the retreat space in order to allow for ease of transferral into a hearse. Location on the ground floor also provides an opportunity to create a double-height space that could hold a "key position in the public face of the hospice" that can serve to "distinguish the hospice from a residential home".⁹⁷ The design of this space can allow architects to create spaces that give the users the freedom to move and exist at whatever pace is most suitable to them. It is a brief pause in the continuum of life for some, and the final departure place for those who have moved on from this world. As the architect, it must be "a place where loss is constantly overcome by creativity and where continual partings are best expressed",⁹⁸ for despite the length of stay in the rest of the hospice, this one room may be the most powerful, evocative, and memorable for the family who survive the patient, and the staff who continually say goodbye to those who are charged to their care.

24-HOUR ACCESSIBILITY

Like many healthcare facilities, the hospice is open at all times of day. While visitation may occur mostly in the daytime hours, overnight staff work around the clock attending to the patients. As such, consideration must be made for how the hospice looks at night. Walkways and parking areas must be appropriately lit. The building must be illuminated in a way that is neither ominous nor foreboding – it must remain vigilant in its cause to alleviate the fear of death and dying. Therefore, the building must have an appropriate amount of lighting and transparency without diminishing the privacy of those inside.



Fig. 52 Mitton Residence. Anchorage, Alaska



Fig. 53 Skrudas Residence. Reykjavik, Iceland
Proper window treatments allow for light to still be emitted whilst maintaining the privacy for those inside the building.

CORRIDORS

The hospice must serve to remind patients and their families as little as possible of the hospitals they may have spent years prior to their admission. As such, the overly wide and impossibly un-ending corridors of the typical hospital facility must be avoided. While there must be a main circulation artery wide enough for a gurney to pass through effortlessly, varying the building material of the hallway may help to avoid the immediate recollection of a hospital. Natural daylighting brought in by large windows with views out to the garden could also help to diminish the monotony of typical hospital corridors. Providing desirable spaces and programming at the end of corridors such as the reading room pictured above to the right, helps to relieve the monotony of long corridors.



Fig. 54 Second Floor Lounge, Park Nicollet Melrose Institute



Fig. 55 Alcoves in the Hallway at Vidarkliniken, Sweden
Small alcoves off to the side of a corridor or an enticing space at the end of a hallway help to foster a feeling of existing in liminality with no need to be anywhere specific.

ARCHITECTURAL ELEMENTS: THRESHOLDS I

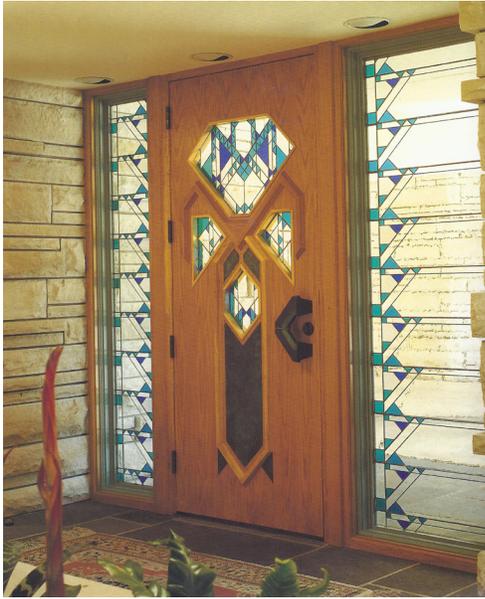


Fig. 56 Front Door Detail and Design

This door at the entranceway to a family home designed by Frank Lloyd Wright as unique as the inhabitants on the other side of it.

While a specific or recognizable form may not exist, there are consistent architectural elements that demand further consideration. After the initial massing is seen and experienced, the most poetic and perhaps powerful element of the building awaits: the door. Thresholds and passageways are paramount in a hospice. Since the hospice aims to shift the focus of palliative care from terminal to liminal, the physical doorways and transition spaces are crucial in concretizing those experiences.

A hospice can be architecturally described as a series of thresholds welcoming the changing states of life that occur within it. As writer Richard Lang wrote, “This threshold where I hospitably receive others into my personal domain is the place of remembrances. Here, at the site of my reunions and farewells, the persons and events of my past quietly continue to dwell...at a doorway there is an intensification of life; I become truly aware of the shifts and turns in life, of openings and closings, of beginnings and ends. Here, I live my transitions concretely.”⁹⁹ The flow of entering, passing, staying, and exiting, all bring into question liminality and the experience of time. For the family members, every time they cross the threshold of the front door, they may be in a different state of mind. Many aspects of the physical door itself may hold weight to the effect on them. For instance, the door’s weight, size, material, width, height, temperature, placement of doorknob, transparency, or degree of automation may set the mood for the remainder of their time in the hospice. Similarly, it must be considered that this is the same door that the caregivers will open day after day. One may ask themselves – does the door get heavier or lighter, easier or harder to open? Will the handle wear to mark the successions of patients and families who have used it? The phrase ‘terminal care’ that was once used to describe those with life-limiting illness is slowly being replaced with ‘specialist palliative care’, and the ‘one-way’ door has been replaced with the idea of a ‘revolving door’ of care.¹⁰⁰

THRESHOLDS II

The door in which all enter must be distinguished as requiring separate thought experiments from the door in which some exit. Poetically, there must be great consideration for the way in which the patient leaves the hospice. This is due to the great amount of tradition and ritual that still exists around death, and because the question may arise as to whether there should be a separate and special exit sequence. The argument of this thesis is that the body should leave through a different type of exit, separate from the front door. This need not be the focus of the project and may not even be visible upon entering, but the way in which a body will leave can be the most indicative element of the hospice in terms of redefining the way that the dying are treated and respected. If a body were known to leave through the same door as the garbage and waste, this would likely decrease the morale of everyone in the hospice. It would seem highly contradictory for the hospice to suggest that it embraces each patient still as a whole human being while under their care, only to have the designated exit for their body be the proverbial 'back door'. Consideration for the way a body leaves the building is therefore as important as the way that everyone else enters.

The correct response may not, however, be to have the body leave through the front entrance either. While it may be considered this is not necessarily the most sensitive approach for the majority of other building users. As a family coming to the hospice for the first time, it may be demoralizing or even traumatizing to face death immediately in the form of a deceased's body. There are other practical reasons such as the way a body is covered or washed or the rituals that still need to be performed that would cause unnecessary conflicts by using the entrance.

The proposed design suggests an alternative to the 'back door', creating a separate exit through the chapel or quiet meditative area. This way, there is more privacy to allow for a family to grieve appropriately with the body, perhaps have a small ceremony in situ, and provide a dignified threshold through which to leave the hospice that is reserved only for those who have reached the end of their hospice stay. Giving such clout and importance to this phase may play a key role in providing the 'good death' that is the final goal in palliative care.¹⁰¹



Fig. 57 Carlo Scarpa's Brion Cemetery
Entrances and exits mark first and final impressions of a place.

COURTYARD

For this specific site, a courtyard typology was explored as an ideal means of organizing the program around an intimate garden area. Regardless of whether or not a distinct courtyard may be created, there are several reasons why this typology should inspire the resolution of a hospice's programming.

PRIVACY

A private garden protected by the mass of the building encourages the hospice's users to step outside and embrace the outdoors to garden, whether it is to collect their thoughts, or have a sensitive conversation away from others, it still provides the solace of nature without being too far removed from the building. Regardless of whether the courtyard is fully or partially covered, privacy is still afforded due to the building's own walls physically separating the courtyard from the public.

CENTRALIZATION

While the program elements of a hospice may need to be grouped based on users and adjacencies, the courtyard is a key centralizing element that helps to resolve the potential for disparate and isolated 'wings' similar to a hospital. Access to and traversing through a courtyard also begins to dissolve the reliance on long, heavily-used corridors and the institutional ambience they create. It also provides a neutral and natural zone at the centre of the hospice, free of program, that could serve to alleviate tensions or frictions that may build up within the building. As with the Aegean temples, courtyards were used as an 'organizing nucleus at once dividing and uniting the parts of the complex'.¹⁰¹

CONNECTION

Besides acting as a physical connection between two program areas, the courtyard also offers users a strong visual connections across the courtyard. For example, having the patient rooms' windows and door face into the courtyard allow for the patients to maintain visual connection to the rest of the building and whatever activities may be happening within it or inside the space directly across from them. It allows them to still feel connected, without feeling exposed or on display to the general public on the street.

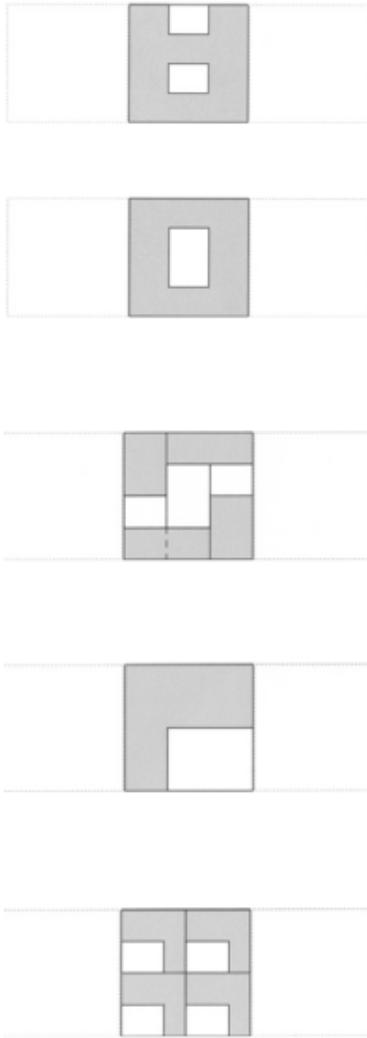


Fig. 58 Examples of Courtyard House Plans

WAYFINDING

Organizing program around a courtyard also allows for a recognizable wayfinding point to locate oneself with. With a larger site, several courtyards may serve as the wayfinding tools through the building, as with the REHAB Center by Herzog and de Meuron in Basel, Switzerland, shown in Fig. 61. Here, the architects have arranged for several different inner courtyards to orientate the users along their route towards their destination. In other words, the various courtyards are used as wayfinding tools for navigating through the complex.

SUNLIGHT

The Minoan Palaces of the Bronze Age sought to create courtyards which allowed for the surrounding residential quarters to access views of their surrounding landscape while affording increased access to natural daylight. ¹⁰³ A glazed courtyard increases the visible daylighting in the building and allows for the sun's warming rays to penetrate through the patient rooms that open up to the courtyard.

SERENITY

As with the early temples, monasteries, mosques, and other religious gathering spaces, courtyards have long since promoted an inner peace reached through contemplation. Historically, the courtyard helped contribute to 'a sense of peace', as noted of the courts in Aegean temples ¹⁰⁴ and generated a tranquility that was conducive to reflection.

LIMINALITY

Architecturally, the courtyard is hardly considered a 'place' in itself. Instead, it can be described as "a junction of paths, a node or central point, which is both centripetal, drawing people towards it, as well as centrifugal, urging them out into the circulation system that surrounds it." ¹⁰⁵ In a place like a hospice, where temporality and liminality are so keenly felt, the courtyard lends itself perfectly to addressing and epitomizing these transient moments.



Figs. 59 Inner Courtyard of St. Oswalds Children's Hospice



Fig. 60 Community Hospital of the Monterey Peninsula Courtyard



Figs. 61 REHAB Basel Entrance Courtyard, Herzog and De Meuron

GARDEN



Fig. 62 Les Maisons Closes: Opening to a Garden

Establishing and strengthening the connection to nature is integral to this proposal. Choosing to locate the hospice in an urban context rather than a rural or natural setting provides a challenge when deciding how to engage the building and its participants with nature. At the end of life, one commonly held belief is that “Nature is our ally and our ultimate home”.¹⁰⁶ Therefore, the treatment and design of this hospice garden is of utmost poetic, as well as practical, importance. In describing his idea of a Garden of Cosmic Speculation, architect Charles Jencks refers to the garden as “a microcosm of the universe...a miniaturization, and celebration, of the place we are in.”¹⁰⁷ Conversely, the garden serves as the antithesis of our frenzied lives and gives credence to slowing down the usual pace. It encourages us to take time to savour the present moment – a luxury afforded by compressing yet suspending time at the end of life. In the struggle to come to terms with one’s terminal condition or the prognosis of a loved one, a garden “provides the ideal, Arcadian image of a profoundly green, harmonious world, a world both lost and desired again.”¹⁰⁸ Further, author Kenneth Worpole suggests that surrendering to the natural world may in fact contribute to the healing process, due to its ‘natrualistic spirituality’.¹⁰⁹

The garden is also an opportunity to bring some aspects of nature into the hospice even in the dense city where it may not afford views of rolling hill-scapes. Although the space may only be a small part of manicured or controlled nature, it can contribute to the entire ethos of palliative care that sets the hospice apart from acute hospitalization. In the case of George Mark Children’s Hospice in San Leandro, California, the adjoining gardens serve as secondary treatment areas.¹¹⁰ Access to fresh, non-mechanized air, the act of feeling the sun’s rays on their skin, or watching a humming bird hover without the distracting glare of a window pane are just a few of the joys that could be experienced by providing accessible garden space from the patientsl rooms. Physical connection and potentially the ability to tend the garden is knownsn to have therapeutic effects on patients and families in stressful situations.¹¹¹ From the garden, patients, families, and caregivers may draw solace and a new meaning in life through nature.

Concessions must be made, of course, for climates that have less hospitable winters and summers, but views to nature without direct access are still more effective in the healing process than not. In 1984, a scientist named Robert Ulrich conducted a revolutionary study that proved empirically, something that seems easily deductible: views to a garden as opposed to a brick wall can help intensive care patients heal faster.¹¹² It should serve then that these views should be a top priority in hospice design, especially because most patients are completely bed-ridden upon admission. Since the view afforded to them may be permanent for the duration of their stay, the importance of providing something comforting to look at should have some priority. The hospice design should provide ‘a continuous flow between house and garden space’.¹¹³

The hospice’s greatest opportunity to appear nothing like the hospital is in its intrinsic ability to have connections to nature. In the hospital, it is now nearly impossible to ‘smell the fresh air’ in the common ‘hermetically-sealed building envelope’.¹¹⁴ Contrary to the intense focus on eliminating contamination and air-borne viruses since the early twentieth century,¹¹⁵ hospices have the opportunity to operate under less restrictive concerns with contagious diseases because few patients’ ailments present a risk of spreading. As a result, operable windows and physical connections to nature should be embraced to their full potential. The garden element should be a central feature in the hospice, programatically and architecturally because for bed-ridden patients, the garden is an opportunity to be “link[ed] to the world beyond [their] room”.¹¹⁶

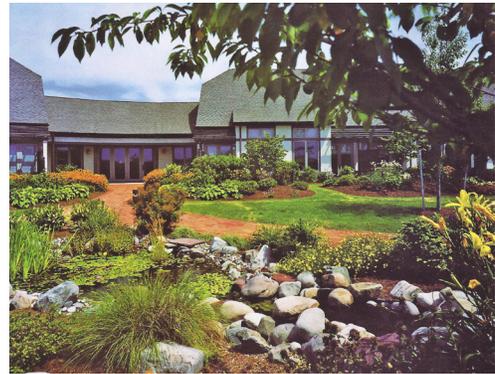


Fig. 63 Essa Flory Hospice Landscape and Restorative Garden



Fig. 64 Indoor Gardening at Maitri Hospice; Above



Fig. 65 Restorative Garden, Houston Hospice; Above

WINDOWS



Figs 66 & 67 The Window as a Portal to Nature
Distant landscapes and paradises fill these full-length windows.



