THE HOSPICE

INTEGRATION ON THREE SCALES:

THE URBAN, THE SITE AND THE STRUCTURE

MAHINA HÉLÈNE WRIGHT
B.Sc. Simon Fraser University, 2003

Submitted in partial fulfillment of the requirements for the degree of Master of Architecture' in The Faculty of Graduate Studies,
School of Architecture and Landscape Architecture, Architecture Program

Committee Chair: Inge Roecker
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ABSTRACT

The topic of death is taboo in our contemporary Western culture, and the want of open dialogue on this subject leaves those going through the process of dying, and their loved ones, in a place that is set apart from the main currents of society's daily life. This effectively robs the person who is dying from their full humanity, which is founded on social belonging. Shame is a vexing burden carried by the dying, their loved ones and the bereaved, in large part due to our culture's enshrinement of traits such as independence and incessant productivity[1]. Dying, caring for the dying, and grieving require interdependence, vulnerability, reflection, readjustment- all qualities in opposition to our fast-paced world's ideals[2]. Cicely Saunders, considered the founder of the modern hospice movement, writes about the concept of 'total pain', which includes physical, emotional, social, and spiritual distress[3]. The fear our culture carries towards death translates not only into social exclusion, but is also manifested in current hospice architecture, which seeks to present itself as unobtrusively as possible, either disguised in the cloak of domestic architecture or hidden behind a veil of greenery. My goal is to imagine a way that design can further the aims of the hospice philosophy; to alleviate the "total pain" of death and dying, not only for the person dying, but also for their loved ones. I want to imagine an alternative to shame and isolation and visualize how a life event as momentous and natural as dying can happen in a way that fosters as much support, consideration, and meaning as possible. Progressing forward from research to synthesis, my aim is to explore the ideas of belonging and integration as they relate to the hospice on three scales: The urban fabric, the community, and within the hospice space itself.

[1] Tyree, Alex. "Shame: A Hospice Worker's Reflections," in The Shame of Death, Grief, and Trauma, ed. Kauffman, Jeffrey (New York: Routledge, 2010), p 87-109.
[2] Vanderpool, Harold Y. 1978. "The Ethics of Terminal Care." The Journal of the American Medical Association Volume 239, No. 9, pp 850-852.
[3] Clark, David. 1999. "'Total pain', disciplinary power and the body in the work of Cicely Saunders, 1958-1967." Social Science & Medicine 727-736.

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THESIS STATEMENT

The spaces for dying need to allow for meaning and belonging by their inclusion in our cultural dialogue and in the fabric of our communities.

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1.1 THE HOSPICE DEFINED

> *"You matter because of who you are. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die."*
>
> -Dame Cicely Saunders, founder of the first modern hospice

While the hospice can be defined primarily as a philosophy of treatment for a patient in a holistic way: i.e., their physical, emotional, social, and spiritual well-being, during the dying stage of life, it is also a physical space born of this philosophy for patients who suffer from a terminal illness, for whom curative measures will no longer be taken. Patients may choose hospice care when their life expectancy has reached six months or less, and their medical treatment shifts from curative measures to instead focus entirely on making the last months and weeks of life as comfortable and enjoyable as possible by treating their physical, emotional, social, and spiritual needs.[1]

The American Cancer Society further defines the hospice in this way: "The hospice philosophy accepts death as the final stage of life: it affirms life, but does not try to hasten or postpone death. Hospice care treats the person and symptoms of the disease, rather than treating the disease itself. A team of professionals work together to manage symptoms so that a person's last days may be spent with dignity and quality, surrounded by their loved ones. Hospice care is also family-centered – it includes the patient and the family in making decisions."[2]

The World Health Organization describes hospice palliative care as having the following features:

- provides relief from pain and other distressing symptoms,
- affirms life and regards dying as a normal process,
- intends neither to hasten nor postpone death,
- integrates the psychological and spiritual aspects of patient care,
- offers a support system to help patients live as actively as possible until death and

[1] Miller, BJ, and Shoshana Berger. 2020. *A Beginner's Guide to the End: Practical Advice for Living Life and Facing Death.* New York: Simon & Schuster. P 188.