Figs 68 & 69 The Open Window as a Frame for the World
In both these paintings, the half-open window frames the horizon and sky between the close reality within the room and the distant land beyond the window sill.

Windows are also symbolic architectural elements that function beyond their physical uses for allowing light and ventilation into a space. They are an architectural element that fostered a change in social attitudes and arguably inspired the entire social, religious, medical, and architectural hospice movements.

It is paramount that the patient rooms have ample exposure to southern light. According to many sources, but Stephen Verderber and Ben Refuerzo's *Innovations in Hospice Architecture* specifically, "[n]atural daylight is life-affirming."¹¹⁷ For some patients, many of their other senses are diminishing at this point in their care, but the ability to feel a ray of direct sunlight as it warms their skin is still feasible and comforting. This access to light also allows for patients to feel a sense of natural time – different from that of a ticking clock – as sunlight moves across their room.

However, there is the ever-present paradox present in the planning and designing of the hospice, where sunlight must be controlled and, in some cases, eliminated. According to Verderber and Refuerzo also, "...as the patient's condition diminishes, whether precipitously or gradually, many tend to begin the process of shutting down, and in so doing crave darkened spaces."¹¹⁸ Therefore, the rooms must be equally conducive to letting in warm light and providing for darkened environment when the patient requests it.

Architecturally, another challenge is in avoiding the repeated window elements indicative of an institutional building, while maintaining the repeating patient room layouts within. It is paramount that the rooms are read as domestic and familiar, perhaps erring on the side of the monumental building rather than an institutional one that many patients and their families have come to fear or loathe. On his tour of hospices while writing the book *Modern Hospice Design*, Ken Worpole noted that “the hospices we have visited share the specific intention of not wanting to look like a hospital”.¹¹⁹

Window placement and height as considered from within the room is also a new and interesting challenge that arises when the person for whom the room is designed is likely bed-ridden and usually resting at the same semi-prone position for days on end. The traditional window setting within a home may, in fact, be too high or too low for the patient to comfortably look out from. Ken Worpole made this note on the large windows installed in a new hospice where, “the patients could look out and see... It was the big glass windows and the big panels, and it was really lovely for them. They didn’t feel closed in like the old hospice...”¹²⁰

Of equal importance to what the view from inside the room looks out onto, is what the window is framing from the outside. The duality of a window’s purpose as both a view out and a frame of the interior, makes it an important architectural element to focus on. Particular sizes, shapes, and orientations of windows invoke different feelings. For instance, Ken Worpole noted that ‘vertical window slots evoke, consciously or unconsciously, feelings of commemoration and the passing of life’¹²¹ especially in this context.



Fig. 70 Tantalus School. *Left*



Fig. 71 View of Inner Courtyard at Maggie’s London



Fig. 72 Maggie’s London Window from Courtyard

CEILINGS

“Architects have long insisted that any building in which the ceiling heights are uniform throughout is an institution, not a place of comfort or elective habitation.”¹²²

Another specific design challenge that the hospice presents is the sudden monumental importance of the ceiling in a room. For many patients, they spend most or all of their time lying back, with their eyes to the ceiling. One researcher of hospital design noted that “[f]or most bed-ridden patients, the ceiling is the most important plane in the room”.¹²³ The ceiling becomes the canvas upon which their thoughts and daydreams are projected upon, and as such the overuse of blank, white dry-walled or acoustic-paneled ceilings should be avoided. To those lying prone, the white ceilings that meet with white walls can have the disorientating effect of converging to the point of visual discomfort.¹²⁴

The height of the ceiling is as crucial as the appearance of it, and “small variations in the height of a ceiling seem to have the power of altering a space more than the variations applied to the width and length.”¹²⁵ Variations in height need to occur between rooms as well as within the room itself, as consistent ceiling heights throughout a building are often understood as institutional, rather than places of ‘comfort’ or ‘elective habitation’.¹²⁶

The ceiling height of the rooms should also be different from that of the hallway directly adjoining. Arguments can be made for a lower room height than hallway, and vice-versa. With the former, rooms with a lower ceiling height than the hallway could suggest intimacy and privacy. A lower ceiling also allows the patient to be the centre and focus of the room, like the central subject of a small painting. Compositionally, this could bring less focus to the fact that the patient is lying prone and therefore embodying less vertical space than those who are standing or even sitting. With the right proportions, in a more horizontal room, a patient may in fact seem more appropriately aligned to their surroundings, compared to those standing. Experientially, the lower ceiling may also be felt as compression to caregivers and family members, especially in a time where the occupants are already feeling tension and fear.



Fig. 73 Maggie's Centre Inverness
The curved skylight draws the eyes up and allows natural daylight to fill the hallway below it.

“It also seems true that the vertical dimensions of rooms, since they are relatively free of ‘functional’ imperatives, are able to carry more their share of emotional content.”¹²⁷This ‘emotional content’ may refer to all possible experiences that occur while a patient is in that room, and all memories and narratives that have followed them there. This is a room that will house and bear witness to the life reminisced and retold by visiting family members, and each life lived is considerably monumental in its own right. Also, the patient room may be the only part of the hospice that the patient experiences or has any conscious awareness of. Therefore, the ceiling height and treatment ought to be properly proportioned to the width and length, in order to allow for the housing and full containment of emotional content that accumulates in this powerful room.



Fig. 74 Ceiling as Art
Ceiling of the Department of Architecture in Pattaya, Thailand



Fig.75 Patient Room at George Mark Children's Hospice
Here, there is direct access to the garden.

CELL | CUBICLE | WARD | ROOM

Cell: any of a small number of chambers in a building; specifically a room for one person in a monastery, etc.; a room for one or more prisoners. A humble dwelling; a lonely nook; an isolated retreat. Also, the grave.

Cubicle: A bedroom. A small, individual sleeping compartment

Ward: A room in a hospital, etc. containing a number of beds, or allocated to a particular class of patients; the smallest administrative division for in-patients in a hospital. Also, more widely, a dormitory in any building providing temporary accommodation.

Room: A compartment within a building enclosed by walls or partitions, floor and ceiling, one set aside for a specified purpose; a person's private chamber within a house, workplace, etc.¹²⁸

Much research has been spent on the efficiency of hospital room layouts, but the fundamental difference between a hospital room and a hospice room is the amount of time spent in each and the liminality of either. For the hospital, the goals of care are centred on curative treatment. Efficiency in attending patient needs and administration of medicine is paramount, along with sanitation and space for large machinery to be wheeled in and out of the room. Successful care on administrative and medical levels is measured by length of stay and speed of recovery. This is not, by any means, a poor way to measure success.

However, with palliative care, many goals of care are focused on holistic comfort. Less machinery is required at this point and the room more resembles a bedroom. Length of stay is dependent solely on the patient's own body and the variable time before they die. The room is theirs and their family's until such a time. Patients spend their last living moments in this room, and as such, monumentality of this should not be overlooked. In one morning, a room may be occupied by a patient who has taken their last breath, perhaps surrounded by family and friends or quietly with no one else around, only to be prepared and essentially cleared of all personal effects before welcoming an entirely new patient and their family later that same afternoon. The room must therefore contain enough elements to suggest a familiar domestic quality, while providing enough flexibility for each patient and family that uses it without appearing sterile.

Sometimes, rooms may be occupied by more than one patient, which “allows for mutual support between several patients and their families, and reduces fear by allowing families and patients to observe that death is peaceful”.¹²⁹ As such, patients and their families should be given the option of choosing a triple room over a single room. While shared accommodations may not be desirable for all, it can be comforting especially to those patients whose families may not be around to visit as frequently. Having the company of another patient or more frequent staff visits could alleviate any feelings of isolation.

Aesthetically, a hospice room should be inviting and beautiful, for ‘a beautiful room allows our personality to expand and exercise itself; a grim room makes our inner self shrink into a hard, resistant stone’.¹³⁰ In keeping with the observation that most patients will die as they lived, which is to say: uniquely, a room should not oppress any expressions of a person at their end of life. It should encourage the patient to feel comfortable in how they have grown and lived and even help in the process of accepting who they are in that moment.¹³¹

“There is more than enough in just one room to keep us occupied for a lifetime. Think of all the different hours of day and night which a room experiences. The silence and darkness of the night. The moment before dawn, before the birds break into song. The slivers of light in the corners, on the table, touching the fruit in the bowl. And all the seasons, late afternoons in autumn and Winter mornings and that period after lunch in high Summer. And then the ultimately, the fact that a room has been constituted as it has by people whose lives are passed in them.”¹³¹

– Painter Pierre Bonnard

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82. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 52
 83. *ibid* p. 24
 84. *ibid* p. 55
 85. *ibid*
 86. Doyle, D., Hanks, G.W.C. and MacDonald, N. (eds.) *Oxford Textbook of Palliative Medicine*. (Oxford: Oxford University Press. 1993) p. 652
 87. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 54
 88. *ibid* p. 99
 89. Doyle, D., Hanks, G.W.C. and MacDonald, N. (eds.) *Oxford Textbook of Palliative Medicine*. (Oxford: Oxford University Press. 1993) p. 651
 90. Lincourt, J. "A Place for Empathy: Ethics Involving Architectural Designs in Healthcare" *HEC Forum* June, 2002. 86-98. p.91
 91. *ibid*
 92. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 42
 93. Jencks, C and Heathcote, E. *The Architecture of Hope* (London: Francis Lincoln Ltd. 2010) p. 12
 94. *ibid*
 95. Jencks, C and Heathcote, E. *The Architecture of Hope* (London: Francis Lincoln Ltd. 2010) p. 27
 96. *ibid* p. 27
 97. *ibid* p. 97
 98. *ibid* p. 99
 99. *ibid* p. 75
 100. *ibid* p. 12
 101. Doyle, D., Hanks, G.W.C. and MacDonald, N. (eds.) *Oxford Textbook of Palliative Medicine*. (Oxford: Oxford University Press. 1993) p. 7
 102. Davies, J. G. *Temples, Churches, and Mosques A Guide to the Appreciation of Religious Architecture*. (New York, The Pilgrim Press: 1982). p. 24
 103. *ibid* p. 26
 104. *ibid* p. 124
 105. *ibid* p. 35
 106. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 80
 107. *ibid*
 108. Corner, J. (ed.) *Recovering Landscapes* (New York: Princeton Architectural Press, 1999) p. 14
 109. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 80
 110. Verderber, S. and Refuerzo, B.J. *Innovations in Hospice Architecture*. (New York: Taylor & Francis Inc., 2006) p. 172
 111. *ibid* p. 37
 112. Ulrich, R. "View Through a Window May Influence Recover from Surgery" *Science*, April 27, 1984. 420-1. p. 421
 113. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 52
 114. Verderber, S. and Refuerzo, B.J. *Innovations in Hospice Architecture*. (New York: Taylor & Francis Inc., 2006) p. 30
 115. *ibid* p. 31
 116. *ibid* p. 33
 117. *ibid* p. 70
 118. *ibid*
 119. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 55
 120. *ibid* p. 52
 121. *ibid* p. 61
 122. *ibid* p. 77
 123. Lincourt, J. "A Place for Empathy: Ethics Involving Architectural Designs in Healthcare" *HEC Forum* June, 2002. 86-98. p. 93
 124. *ibid*
 125. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 77
 126. *ibid*
 127. *ibid* p. 78
 128. *ibid* p. 64
 129. Doyle, D., Hanks, G.W.C. and MacDonald, N. (eds.) *Oxford Textbook of Palliative Medicine*. (Oxford: Oxford University Press. 1993) p. 656
 130. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 71
 131. Doyle, D., Hanks, G.W.C. and MacDonald, N. (eds.) *Oxford Textbook of Palliative Medicine*. (Oxford: Oxford University Press. 1993) p. 651
 132. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 71

2.3 SUMMARIZED: The Architectural Brief

As architects, it is important to understand the needs of the client and final intentions for the building with every building designed. In the case of the hospice, there are three major clients and the final intentions of the program and building are in constant flux. Our goal then is in resolving complex adjacencies, facilitating all programming elements to work to the best of their abilities within the constraints of a budget and site, while presenting a visually and experientially-pleasing atmosphere.

As mentioned earlier, this thesis will focus on the three main user groups: patients, families, and palliative care providers. At times, their needs are overlapping in terms of the holistic design of the hospice. At other times, their needs are distinctly unique to their group and sometimes at odds with the other's. Regardless, they are all primary stakeholders in the effective resolution of programmatic adjacencies, spatial qualities, and visual aesthetic. The following citations come from various sources that most accurately describe the needs or expectations of each group in order to portray the importance of addressing all three when preparing the architectural brief.



Fig. 76 Robin's House Children's Hospice

FOR THE CAREGIVERS:

The caregivers are the most permanent users of the building. They are deeply committed to ensuring the services and the ethos of the building are consistent and effective. While families and patients may come and go, the staff work all times of day throughout the year. For many, this is a lifelong career choice and the space must be conducive to preventing fatigue and emotional burnout in order to allow for the most effective delivery of palliative care services.

As cited in the preface to the Report of the National Advisory Committee on Palliative Care:

“Palliative care is about people; it is concerned with ordinary people who find themselves facing extraordinarily difficult situations: the loss of independence, the loss of financial security, the loss of all that is safe and familiar, the loss of friends and family, the loss of future and ultimately, the loss of life. It is in part concerned with providing answers, and in greater part is concerned with being there for people when there are no answers. It is in part concerned with accompanying people to a place where few are comfortable, and being there for them. It is more often dealing with uncertainty than certainty and fundamentally it seeks to respect the individual for who they are, rather than for what they do or have achieved.

In the context of palliative care, we do not always get a second chance to get things right. We have a duty of care to our patients and we also recognise the need to address the pain and suffering inevitably experienced by family members. By achieving and maintaining an optimal level of pain and symptom control for patients, we create the space and opportunity where they are free to address the many personal issues that inevitably surface at this time of life. For families, we need to ensure that as they begin to undertake the demanding work of grieving, and it is hard work, that they themselves have the opportunity to be heard and understood. The work of bereavement support begins not after the patient has died, but at the first point of contact. All of us, in sickness and in health, have a basic need to be heard and to be understood”.¹³³

FOR THE FAMILIES

While families are afforded some reprieve when a patient elects hospice care, it is important to remember that they may have been heavily involved in the patient's care prior to admission. As such, the families should feel comfortable in the hospice, instead of feeling forced to take a backseat to their loved one's care. In many situations, the families often visit the hospice before a patient is admitted, which allows them to familiarize themselves with the program and layout. Many factors are weighed in the process of choosing the right hospice, but in the end the families should feel comfortable that the specific hospice chosen for their loved one is suitable for themselves just as much as the patients.

“Family members need to feel that they are being helpful to the patient and contributing to his comfort. In the terminal stage, family members should not be discouraged from any self-sacrifice they wish to make as their last gift to the dying patient. They should not be made to feel inadequate if they are no longer able to care for the patient at home or to feel intruders at the hospital bedside.”¹³⁴

“They should be encouraged to stay close so that they will learn from the example of nurses who talk to the patient even when unconscious and hold his hand, and will develop the confidence to do the same. For those who find it too painful to be present at the death, reassurance will need to be given so that they do not suffer feelings of remorse or guilt. They will be helped by the knowledge that a member of the caring team will not leave the dying patient unattended.”¹³⁵

“Relatives need special consideration. These people are often very stressed, and physically and emotionally exhausted, and may be very emotional in terms of grief, anger, or depression. Every effort must be made in the physical environment to lessen their stresses and frustrations. They are not an additional encumbrance, but people with a legitimate right to be there.”¹³⁶

FOR THE PATIENT

While a hospice is arguably built for the purpose of caring for patients at the end of life, it is important to note that many of the services and areas in the hospice will not be frequented by them. Most patients spend the majority of their day in bed by the time that hospice care becomes appropriate and available.¹³⁷ As such, their needs are more emotionally, spiritually, and physically-based, on an individual basis. These needs are generally met within the four walls of the patient room, which should be designed to allow for the best care possible, which will vary from patient to patient. While the stay may not be longer than three weeks, one must remember that the intensity of every minute and day may surpass that of an entire lifetime. Although the patient may not directly use the hospice's other program elements or rooms, those spaces are there to support the family before and after visits with the patient. After all, the room may be the space in which last breaths are taken, last wishes are expressed, and last impressions are made. One must be prepared every time the threshold into a patient room is crossed, as well as comforted every time they leave. This may very well be the last room; the last home.

“[T]he patient who is dying wants freedom from pain, yet not in the dulling of awareness that interferes with his relationships with others. He wants friendliness and kindness and the comforting measures that tell him he is still important. He wants the familiar things that he enjoyed when he was well – the favourite foods, flowers, music, the companionship of family and friends. He wants to be well-groomed, attractively dressed. And above all, he wants to be accepted as he is, to maintain his own individuality, and to be assured that when the time comes, he will be remembered with love and respect by those who have been close to him.”¹³⁸

“Patients will live and die in these rooms and for many it will be their last contact with this world. In this context, there is no compromise, it must be absolutely right.”¹³⁹

“[I]t is of utmost importance for patients to retain their sense of self. Far more important than the patients they have become are the human beings they have always been.”¹⁴⁰

Brief for a hospice in Cork, England

“A hospice is a very special place, where patients and families live lives that are special. In this context, time is precious because it is scarce and clearly finite. A hospice is a place where ordinary people face up to extraordinary challenges and win with the help of skilled and dedicated health care professionals., triumph in the face of progressive physical deterioration and sequential losses. People live until they die and it is the job of the hospice to support and enable each patient to live their life as fully as possible. It is a place for reflection and a place to search for meaning and purpose. For many, it is perhaps the first time that they have seriously addressed the fundamental issues of life and death. The hospice building must be sympathetic to, and supportive of, our best efforts. The building must be planned to the finest detail, because we cannot afford to get it wrong”¹⁴¹

Design Guidelines for Specialist Palliative Care Settings:

“A hospice is a busy place that supports a great deal of activity; yet it must also be a calm, safe and tranquil place that facilitates quiet personal reflection. A hospice must be able to meet the needs of men and women, young and old, in-patients and out-patients and families, those with cancer and those with other conditions, those who will be discharged home and those who will not, paid staff, and volunteers. A hospice is a place where people can live, truly live, until they die. The design of a hospice unit is an extremely complex, challenging and rewarding undertaking. It does not simply involve the design of a building. It involves creating a most special place that will support the efforts of countless thousands of patients, families and staff over many years”¹⁴²

After synthesizing the aforementioned briefs and appreciating the rules and guidelines put forth by the province of Ontario, the following is the proposed brief for the 1 Riverdale Lane:

The proposed design for 1 Riverdale Lane must dissolve the boundaries between the built world and the primal world of nature where we all associate with our final resting place by allowing direct access to the outdoors and framed views of nature from inside. New habits are formed within the building, reflecting a different tempo of life. The hospice must respond to this change by providing ample opportunities for flexible programming, while maintaining a degree of purposeful adjacencies and room layouts. All at once, the hospice must allow for personal and private moments of grief or reflection, while also creating situations where family members and visitors feel at ease to explore and navigate the hospice in groups or alone.

1 Riverdale Lane will set the new standard for a purpose-built place designed to provide optimal palliative care for families who are in need of its services. It reflects the ten-bed model outlined by the Ministry of Health and Long-Term Care set forth by the Hospice Association of Ontario¹⁴³ and will provide medical support, psychotherapeutic, and bereavement services for those facing the end of life.

The proposed location is at the North Eastern corner of the new Bridgepoint Health Medical Complex at Broadview Avenue and Gerrard Avenue in Toronto, Ontario. Nearby, are Bridgepoint Hospital, Riverdale Public Library, and Riverdale East Park, as well as various restaurants and cafes. It is easily accessible by public transportation and ample parking will be provided.

Upon arrival, the hospice welcomes new patients to an environment that immediately feels like a sanctuary from the rest of the city, without being entirely removed from it. The arrival sequence cuts through the central courtyard where the sounds and stresses of the city begin to melt away and all thoughts may be centred on the coming emotional, spiritual, and physical demands of end-of-life care.

The front entrance is welcoming and familiar for those who are arriving for the first time, or twentieth time. It has a long and sheltering overhang that allows people to linger whether they require an extra moment before entering, or are unsure as to whether or not they are ready to leave. It establishes immediately, the importance of allowing for liminality and transience.

Practically, there is ample space for larger service vehicles to transport patients, while maintaining a smaller scale compared to the adjacent hospital. Ample parking is located to the side of the building, along with access for other service vehicles.

Immediately upon entering the building, one is greeted with a constantly rotating series of art installations against the backdrop of a lush courtyard beyond. The art encourages the users to re-focus their intentions, expectations, and thoughts. This central lobby subtly separates the main programming clusters in the hospice. To the left are areas such as a fireplace and dining area that are meant for the family to gather and relax. To the right are the staff offices as well as patient rooms beyond, as well as the chapel. The lobby is a generous space for decompressing before continuing to other parts of the hospice.

Another major element is the courtyard, which can be accessible from all surrounding wings. Patients have direct access from their rooms, as well as family from the eating area. For those leaving the chapel, there is a generous trellised overhang that again allows for one to take their time to come to terms with their recent experiences with death and dying.

The chapel should be visible from the street, denouncing the hospice's understanding of the spirituality involved in end-of-life care. It should have a separate entrance to accommodate visitors for a small service without disturbing others within the hospice. Its material should be warm and solid, without being ominous. It is there to acknowledge the monumentality of death without creating a separate building typology that is so foreign to the rest of the more domestic hospice.

The way in which all these separate program elements are related should reflect the seamless flow of life and end of life. Deliberate and long corridors should be avoided in favour of rooms and spaces that flow easily one into another. Special attention must be paid to creating opportunities for and quiet private moment, especially in areas where there is shared programming such as the family or dining areas.

Above all, the hospice should instill a sense of peace and tranquility while acting as a backdrop to the organic process of understanding and witnessing the end of life. 1 Riverdale Lane should be a welcoming place where patients, families, friends, and caregivers can lay down their burdens and embrace this unique, immeasurable time where humanity, love, regret, fear, grief, and loss all converge.

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133. "Design Guidelines for Specialist Palliative Care Settings" *An Roinn Sláinte (Irish) Department of Health* http://www.dohc.ie/publications/design_guidelines_palliative.html (Accessed October, 2012) pg.10-11
134. Parkes CM "Psychological Aspects" in: Saunders CM ed. *The Management of Terminal Disease*. (London, Edward Arnold, 1978.) p. 60
135. Doyle, D., Hanks, G.W.C. and MacDonald, N. (eds.) *Oxford Textbook of Palliative Medicine*. (Oxford: Oxford University Press. 1993) p. 653
136. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 35
137. *ibid* p. 67
138. Harold, M.P. and Reid, H.F. (eds.) *A New Way to Care for the Dying* (Grand Rapids: William B. Eerdmans Publishing Company, 1980) pg. 47-48
139. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 35
140. "Living Lessons" *Canadian Hospice Palliative Care Association* <http://www.living-lessons.org/resources/secured/PhysicianStoriesEN.pdf> (accessed June 2012) p. 9
141. Worpole, K. *Modern Hospice Design*. (New York: Routledge. 2009) p. 37
142. *ibid* p. 11
143. "A Residential Hospice Plan For Southeastern Ontario" *Southeastern Ontario Palliative & End-of-Life Care Network*. <http://www.seopalliativeeolcare.ca/documents/aresidentialhospiceplanforthesoutheastthin333.pdf> (accessed October 2012)

2.4 **DEVELOPED:** Design Iterations and Experiments

The design of this thesis involved many iterations and site options. Its constant re-development has resulted in the proposed design in Part III. Over the last year, there have been three sites chosen to explore, and several building designs for each. Practically speaking, the previous site options were not feasible and were only explored for their poetic opportunities. Similarly, many building designs were favoured for their gestural forms and massing, but did not meet the practical or domestic qualities that became important factors in the final design.

Conversely, this design process yielded an interesting revelation that hospices can take on a variety of different forms in just as many sites. As such, it must be noted that there need to be many buildings in many places to provide hospice palliative care services to the people who live in different places. Ultimately, each hospice should maintain the fine balance of responding appropriately to the site, creating an inviting and non-institutional street presence, while providing intimate and sensitive spaces within.

PART III

1 Riverdale Lane

3.1 THE NEED: Hospice Care in Ontario

In 2007, when the population of Ontario was roughly 13 million, there were only 183 hospice beds in Ontario receiving Ministry of Health and Long-Term Care (MOHLTC) funding.¹⁴⁴ According to the Fraser Health Authority from British Columbia, the acceptable minimum ratio of residential hospice beds to population is 7: 100, 000.¹⁴⁵ As such, 910 beds are required to meet this minimum, resulting in a lack of 727. Since then, the overall population has increased and the senior population over the age of 65 has particularly spiked due to aging ‘Baby Boomers’.

In less than fifteen years, the projected number of seniors will more than double to 11 million,¹⁴⁶ driving the demands for hospice care up as well. If awareness increases as well, demand may rise exponentially. As such, using the ten-bed hospice building model established by the MOHLTC at least 180 hospices will need to be built to keep up with demands before the 11-million mark is reached in 2026. Clearly, there is a need to explore this building typology in Ontario before the need increases drastically.

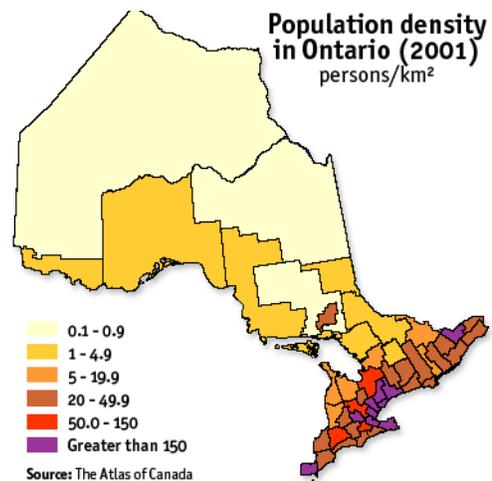
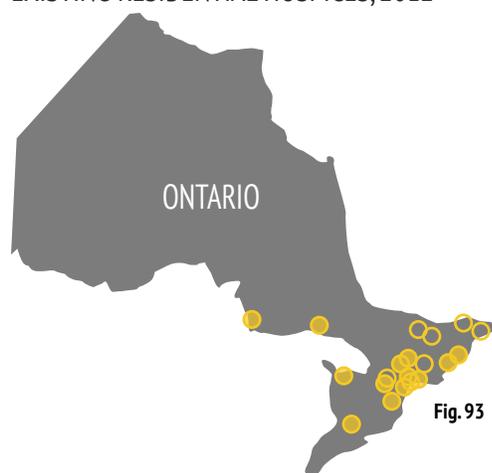


Fig. 92 Population Density in Ontario in 2001
The map shows the highest concentration in Southern Ontario, specifically Toronto.

EXISTING RESIDENTIAL HOSPICES, 2012



- 1 Beth Donovan Hospice, Kemptville
- 2 Bethell Hospice, Inglewood
- 3 Bruce House, Ottawa
- 4 Carpenter House, Burlington
- 5 Casey House, Toronto
- 6 Darling Home for Kids, Milton
- 7 Doane House Hospice, Newmarket
- 8 Dorothy Ley Hospice, Etobicoke
- 9 Dr. Bob Kemp Hospice, Hamilton
- 10 Dundas County Hospice, Williamsburg
- 11 Hill House Hospice, Richmond Hill
- 12 Heart House Hospice, Mississauga
- 13 Ian Anderson House, Oakville
- 14 Kensington Hospice, Toronto
- 15 Lisaard House, Waterloo
- 16 Maison Vale Hospice, Sudbury
- 17 McNally House Hospice, Grimsby
- 18 Perram House, Toronto
- 19 Roger's House, Ottawa
- 20 Stedman Community Hospice, Brantford

Although Ontario currently has twenty hospices dedicated to palliative care, there are at least seventy lacking to fulfill the Fraser Health minimum ratio. This number has a farther-reaching audience than only the number of beds that this will provide. The CHPCA has claimed that for every death, at least five others are critically affected who would benefit from the respite, bereavement, and support services offered in a hospice. This means that in 2020, when the number of estimated deaths due to illness will be approximately 300,000, the number of people who will benefit from hospice services will be 1.5 million Ontario residents.¹⁴⁷

Similarly, the effect of compounding numbers can be understood from an economical perspective. The provincial average cost of caring for a palliative care patient in a hospital ward is approximately \$850/day. Simply changing the location of that care from a hospital to a hospice results in a drop to \$439/day for at least the same level of care. Such a difference in cost amounts to nearly \$52 million annually that is essentially 'saved' by the province by providing palliative care services to patients in a residential hospice instead of a hospital. This number is based only on the existing twenty hospices.¹⁴⁸

Evidently, this number would increase exponentially with every new hospice built, where care is moved from within a hospital to a setting purpose-built for palliative care. Therefore, there is an economic argument for the efficacy of residential hospice care for those who cannot remain at home, but also do not require the more complex medical interventions found in hospitals. Further, the level of specialized emotional, physical, and spiritual care that can be afforded in a hospice setting is not found in the sterile, cure-driven environment of the hospital. The province of Ontario benefits in countless ways by exploring the options and importance of investing in residential hospices in as many places as there are people. This care should be accessible and available to all who are within a reasonable distance to a populated area in Ontario.