[2] American Cancer Society, "What is Hospice Care?" cancer.org American Cancer Society, May 10, 2019. Accessed on December 16, 2020. https://www.cancer.org/treatment/end-of-life-care/hospice-care/what-is-hospice-care.html#:~:text=Hospice%20care%20is%20a%20special,fully%20and%20comfortably%20as%20possible.

help the family cope before and after a person's death,

- uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated,
- enhances quality of life and may also positively influence the course of illness,
- applies early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy.[3]

Palliative care on the other hand is care related to pain management and does necessarily need to be associated with end-of-life. Palliative care can be offered in conjunction with other forms of curative disease treatment and is care that is focused on pain reduction and enhancing the quality of the patient's life. Palliative care is provided by a specially trained team of doctors, nurses and other specialists who work with the patient's other doctors to provide an additional layer of support. It is appropriate for any age patient, at any stage of their illness, wherever added symptom management support is needed, and its delivery is not determined by the patient's prognosis.[4] While it is for the most part delivered in hospital, it can also be delivered in clinics and in the home.

While hospice care and palliative care are two independent parts our healthcare system, they do share overlap because treatment at the hospice, while no longer including curative disease interventions, focuses primarily on symptom management. It is important to note that patients who receive hospice and palliative care experience less depression and anxiety in comparison to those who do not.[5] Patients who use hospice inpatient/residential facilities share the following characteristics: they have no caregiver or have an incapable caregiver; they have imminent death; and they have been admitted to a hospice after discharge from a hospital.[6]

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[3] Chad Hammond and Sharon Baxter, "Mapping a New Philosophy of Care: The state and Future of Implementing a Palliative Approach Across Canada," in *Hospice Palliative Home Care and Bereavement Support*, ed. Lorraine Holtslander, Shelley Peacock and Jill Bally (Switzerland: Springer, 2019) p 64.

[4] Centre to Advance Palliative Care. "What is Palliative Care?" getpalliativecare.org Centre to Advance Palliative Care. 2020. Accessed on December 16, 2020. https://getpalliativecare.org/whatis/

[5] Miller and Berger. p 189.

[6] Kyusuk Chung and Sloane C. Burke. "Characteristics of Hospice Patients Utilizing Hospice Facilities." *American Journal of Hospice & Palliative Medicine* Vol 30, No. 7 (2013) p 640.

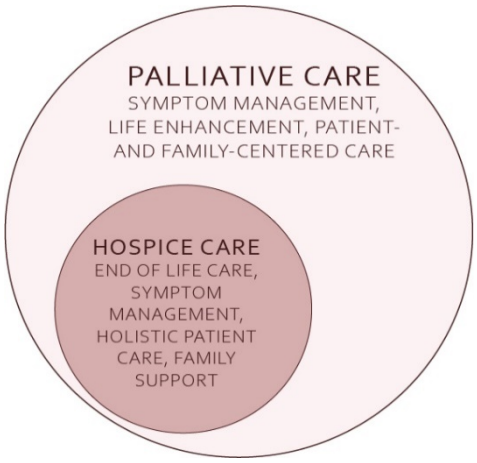

Figure 1: Palliative care and hospice care are two independent entities, though much of the treatment delivered in hospice would be under the umbrella of palliative medicine. (Miller and Berger 2020)

The hospice care team includes palliative doctors, nurses, social workers, counselling professionals, physical care and treatment professionals, volunteers, and alternative forms of therapy professionals, such as music and art therapists.[7] End of life care does not only need to occur in a hospice; some patients choose to die at home and can receive hospice care in the home with a nurse visiting approximately once per day to help with the administration of medicine, wound dressings, catheter care, and to assist with moving the patient, amongst other physical care treatments.