144. "A Case for Investing in Ontario's Health Care System by Funding Residential Hospices" *Hospice Association of Ontario*. <http://www.cehpcn.ca/uploads/HAOResidentialCaseFinalOct920091282768313.pdf> (accessed June, 2012)

145. "Business Case for Grey Bruce Hospice Palliative Care Program" *Grey Bruce End of Life Care Partnership*. <http://www.greybrucehospice.com/need-for-a-grey-bruce-hospice.html> (accessed June, 2012)

146. "Ontario Population Projections Update" *Ontario Ministry of Finance*. <http://www.fin.gov.on.ca/en/economy/demographics/projections/> (accessed November, 2012)

147. "Fact Sheet: Hospice Palliative Care in Canada" *Canadian Hospice and Palliative Care Association*. http://www.chpca.net/media/7622/fact_sheet_hpc_in_canada_may_2012_final.pdf (accessed October, 2011)

148. "A Case for Investing in Ontario's Health Care System by Funding Residential Hospices" *Hospice Association of Ontario*. <http://www.cehpcn.ca/uploads/HAOResidentialCaseFinalOct920091282768313.pdf> (accessed June, 2012)

3.2 THE PLAN: A Hospice for Every Neighbourhood

Although the exact site changed over the course of developing this thesis, the overall context has always been Toronto. It is arguably one of the most diverse cities in Ontario, which adds another layer of consideration for specialized hospices based on the community they serve. While various cultures are spread across Toronto, there are still noticeable pockets of distinct cultural backgrounds and religious. Knowing the target population allows for design decisions to be made specifically for their cultural and religious needs at the end of life. These more specialized hospices should not discourage others from surrounding communities who subscribe to a different faith or are part of a different cultural heritage, but simply allow for more nuanced design decisions to be made, with alterations to the program elements or chapel layouts based on that specific cultural group. Ultimately, the hope is to provide enough hospices in Toronto to serve every population group, to be within a reasonable traveling distance from as many people as possible, and to provide a network of care that is consistent and accessible.

NEIGHBOURHOODS OF TORONTO

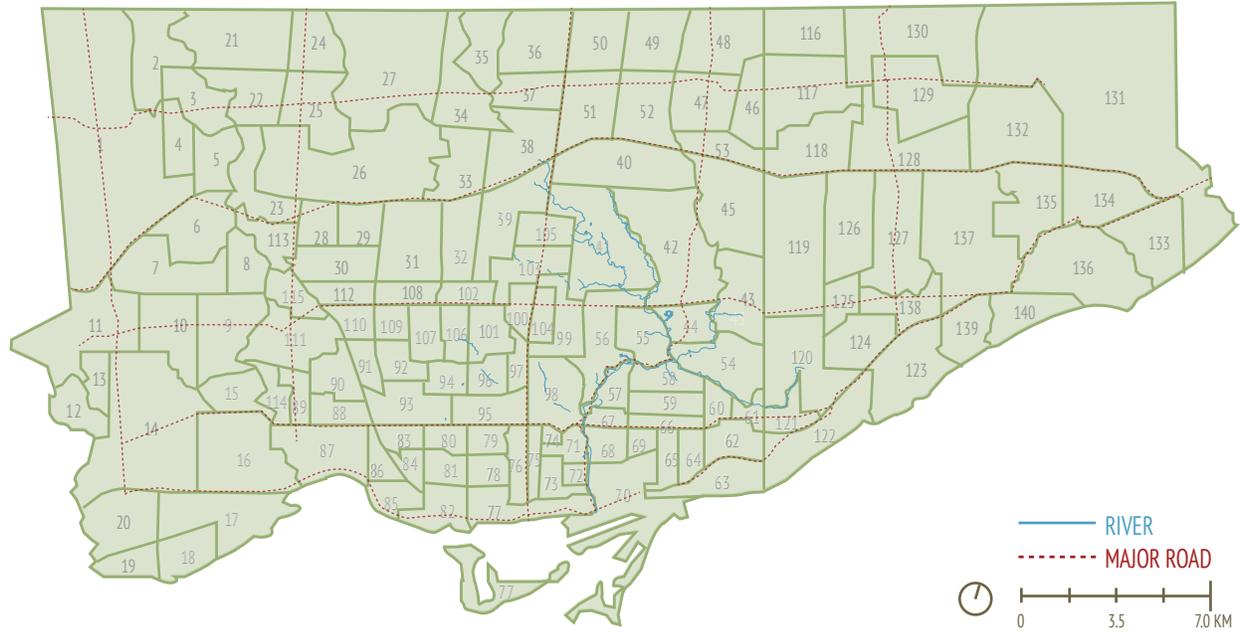


Fig. 94

- | | | | |
|-------------------------------------|--------------------------------------|---------------------------------------|----------------------------------|
| 1 West Humber-Clairville | 36 Newtonbrook West | 71 Cabbagetown-South St.James Town | 106 Humewood-Cedarvale |
| 2 Mount Olive-Silverstone-Jamestown | 37 Willowdale West | 72 Regent Park | 107 Oakwood-Vaughan |
| 3 Thistletown-Beaumont Heights | 38 Lansing-Westgate | 73 Moss Park | 108 Briar Hill-Belgravia |
| 4 Rexdale-Kipling | 39 Bedford Park-Nortown | 74 North St.James Town | 109 Caledonia-Fairbank |
| 5 Elms-Old Rexdale | 40 St.Andrew-Windfields | 75 Church-Yonge Corridor | 110 Keelesdale-Eglinton West |
| 6 Kingsview Village-The Westway | 41 Bridle Path-Sunnybrook-York Mills | 76 Bay Street Corridor | 111 Rockcliffe-Smythe |
| 7 Willowridge-Martingrove-Richview | 42 Banbury-Don Mills | 77 Waterfront Communities-The Island | 112 Beechborough-Greenbrook |
| 8 Humber Heights-Westmount | 43 Victoria Village | 78 Kensington-Chinatown | 113 Weston |
| 9 Edenbridge-Humber Valley | 44 Flemingdon Park | 79 University | 114 Lambton Baby Point |
| 10 Princess-Rosethorn | 45 Parkwoods-Donalda | 80 Palmerston-Little Italy | 115 Mount Dennis |
| 11 Eringate-Centennial-West Deane | 46 Pleasant View | 81 Trinity-Bellwoods | 116 Steeles |
| 12 Markland Wood | 47 Don Valley Village | 82 Niagara | 117 L'Amoreaux |
| 13 Etobicoke West Mall | 48 Hillcrest Village | 83 Dufferin Grove | 118 Tam O'Shanter-Sullivan |
| 14 Islington-City Centre West | 49 Bayview Woods-Steeles | 84 Little Portugal | 119 Wexford/Maryvale |
| 15 Kingsway South | 50 Newtonbrook East | 85 South Parkdale | 120 Clairlea-Birchmount |
| 16 Stonegate-Queensway | 51 Willowdale East | 86 Roncesvalles | 121 Oakridge |
| 17 Mimico | 52 Bayview Village | 87 High Park-Swansea | 122 Birchcliffe-Cliffside |
| 18 New Toronto | 53 Henry Farm | 88 High Park North | 123 Cliffcrest |
| 19 Long Branch | 54 O'Connor-Parkview | 89 Runnymede-Bloor West Village | 124 Kennedy Park |
| 20 Alderwood | 55 Thorncliffe Park | 90 Junction Area | 125 Ionview |
| 21 Humber Summit | 56 Leaside-Bennington | 91 Weston-Pellam Park | 126 Dorset Park |
| 22 Humbermede | 57 Broadview North | 92 Corso Italia-Davenport | 127 Bendale |
| 23 Pelmo Park-Humberlea | 58 Old East York | 93 Dovercourt-WallaceEmerson-Junction | 128 Agincourt South-Malvern West |
| 24 Black Creek | 59 Danforth Village - East York | 94 Wychwood | 129 Agincourt North |
| 25 Glenfield-Jane Heights | 60 Woodbine-Lumsden | 95 Annex | 130 Milliken |
| 26 Downsview-Roding-CFB | 61 Crescent Town | 96 Casa Loma | 131 Rouge |
| 27 York University Heights | 62 East End-Danforth | 97 Yonge-St.Clair | 132 Malvern |
| 28 Rustic | 63 The Beaches | 98 Rosedale-Moore Park | 133 Centennial Scarborough |
| 29 Maple Leaf | 64 Woodbine Corridor | 99 Mount Pleasant East | 134 Highland Creek |
| 30 Brookhaven-Amesbury | 65 Greenwood-Coxwell | 100 Yonge-Eglinton | 135 Morningside |
| 31 Yorkdale-Glen Park | 66 Danforth Village - Toronto | 101 Forest Hill South | 136 West Hill |
| 32 Englemount-Lawrence | 67 Playter Estates-Danforth | 102 Forest Hill North | 137 Woburn |
| 33 Clanton Park | 68 North Riverdale | 103 Lawrence Park South | 138 Eglinton East |
| 34 Bathurst Manor | 69 Blake-Jones | 104 Mount Pleasant West | 139 Scarborough Village |
| 35 Westminster-Branson | 70 South Riverdale | 105 Lawrence Park North | 140 Guildwood |

LOCAL HEALTH INTEGRATION NETWORKS

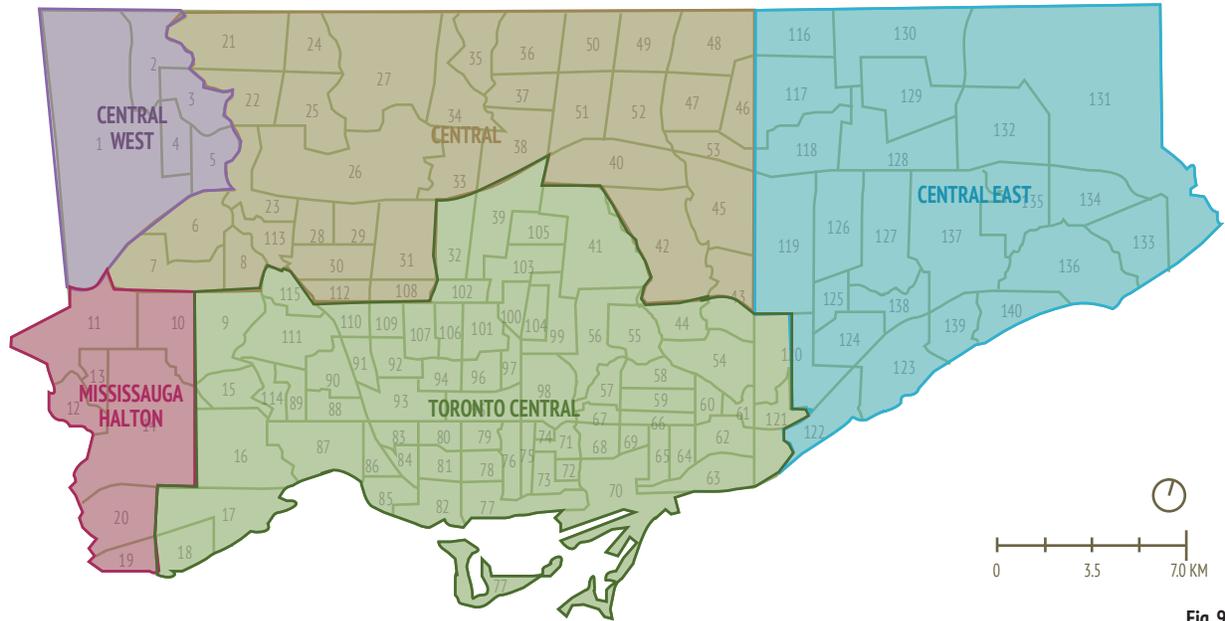


Fig. 95

The Local Health Integration Network (LHIN) was an initiative put forward by the Ontario Ministry of Health and Long-Term Care that has been in place since April 1, 2007. Each LHIN is comprised of hospitals, community care, community support programs, health centres, and long-term care. Recently, residential hospices have been added to this list. All of Ontario is divided into 14 LHINs, charged with the tasks of most efficiently planning, funding, and integrating health services within their community. This approach allows for a more tailored approach to each locality based on the different needs and priorities of each.¹⁴⁹

- | | | | |
|----|-----------------------------------|-----|------------------------------------|
| 9 | Edenbridge-Humber Valley | 80 | Palmerston-Little Italy |
| 15 | Kingsway South | 81 | Trinity-Bellwoods |
| 16 | Stonegate-Queensway | 82 | Niagara |
| 17 | Mimico | 83 | Dufferin Grove |
| 18 | New Toronto | 84 | Little Portugal |
| 32 | Englemount-Lawrence | 85 | South Parkdale |
| 39 | Bedford Park-Nortown | 86 | Roncesvalles |
| 41 | Bridle Path-Sunnybrook-York Mills | 87 | High Park-Swansea |
| 54 | O'Connor-Parkview | 88 | High Park North |
| 44 | Flemingdon Park | 89 | Runnymede-Bloor West Village |
| 55 | Thorncliffe Park | 90 | Junction Area |
| 56 | Leaside-Bennington | 91 | Weston-Pellam Park |
| 57 | Broadview North | 92 | Corso Italia-Davenport |
| 58 | Old East York | 93 | Dovercourt-WallaceEmerson-Junction |
| 59 | Danforth Village - East York | 94 | Wychwood |
| 60 | Woodbine-Lumsden | 95 | Annex |
| 61 | Crescent Town | 96 | Casa Loma |
| 62 | East End-Danforth | 97 | Yonge-St.Clair |
| 63 | The Beaches | 98 | Rosedale-Moore Park |
| 64 | Woodbine Corridor | 99 | Mount Pleasant East |
| 65 | Greenwood-Coxwell | 100 | Yonge-Eglinton |
| 66 | Danforth Village - Toronto | 101 | Forest Hill South |
| 67 | Playter Estates-Danforth | 102 | Forest Hill North |
| 68 | North Riverdale | 103 | Lawrence Park South |
| 69 | Blake-Jones | 104 | Mount Pleasant West |
| 70 | South Riverdale | 105 | Lawrence Park North |
| 71 | Cabbagetown-South St. James Town | 106 | Humewood-Cedarvale |
| 72 | Regent Park | 107 | Oakwood-Vaughan |
| 73 | Moss Park | 109 | Caledonia-Fairbank |
| 74 | North St. James Town | 110 | Keelesdale-Eglinton West |
| 75 | Church-Yonge Corridor | 111 | Rockcliffe-Smythe |
| 76 | Bay Street Corridor | 114 | Lambton Baby Point |
| 77 | Waterfront Communities-The Island | 115 | Mount Dennis |
| 78 | Kensington-Chinatown | 120 | Clairlea-Birchmount |
| 79 | University | 121 | Oakridge |

TORONTO CENTRAL SUB-LHINs

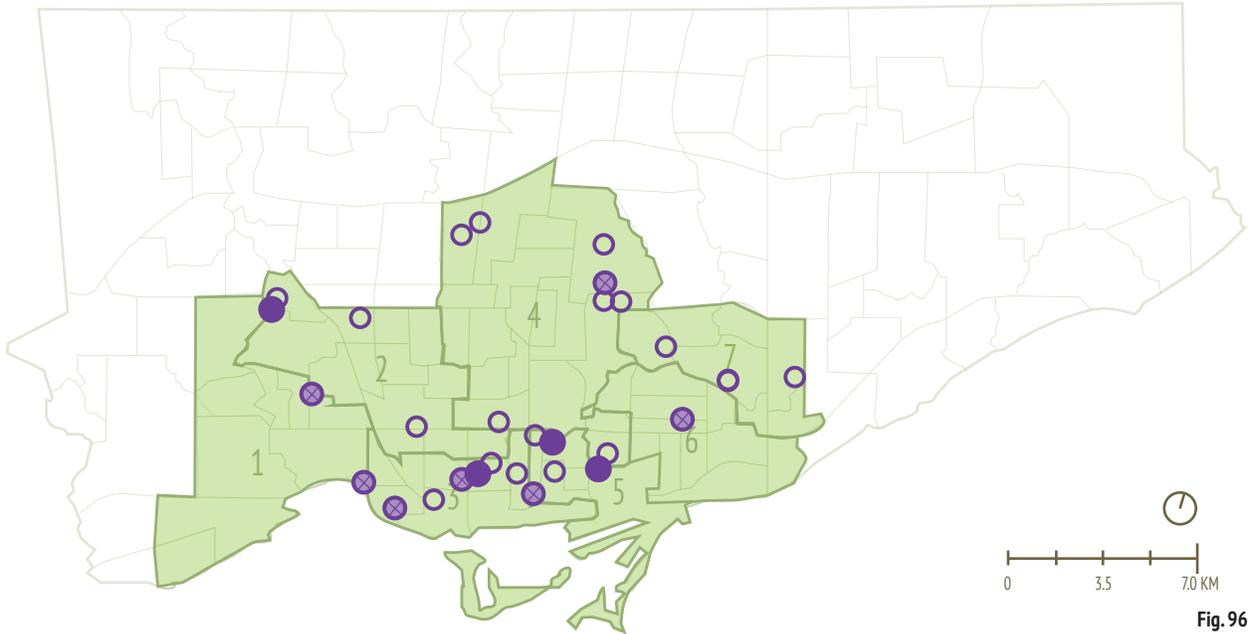


Fig.96

- GENERAL HOSPITAL
- ⊗ HOSPITAL WITH PALLIATIVE CARE SERVICES
- RESIDENTIAL HOSPICE

- 1 WEST ETOBICOKE | HIGH PARK
- 2 NORTH WEST DAVENPORT | BLOOR
- 3 SOUTH WEST WEST DOWNTOWN | PARKDALE
- 4 NORTH CENTRAL MIDTOWN | LEASIDE | NORTH RIVERDALE | FOREST HILL
- 5 SOUTH EAST EAST DOWNTOWN | SOUTH RIVERDALE
- 6 EAST OLD EAST YORK | EAST END | THE BEACH
- NORTH EAST FLEMINGDON | THORNCLIFF | CRESCENT TOWN

For the purpose of this thesis, the focus will be on the Toronto Central LHIN highlighted in green above. Toronto Central is the most densely populated with approximately 1.15 million residents, of which 43% are immigrants who speak over 160 languages and dialects. Toronto Central LHIN's health services are also used by over 2 million daily commuters into the city.¹⁵⁰ Due to such diversity and unique needs of individuals and specific cultural communities, Toronto Central is divided further into six sub-LHINs as shown above.

TORONTO CENTRAL LHIN POPULATION DENSITY

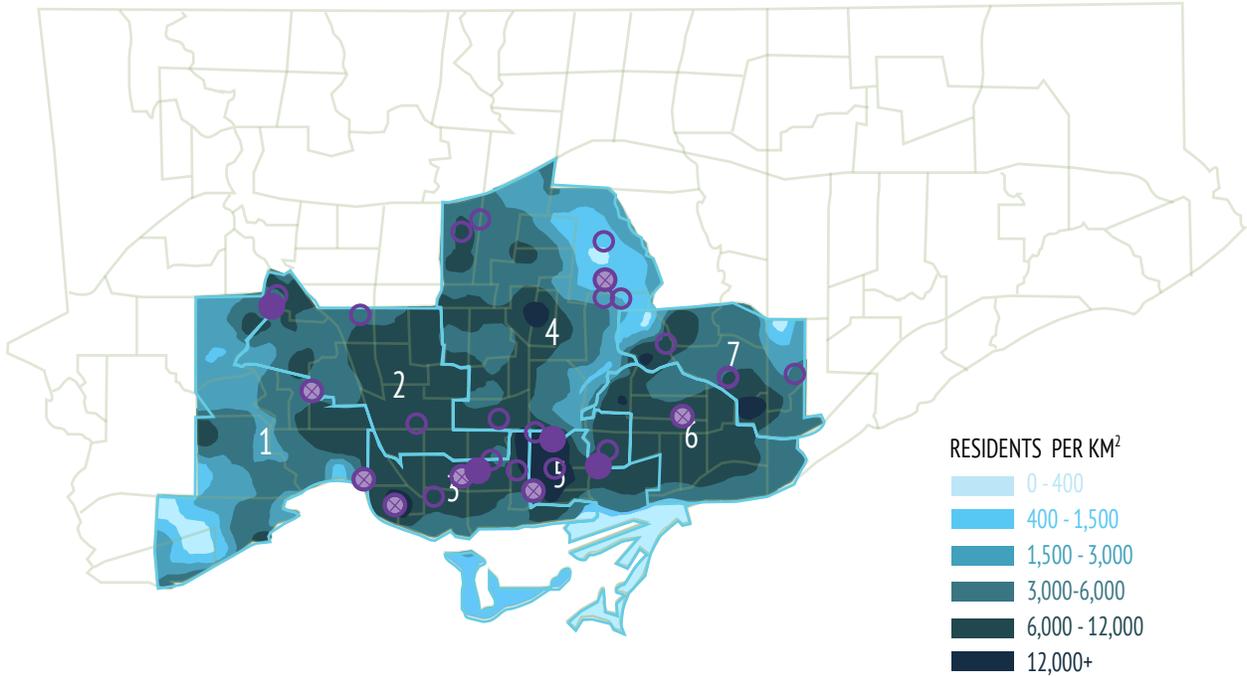


Fig.97

SENIOR (65 YRS +) POPULATION DISTRIBUTION

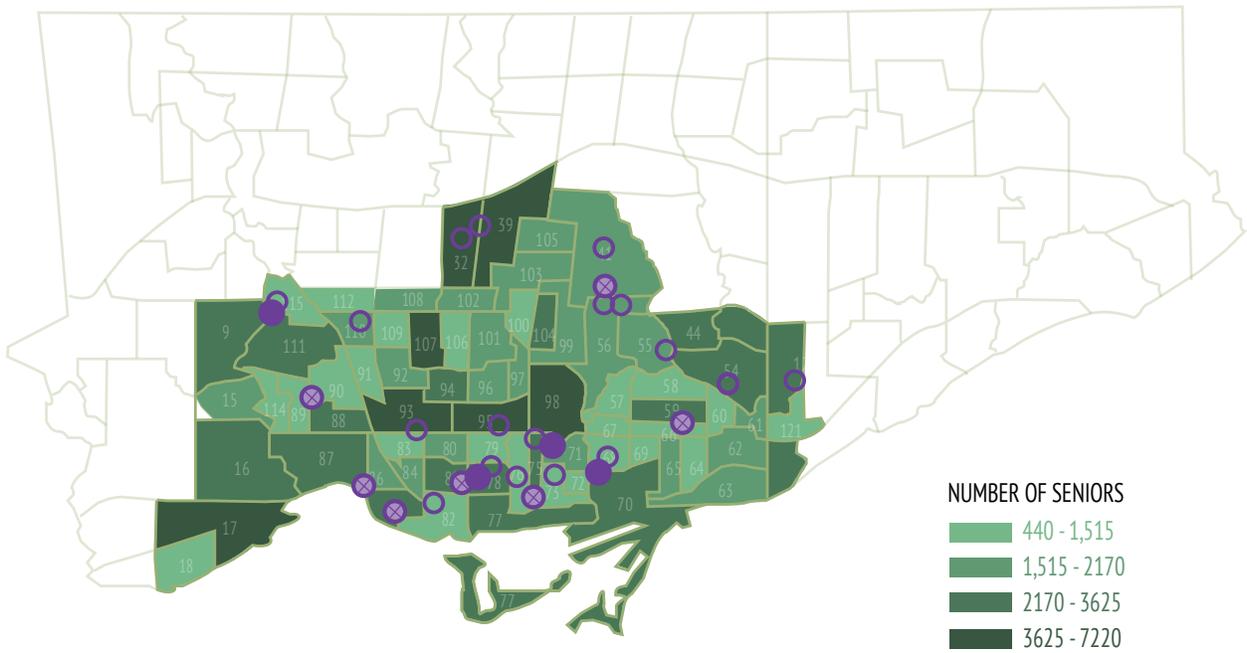


Fig.98

HOSPICE IMPLEMENTATION PER NEIGHBOURHOOD

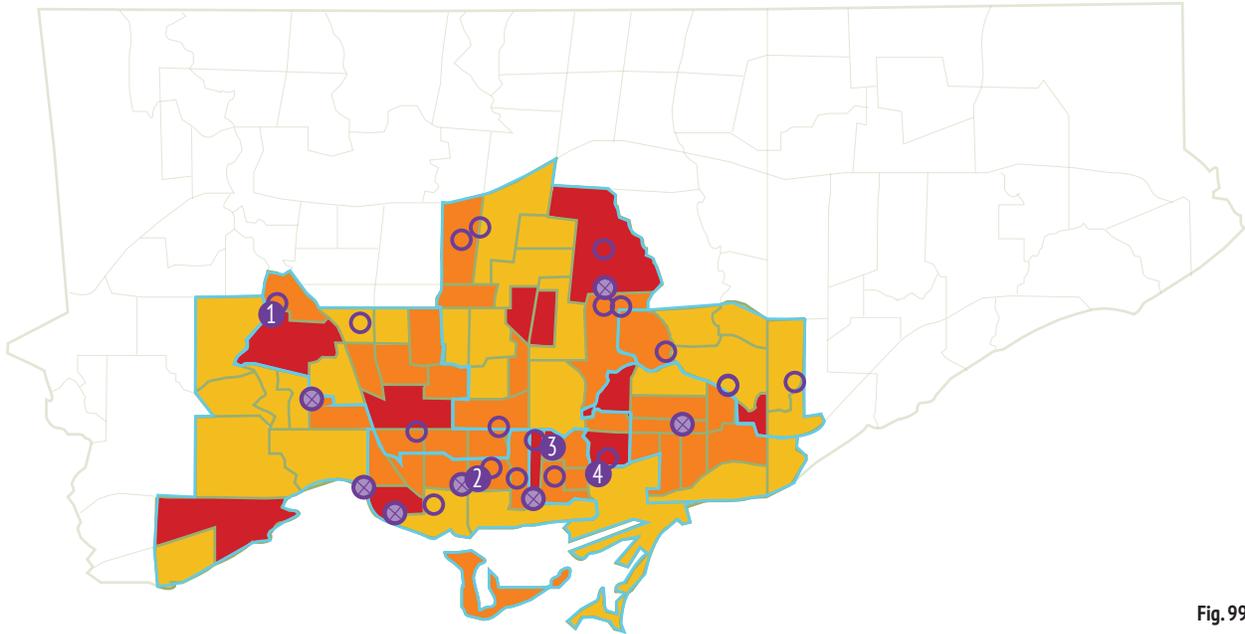


Fig. 99

NEIGHBOURHOOD PRIORITY

■ PRIORITY-3

■ PRIORITY-2

■ PRIORITY-1

① DOROTHY LEY HOSPICE

② KENSINGTON HOSPICE

③ CASEY HOUSE (AIDS Specialty Hospice)

④ EMILY'S HOUSE (Children's Hospice)

The distribution of seniors over the age of 65 is varied across Toronto. Toronto Central LHIN has the fastest growing 85+ population in Ontario and requires much attention.¹⁵¹ Arguably, those over the age of 85 and the families who care for them, would benefit greatly from hospice services. Therefore understanding their population distribution within the LHIN can help to determine which areas would benefit the most from hospice implementation. It is visible by the distribution of people, specifically seniors, and medical facilities with or without access to palliative care services, that there are many distinct neighbourhoods that lack nearby services. The map above shows recommendations for implementing a network of residential hospices in each neighbourhood in the Toronto Central LHIN. Priorities were ranked based on neighbourhoods that displayed the greatest need and benefit based on population density senior and distribution, which are good indicators of vehicular accessibility as well as living desirability. It is also based on proximity to existing facilities. While there are four residential hospices as listed, only Dorothy Ley and Kensington Hospice fall into the category of residential hospice for this specific demographic. While priority has been given to certain neighbourhoods, over time, the hope is that there is a hospice in every neighbourhood.