1.2 WHY HOSPICE CARE MATTERS

Canada's population is aging; for the first time in our national history, our nation recently reported that more Canadians are retiring than entering the work force. Seniors are currently our fastest-growing age group: in 2009, Canada had 4.7 million persons over the age of 65, twice the number recorded in 1981. According to all the projection scenarios, the growth of this age group will accelerate in the coming years. By 2061, it is estimated that there will be between 11.9 million and 15.0 million persons aged 65 years or older in Canada.[8] In 2018, Statistics Canada reported the percentage of Canadians that were aged 65 and over to be 17.2%; in comparison, by the year 2068, the proportion of the population aged 65 and older is estimated to reach between 21.4% and 29.5% depending on the scenario.[9]

[7] Stephen Verderber and Ben J. Refuerzo.. *Innovations in Hospice Architecture, Second Edition.* (Oxon: Routledge, 2020), p 14.
[8] "Fact Sheet: Hospice Palliative Care in Canada," Canadian Hospice Palliative Care Association, 2017, https://www.chpca.ca/wp-content/uploads/2019/12/new_fact_sheet_hpc_in_canada-summer2017-final-en.pdf
[9] "Population projections: Canada, provinces and territories, 2018 to 2068," Statistics Canada, September 17, 2019, https://www150.statcan.gc.ca/n1/daily-quotidien/190917/dq190917b-eng.htm

> In 2018, 17% of Canadians were senior citizens. By 2068, it is estimated that approximately 25% of Canadians will be aged 65 and older.
>
> -Statistics Canada

Hospice palliative care is under a growing pressure to deliver services in a financially effective way, and this pressure will only grow as the proportion of the population aged over 65 grows. In Western Canada, most people when asked have indicated that they would prefer to die at home in the presence of loved ones, yet almost 70% of Canadian deaths occur in a hospital.[10] Compared to other developed nations, Canada has a higher mean per capita hospital expenditures, of which a large proportion is for care during people's final weeks of life, and we have the highest proportion of people dying in acute care hospital settings.[11]

Healthcare systems want to reduce expenditures by avoiding inappropriate and costly hospital and emergency admissions by providing more cost-effective care on the scale of the local community. In addition to the inpatient care provided by the bricks and mortar hospice, there is also a branch of at-home hospice care. An integrated palliative approach to care focuses on meeting the many facets of a patient's needs, at all stages of their illness, and in all settings where they live and receive care.[12] By being an active presence in the patient's care through the course of their illness, the integrated palliative team can more effectively plan for the patient's care, the patient can play a stronger decision-making role in their preferences for care, and the degree of care can change and increase when needed with open lines of communication.

Research has shown that an integrated palliative care approach results in improvements in the quality of patient care, reduction of avoidable hospital visits and deaths, and the minimization of costs related with care at the end of life.[13] When an integrated palliative care approach is used, the caregivers report a greater satisfaction with the care that their loved ones received, in addition to expressing less decline in their own psychological, social, and spiritual quality of life scores.[14] While most patients prefer to die at home, this is not feasible for patients living alone, or for those whose family members are not able to sustain the 24/7 care required. With the advances of medicine, time of death has become more difficult to predict, and hospice palliative care can often be needed for longer than the

[10] Canadian Hospice Palliative Care Association, "Hospice Palliative Care in Canada."
[11] Hammond and Baxter, "Mapping a New Philosophy of Care", p 64.
[12] Hammond and Baxter, p 65.
[13] Hammond and Baxter, p 65.
[14] Hammond and Baxter, p 66.

previously commonly accepted 6-month time period. Based on the estimate of 54 hours per week required to care for a dying loved one, 64% of Canadians surveyed responded that they could not devote the estimated

> "Hospital-based palliative care decreases the cost of end-of-life care by 50% or more, primarily by reducing the number of admissions to the ICU, diagnostic testing, interventional procedures, and overall length of stay."
>
> -Canadian Hospice Palliative Care Association

number of hours per week within their current schedule.[15] An integrated approach allows for seamless support to patients and their families choosing hospice care to be delivered in the home from a single communication point that is accessible 24/7, and it allows for care to escalate as increasing support is needed. An approach such as this would allow patients to spend as much time as possible in their home, and it makes the transition to a residential hospice facility more gradual and less jarring. One of the main advantages of residential hospice care is that it allows the caregiver to devote themselves entirely on being emotionally present for their loved ones, as many caregivers underestimate the amount of time and energy required for end-of-life care. Many families express a sense of relief when they finally do make the decision to enter residential hospice care; it is even common for families to express regret at having waited so long before they seek the next level of support.[16, 17]