TWELVE PRIORITY-1 NEIGHBOURHOODS

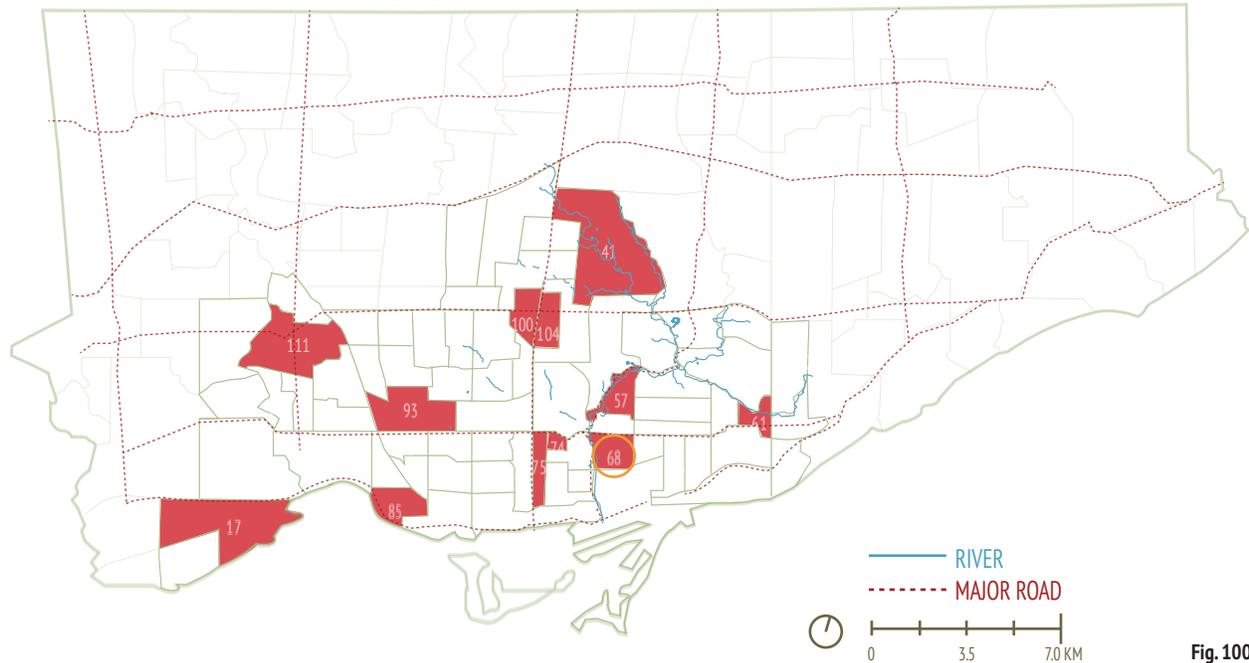


Fig. 100

Each of the twelve neighbourhoods listed to the right could benefit from the earliest wave of hospice implementation. Geographically, they are situated in very accessible areas that would allow for easier access for those Priority-2 and Priority-3 neighbourhoods that may not yet have a hospice of their own. They are also some of the denser neighbourhoods, which increase their usefulness to more people at once. As well, there is a strong seniors presence in these areas, who could be direct beneficiaries of these services.

PRIORITY 1 NEIGHBOURHOODS

- 17 Mimico
- 41 Bridle Path-Sunnybrook-York Mills
- 57 Broadview North
- 61 Crescent Town
- 68 North Riverdale
- 74 North St. James Town
- 75 Church-Yonge Corridor
- 85 South Parkdale
- 93 Dovercourt-Wallace Emerson-Junction
- 100 Yonge-Eglinton
- 104 Mount Pleasant West
- 111 Rockcliffe-Smythe

During the development of this thesis, many of these neighbourhoods were considered for choosing the final site. Both Mimico and South Parkdale were enticing choices for their proximity to Lake Ontario. Broadview North, Crescent Town, North Riverdale, and the Sunnybrook neighbourhoods were favourable due to their proximity to the Don River. Many also had impressive parks and established public places. In the end, the neighbourhood of North Riverdale was chosen to explore in greater depth, as will be discussed in the following section.

149. "Ontario's Local Health Integration Networks" Ontario *Ministry of Health and Long-Term Care*. <http://www.lhins.on.ca/> (accessed November, 2012)

150. "Toronto Central LHIN" Ontario *Ministry of Health and Long-Term Care*. <http://www.torontocentrallhin.on.ca/> (accessed November, 2012)

151. *ibid*

3.3 THE SITE: Bridgepoint Health

Although the exact site changed over the course of developing this thesis, the overall context has always been Toronto. It is arguably one of the most diverse cities in Ontario, which adds another layer of consideration for specialized hospices based on the community they serve. While various cultures are spread across Toronto, there are still noticeable pockets of distinct cultural backgrounds and religious. Knowing the target population allows for design decisions to be made specifically for their cultural and religious needs at the end of life. These more specialized hospices should not discourage others from surrounding communities who subscribe to a different faith or are part of a different cultural heritage, but simply allow for more nuanced design decisions to be made, with alterations to the program elements or chapel layouts based on that specific cultural group. Ultimately, the hope is to provide enough hospices in Toronto to serve every population group, to be within a reasonable traveling distance from as many people as possible, and to provide a network of care that is consistent and accessible.

THREE SITE LOCATION OPTIONS

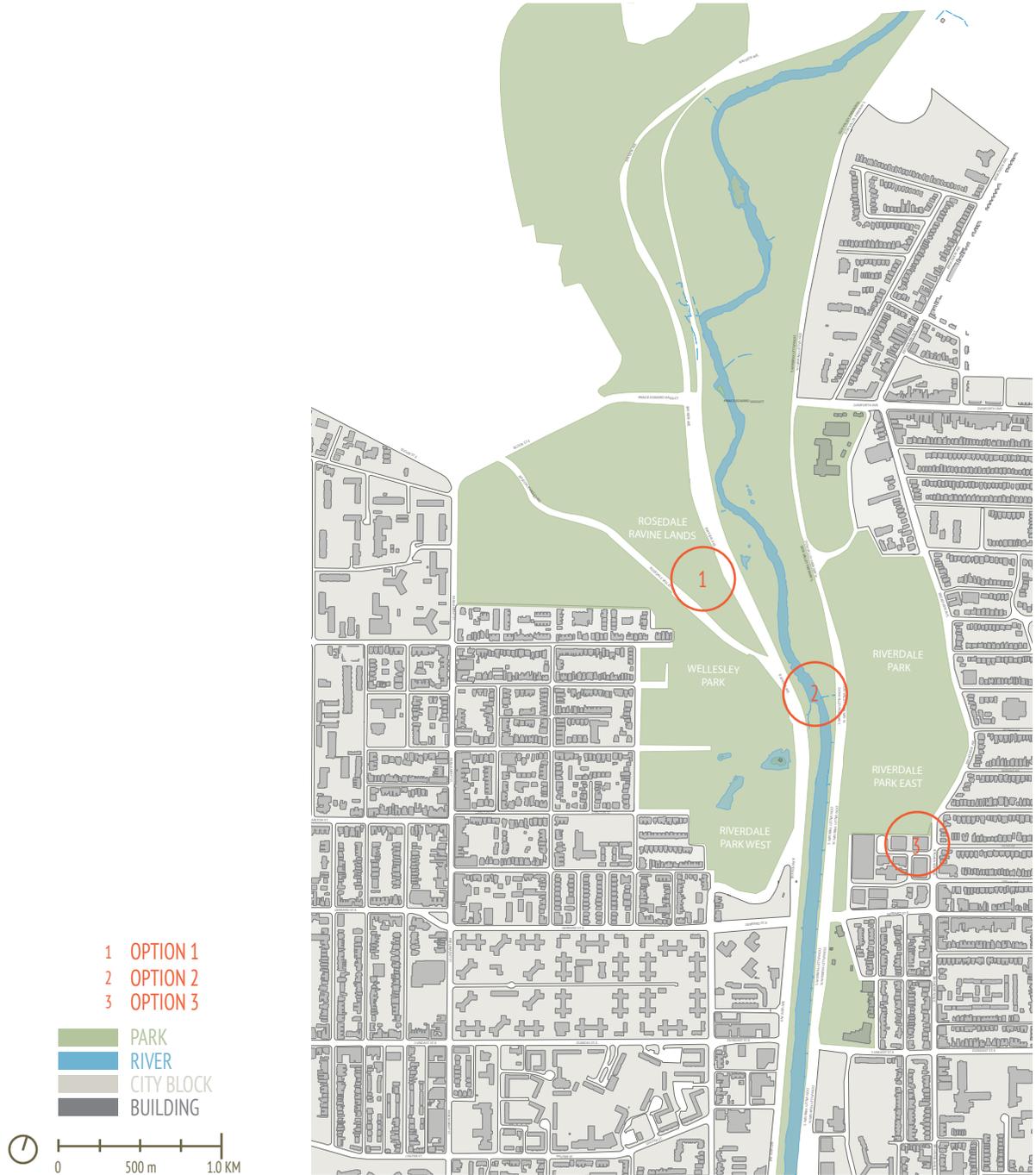
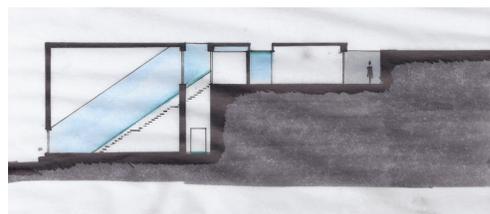
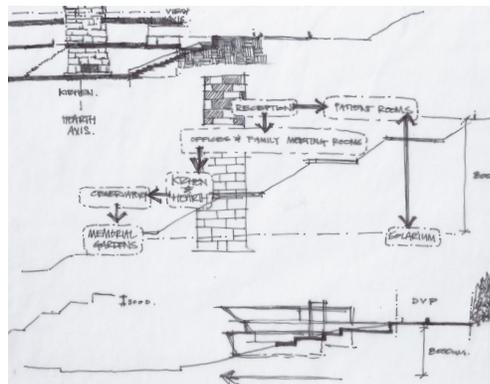
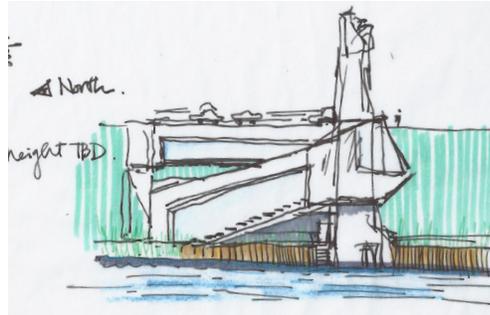


Fig.101

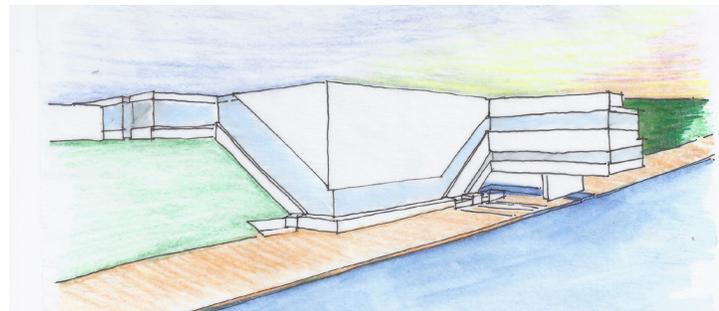
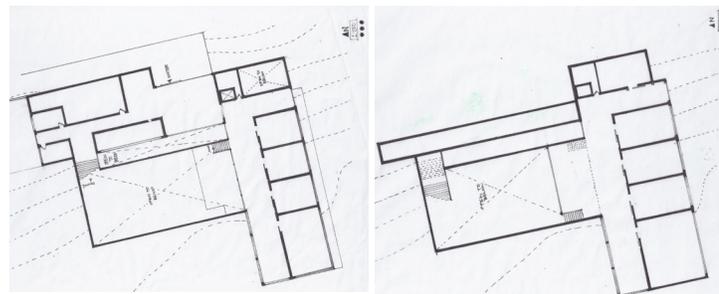
Figs. 107-113 Sketches for Site Option 2



OPTION 2: DON RIVER

The Don River site was favoured for the poetic opportunities to incorporate the metaphor of water into the building. There were opportunities to also use the hospice to bring more attention to an equally marginalized portion of Toronto's landscape by providing programming for those exploring the Don River Trail by foot or bike. There was also an interesting dynamic between situating the hospice on the banks between the man-made Don Valley Parkway and the natural Don River, which run side by side in a continuous race towards Lake Ontario. Its historical significance was also a desirable facet to explore.

Views to the water, sunsets down the river, and an interesting sloping terrain were all contributors to an interesting design exercise. Providing a shared communal space along the river's edge was a strong key concept, but provided some practical difficulties and privacy issues by mixing private and public programming. Accessibility via the Don Valley Parkway was feasible, though no public transportation was available. Ultimately, the Don River site was purely speculative, for the practical impossibilities of building on this site far outweighed the poetics it would afford. The sensitivity of the site, in the end, hindered the design develop, instead of helping it.



BRIDGEPOINT HEALTH AND SURROUNDING NEIGHBOURHOOD ANALYSIS



Fig. 114



Fig. 115 North-East Corner of Site



Fig. 116 Dense Residential Neighbourhood Street: Langley Ave.



Fig. 117 Riverdale Park East with DVP and Bloor Viaduct



Fig. 118 Busy Street Corner of Broadview and Gerrard



Fig. 119 View from North Edge of Site into Riverdale Park East

OPTION 3: BRIDGEPOINT HEALTH

Bridgepoint Health is located at the corner of Gerrard Avenue and Broadview, Avenue to the East side of the Don River, and south end of Riverdale Park East. The entire site is currently under renovation for a new Master Plan for a state-of-the-art medical health complex designed by Toronto architecture firm Diamond and Schmitt, as indicated by the dark red buildings on the site plan. The hatched section indicates the site boundaries for the hospice itself. This corner of the complex is currently zoned for an 8-10 storey mixed use building¹⁵², whose use is to be determined at a later phase of development. This became the ideal location to situate the hospice: at 1 Riverdale Lane.

Overall, the neighbourhood is densely residential, with ample park space and a good balance of commercial activity along the major streets of Gerrard and Broadview. Within this small area, there are four churches that are firmly tucked into the residential fabric, which suggests a high importance on spirituality within the community. As well, they are recognizable landmarks located at the corner of each block. This is an important precedent for the further development of the hospice programming.

There is also ample public transportation available along Broadview and Gerrard, as indicated on the map. There is notable pedestrian traffic in this tightly spaced neighbourhood and Riverdale Park East is always filled with runners, families, sports teams, and various other activities. While the Don Valley Parkway is just to the West of the site, the noise from the busy highway is muffled by the dense greenery that surrounds the site and is replaced by the sounds of more immediate neighbourhood activities.

The area has a rich cultural history, which remains a large part of the Bridgepoint development. Situated within the site are the historical Don Jail and Don Jail Governor's House. The former is being preserved and incorporated into the administrative wing of the new, attached hospital and the latter is being preserved and renovated to become the new Philip Aziz Children's Hospice (Emily's House). This introduction of palliative care into the complex provides a significant advantage to the idea of designing another hospice located within the same health complex for adults and seniors.

152. "Community Master Plan" *Bridgepoint Health*. <http://www.bridgepointhealth.ca/masterplan> (accessed June, 2012)

3.4 THE DESIGN: Hearth, Garden, Chapel

1 Riverdale Lane can best be summarized as a series of thresholds from one space to another, guiding patients and families through the various stages of the end of life. Like a domestic home, the wayfinding is easy and there is an instinctive ease to maneuvering around. When designing this, the most important consideration was for all users to feel that there was no rush and that ample space was given for the difficult time ahead. Whether it is a mother visiting her daughter, or a son reuniting with an estranged father, the hospice provides a safe place for emotions and intimate human moments.

Families are welcome at all times of day and are invited to stay for minutes or days, if they so choose. By the time they arrive for the first time to visit their loved one, a previous visit will likely have been arranged for a quick tour. After that initial walk-through, families should no longer feel like strangers. Meals can be prepared and shared in the generous space of the kitchen (hearth) or privacy is afforded for those in the garden, chapel, or library. Regardless of what state of mind someone enters the hospice with, whenever they choose to leave, they should feel less fearful and perhaps more hopeful.

1 RIVERDALE LANE



Fig.120

SITE PLAN

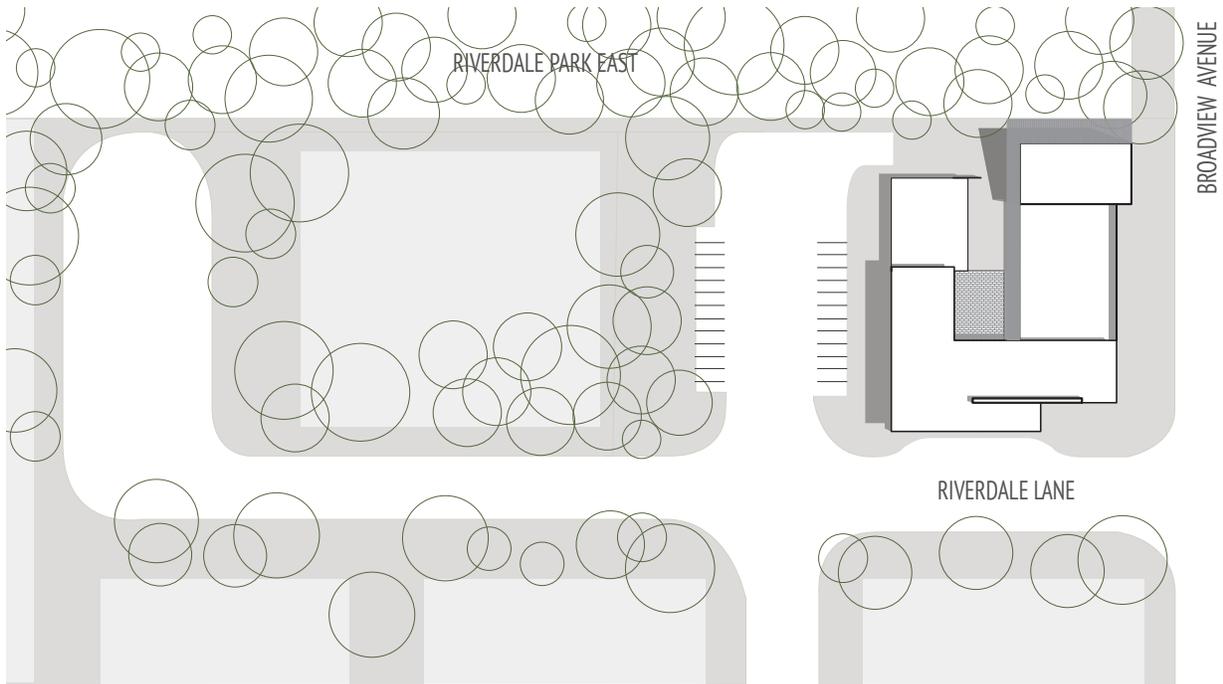


Fig.121

ROOM DESCRIPTIONS

- | | |
|-------------------------------|----------------------------|
| 1 Foyer and Greeting Area | 30 Mortuary |
| 2 Staff and Volunteer Hearth | 31 Viewing Room |
| 3 Director's Office | 32 Sitting Area |
| 4 Staff Offices | 33 Family Hearth |
| 5 Private Courtyard Suite | 34 Communal Dining Room |
| 6 Triple Courtyard Suite | 35 Communal Kitchen |
| 7 Triple Streetview Suite | 36 External Courtyard |
| 7 Informal Meeting Area | 37 Family Quiet Room |
| 8 Servery / Patient Food Prep | 38 Laundry & Back of House |
| 9 Chapel / Meditation Room | |



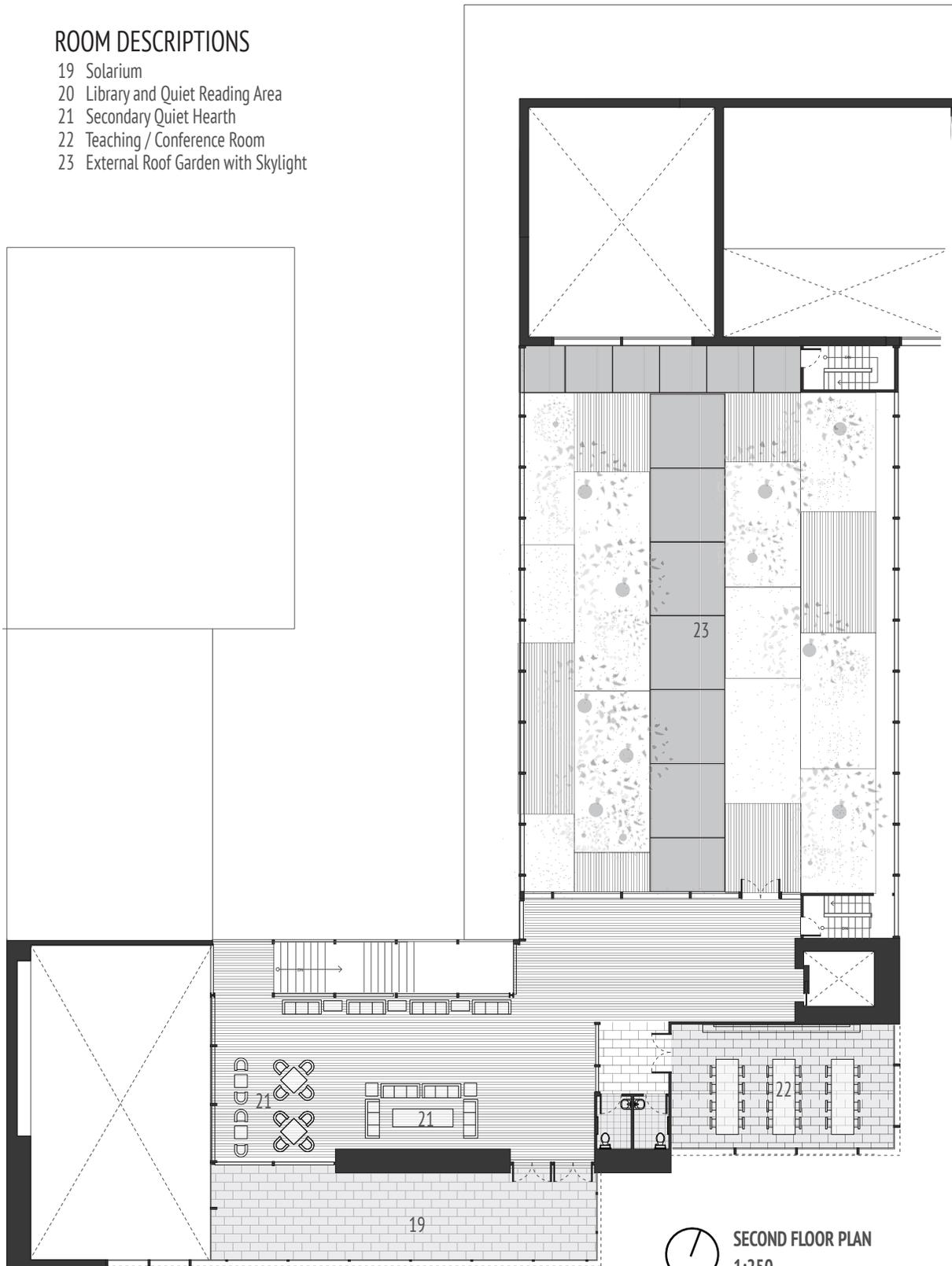
FIRST FLOOR PLAN

1:250

Fig. 122

ROOM DESCRIPTIONS

- 19 Solarium
- 20 Library and Quiet Reading Area
- 21 Secondary Quiet Hearth
- 22 Teaching / Conference Room
- 23 External Roof Garden with Skylight



SECOND FLOOR PLAN
1:250
Fig.123

'BIG MOVES'

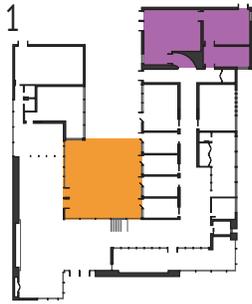


Fig. 124

Chapel to have street presence and proximity to park

Establish interior courtyard



Fig. 125

Suites with connection to courtyard or street depending on preference of patient

Option for either triple and single-occupancy

Orientaion to allow direct morning or afternoon sunlight

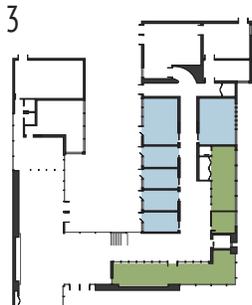


Fig. 126

Staff to act as 'buffer' between street and interior programming

Act as first point of contact

Proximity to patient suites

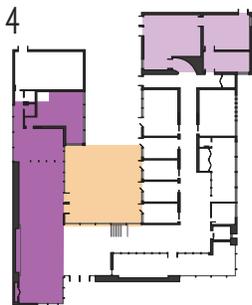


Fig. 127

Family areas with easy access from foyer and to courtyard

Allow for distance from patient bedrooms to decrease noise and encourage emotional

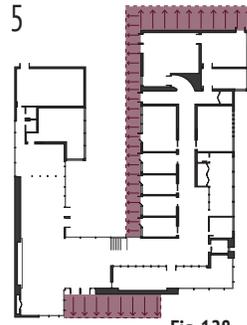


Fig. 128

Provide interstitial, liminal space between inside and out that encourages users to decompress before entering and exiting

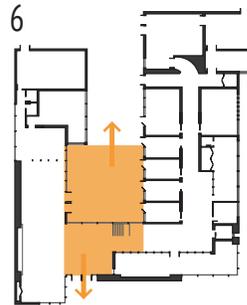


Fig. 129

Use courtyard as buffer space between entrance and park beyond

Encourage connection and views to nature

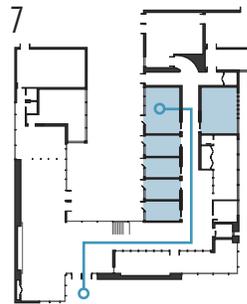


Fig. 130

Patient transfer route from main entrance drop-off to bedroom, past staff rooms and courtyard

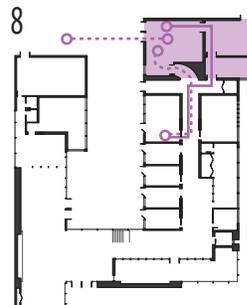


Fig. 131

Sequence from patient suite to viewing room for families after death

Viewing room to mortuary or holding room with direct access out for transferral of body

Mortuary to chapel for service

SOUTH ELEVATION (RIVERDALE LANE)
1:250

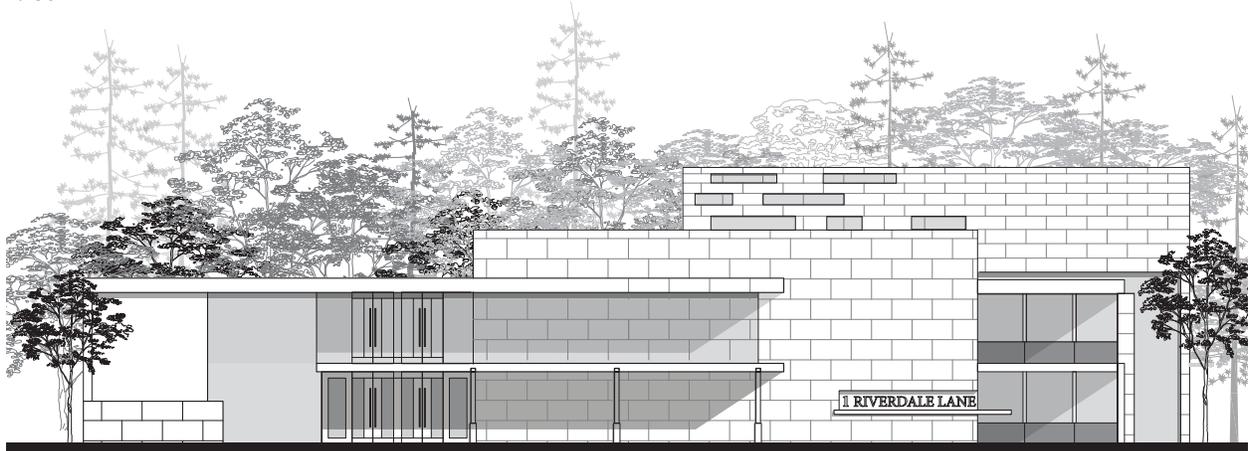


Fig. 132

NORTH ELEVATION (RIVERDALE PARK EAST)
1:250

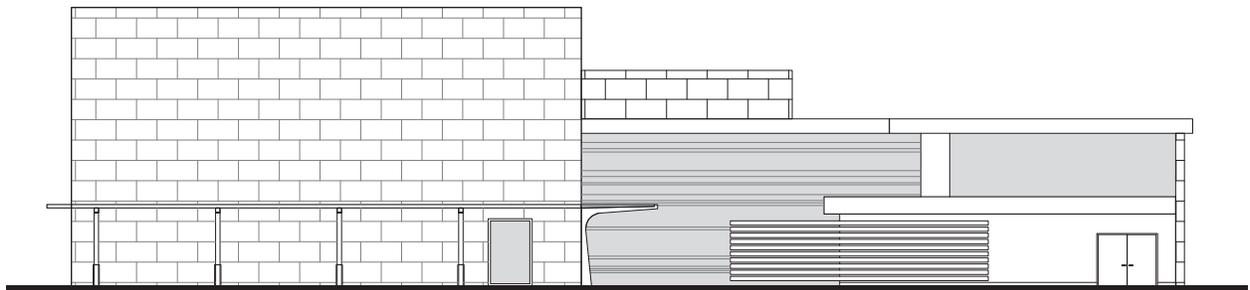


Fig. 133

WEST ELEVATION (BRIDGEPOINT HOSPITAL)
1:250

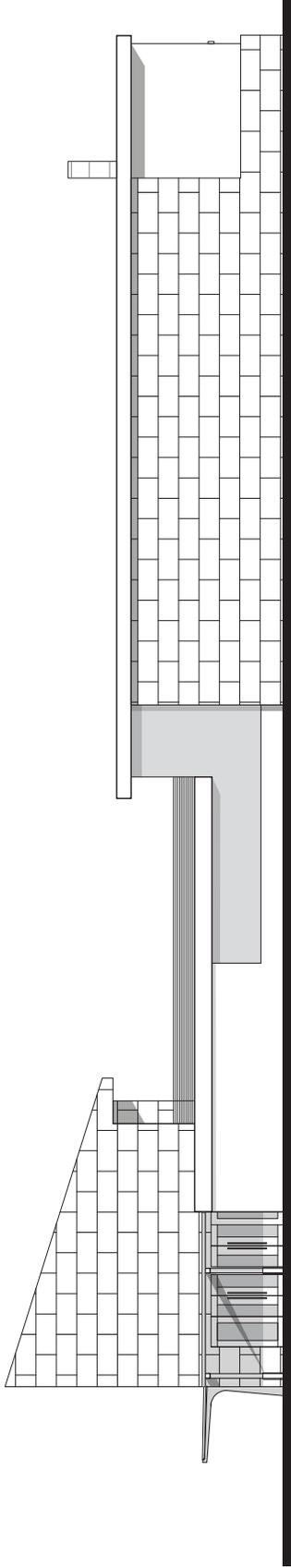


Fig. 134

SECTION LOOKING EAST TO PATIENT BEDROOMS
1:250

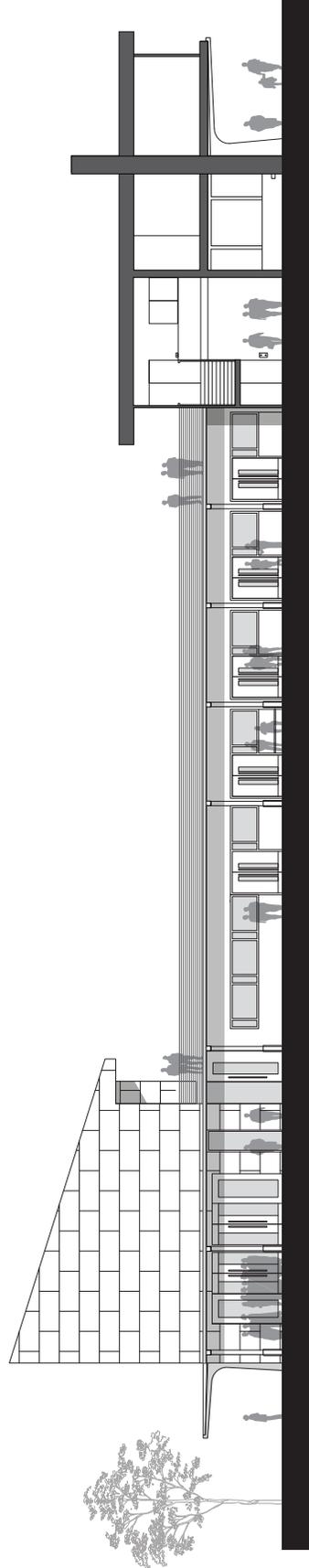
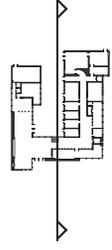


Fig. 135



EAST ELEVATION (BROADVIEW AVENUE)
1:250

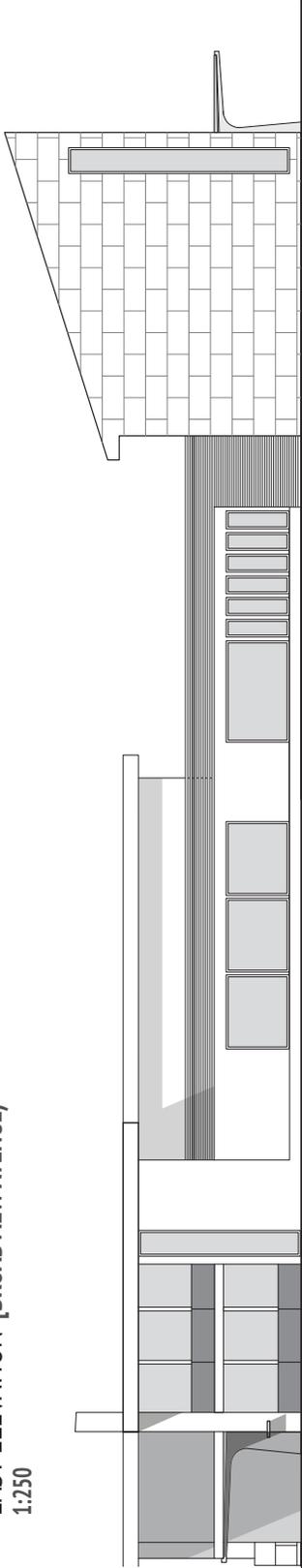


Fig. 136

SECTION LOOKING WEST TO KITCHEN AND FAMILY QUIET ROOM
1:250

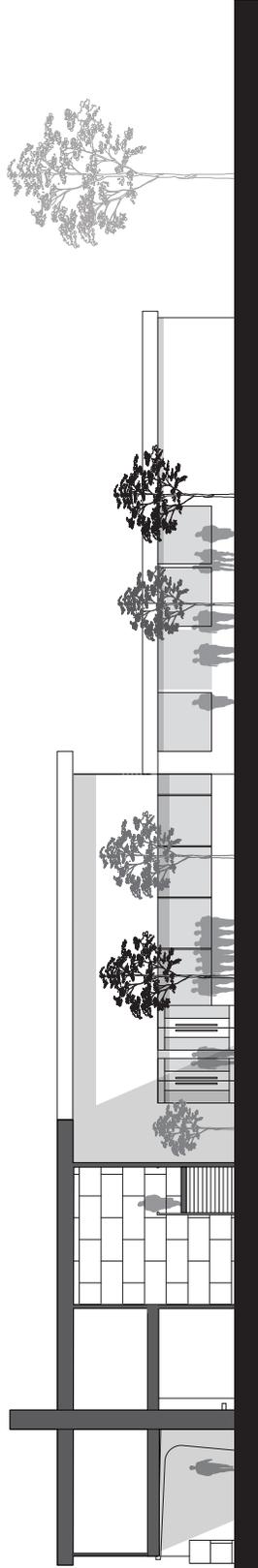
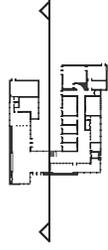


Fig. 137



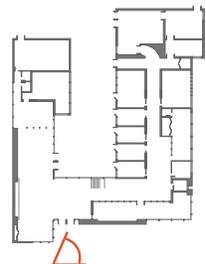
ENTRANCE



Fig. 138

The entrance of the hospice features a long overhang that allows for families to linger a while before entering or exiting the building. The glass facade reflects the life and city around it, supported by wood and stone. The entrance is a true buffer as it keeps the entrance off the immediate sidewalk and allows for a different surface than asphalt to greet each visitor.

It is busy, with Broadview Avenue's consistent traffic. Cyclists, pedestrians, drivers, and public transportation can be seen whirring by, while Riverdale Lane itself is a little quieter. Throughout the day, families of every race, size, and social status can be seen entering and exiting. The hospice is one of the first buildings to be encountered upon entering the Bridgepoint Health Complex and states boldly that the activities that occur within its walls are not shameful or foreign. Instead, it stands to say to the neighbourhood that dying is just as much a part of life as living itself.



FOYER & GREETING AREA

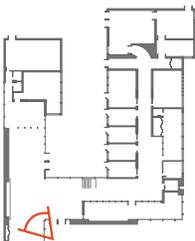


Fig. 139

The foyer is a generous area where the users are encouraged to proceed at their own pace. Whether they are visiting for the first time to determine if this is the right facility for their loved on, or they have been visiting for weeks, the foyer accommodates for everyone. Immediately, and without signage, it is easy to understand the domestic layout of the shared areas.

Throughout the year, there is a rotating art collection as well as permanent pieces that allow for reflection and contemplation. Beyond is the courtyard for those who are not ready to be inside quite yet. To the left, is the hearth, where a warm fire can be enjoyed with others.

Beyond, is the open dining area where families can meet and share over a small meal. The kitchen area is open and accessible, allowing family members to make a cup of tea or warm up a meal at their convenience. Behind the kitchen is a quiet family room for those who would like some privacy. Families can look through the courtyard to the patient bedrooms, establishing a strong visual and physical connection to their loved ones.



HEARTH

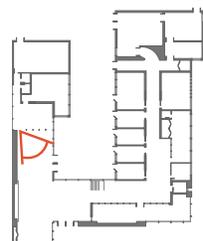


Similar to most domestic places, the kitchen is at the heart of the shared space, encouraging interaction and sharing amongst the users. There is both a visual connection to the courtyard as well as the entrance.

Fig. 140

This is not a traditional 'dining room', allowing instead for impromptu and casual meals. Due to the round-the-clock activity in a hospice, the kitchen will be in use at all times of the day. Even if a meal is not being prepared, it is a well-lit area that provides seating and a comfortable environment to enjoy each other's company.

Here, no user should feel like a stranger who is intruding. It is a communal area that allows for flexibility and ease of use. On a sunny day, the courtyard doors can be open and meals can be brought outside.



COURTYARD - GARDEN



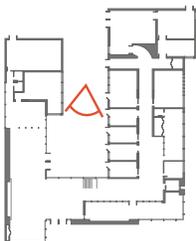
Fig. 141

The courtyard is accessible via the kitchen, patient bedrooms, and chapel. It serves as a strong visual connector between these three spaces. It is a neutral program area for an abundance of activities and users. Throughout the day, the sun moves across it, creating interesting shadows and reflections, and warming up the stone.

Patients with a courtyard bedroom have visual and direct access to it, as they watch and potentially interact with those who are in the space. As the seasons change, so do the trees, providing different colours and coverage as the year moves on.

There are opportunities for gardening and planting, which everyone may contribute to. Fresh herbs and flowers can change the fragrances that come into the patient bedroom windows.

The chapel doors also open up to this courtyard, where one can take a brief moment to reflect while under the generous trellis covering.



PATIENT SUITES



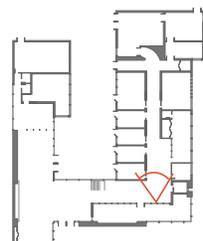
Fig. 142

The patient rooms are located on the other wing of the hospice from the family areas, though they still share the connection of the courtyard.

One end of bedroom corridor are the staff offices. This allows for the caregivers to provide immediate and constant care for the patients while they are here. It is the quieter side of the hospice, where the other end of the corridor leads to the chapel and meditation area. The ample corridor width allows for transferring patients on gurneys and hospital beds.

The beam of sunlight on the stone wall moves downwards throughout the day as it comes in through a skylight separating the bedrooms from the chapel. Noise from the street is buffered by an informal meeting area where caregivers and families can meet to discuss goals of care or any concerns that are arising.

From the bedrooms, patients can be brought upstairs to the solarium or accessible roof garden via the elevator next to the staff offices.



SUITE INTERIOR



Fig. 143

There are three options for bedrooms in this hospice. Private rooms for one patient look out into the courtyard. Warm light enters the windows from noon onwards, until the sun sets. Each private suite has its own door to access the courtyard. This is an ideal option for patients who have frequent visitors who like to sit and keep vigil for hours on end. However, this may not always be the case, so a shared suite with courtyard access is also available. Instead of a double room, a triple room is offered. This ensures that even if one patient dies, there is still moral support and company for the remaining two. The triple room is a recommended choice for families who may not have experienced death before and may observe that the process is not horrifying or filled with pain. Finding closer support from other visitors in that room may also help to ease the fear and uncertainty around a dying family member. Across the hallway is another triple suite with views out onto the street. While noise control will be vigilantly controlled, there may be some patients who enjoy feeling as though they are still very much a part of life outside the hospice's walls. Regardless of which suite is chosen, the patients and families will feel at ease, and prepared to face the emotional and physical challenges of coming weeks, together.



CHAPEL -- MEDITATION -- REFLECTION

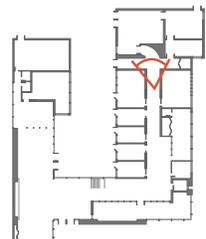


Fig. 144

The chapel is located on the North end of the building next to Riverdale Park. Made entirely of stone, it is an anchor for the rest of the hospice. While there is no religious affiliation, it roots the idea of end of life in spirituality and reflection.

During the day, families may choose to retreat here and simply watch the sunbeams move across the stone walls. Other days, there may be an official service being held, where families and friends may enter through separate doors so as not to disturb the hospice residents.

It strives not to serve as a reminder of the eventuality of death, but instead provides spiritual solace and comfort. The separation under the skylight once again infers an idea of liminality: subtle, yet apparent. Those entering and exiting the chapel should feel the warmth of the sun's rays and take comfort in the solidarity of those around them at 1 Riverdale Lane.



“It is the work of architecture at such times and such places to inspire and provide solace, even if it cannot heal.”

-Ken Worpole, *Modern Hospice Design*

3.5 THE FUTURE: Redefining Hope

As our society develops a greater acceptance for addressing the end of life, it follows that more hospices should be built to support this value. Eventually, the fear surrounding the idea of dying will slowly lose its hold, and the marginalization of those who find themselves in this time will dissipate. Perhaps, we will evolve to gain another level of understanding our mortality and finitude when our society no longer fears the inevitability of dying, but feels prepared with bold resolve to face it together.

1 Riverdale Lane was an attempt to embody an environment that is conducive to providing support and care for those at the end of life. However, this was a modest proposal, given the intensity of human emotion and stress that often accompanies this stage of life. There is no prescribed way to come to terms with dying, nor is there a way to know when it will happen. Instead, there is just the hope that when it happens, it will be dignified and comfortable.

However, the goal was to define a new typology for the hospice, somewhere between the domestic home and the institution of the hospital. Through the many design iterations, it became clear that much of the direction was determined by which user was deemed the priority. The shapes and sizes continued to change as the public, patients, caregivers, and family members

were each given their chance to influence the design. As such, the most important lesson learned was one about balancing these different needs and perspectives.

This differs from a domestic setting where there are consistent users, over many years, who learn to adapt to their settings. Whether one lives in the city or the suburbs, a home can be fairly restrictive with its uses and size. Similarly, any institution exerts a certain amount of control over its users, with wayfinding and authorized areas, due to a power differential between those who work there and those who are its patrons.

The hospice is different from both these scenarios in its fundamental ideology of being as unrestrictive as possible to allow for the bevy of human emotions and needs that arise at the end of life. While certain restraints and security measures are necessary, the transcendence of its users makes the hospice, simply, a stage. It has some function, but is essentially a container for life to occur within it. Therefore, it must still maintain elements of the home that are familiar enough to promote comfort and ease, while maintaining the confidence that the level of care provided will be unmatched. It is ultimately a resolution of paradoxes that are finely balanced the way life itself is as well.

The hospice must be a quiet observer and sympathetic backdrop for those who will only come through for the briefest of times, at the greatest of times. It must be humble. Instead of proclaiming its importance, it must simply be ready for those when they need it most. At times, the architecture is almost secondary to the emotions; but it is unparalleled in importance for its ability to change the perspective built up over hundreds of years' of fear towards death. Our Last Home is an architectural exploration into the intense human emotions, needs, and expectations surrounding the end of life, and the possibility of embracing its liminality.

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