In terms of cost in Canada, dying ranges from $10,000 for a sudden death to between $30,000 and $40,000 for someone with a terminal disease such as cancer. It is estimated that, compared to usual acute care, hospital-based hospice palliative care may reduce cost to the health care system by approximately $7,000 to $8,000 per patient. Hospital-based palliative care decreases the cost of end-of-life care by 50% or more, primarily by reducing the number of admissions to the ICU, diagnostic testing, interventional procedures, and overall length of stay.[18]

Although palliative hospice care has been shown to reduce costs to the healthcare system, not everyone has access. Residential Hospice palliative care programs are at least 50% funded by charitable donations, making them vulnerable to fluctuations year to year. For home-based services, Canadian families must provide approximately

[15] Canadian Hospice Palliative Care Association, "Hospice Palliative Care in Canada."
[16] Dr. Lauren Daley. Conversation with author over Zoom, October 20, 2020.
[17] Miller and Berger. *A Beginner's Guide to the End.* P 189.
[18] Canadian Hospice Palliative Care Association, "Hospice Palliative Care in Canada."

25% of the total cost of palliative care for nursing and personal care services. In comparison, there are no direct costs for patients in residential hospices.[19]

The Canadian Institute for Health Information (CIHI) reported that in 2009, 45% of provincial and territorial health expenditures were directed to seniors, a group that accounted for 14% of the population.[20] The expenditures our healthcare system makes on end-of-life care are proportionately significant and they present an opportunity to make a substantial impact in cost reduction by investing in palliative care. Estimates vary, however, expanding access to quality palliative care in Ontario alone would reduce provincial expenditures between 2003 and 2011 by between $40 million and $345.5 million. Projected savings for the same framework between 2012 to 2036 would reduce costs by just under $247 million to just over $2.1 billion, depending on the specifics of the estimate.[21]

1.3 MOTIVATION

Contemporary Western society has a complicated relationship with death, and the subject in our culture is taboo.[22, 23,24] However, a growing discussion in medical and social science circles is examining how our fear of death and the process of dying is undermining the final stage of life. The process of dying involves the sequential loss of many of the attributes our western society equates with value and worth; qualities such as self-sufficiency, economic productivity, physical strength, sex appeal, beauty, and vitality.[25] How is self-perception affected by the loss of these traits? When we collectively buy into temporary definitions of worth, either consciously or subconsciously, we negate a wholly natural process in the arc of our lives. We devalue the person who is dying, burdening them with shame, which sustains our own collective fear of death.[26] By sentencing the dying and their caregivers to a social death prior to a physical death, they become isolated from the very fabric that traditionally would have supported them.[27, 28] This limiting attitude exists still today in new and contemporary hospitals where

[19] Canadian Hospice Palliative Care Association, "Hospice Palliative Care in Canada."
[20] Canadian Hospice Palliative Care Association, "Hospice Palliative Care in Canada."
[21] Canadian Hospice Palliative Care Association, "Hospice Palliative Care in Canada."
[22] Parkes, Colin Murray, Pittu Laungani, and Bill Young. 2015. *Death and Bereavement Across Cultures.* Sussex: Routledge. p 4.
[23] Verderber and Refuerzo. *Innovations in Hospice Architecture, Second Edition.* p 2.
[24] Vanderpool, Harold Y. 1978. "The Ethics of Terminal Care." *The Journal of the American Medical Association* Volume 239, No. 9, p 851.
[25] Vanderpool, "The Ethics of Terminal Care." p 851.
[26] Alex Tyree, "Shame: A Hospice Worker's Reflections." In *The Shame of Death, Grief, and Trauma*, ed. Jeffrey Kauffman (New York: Routledge, 2010), p 92.
[27] Geoff MacDonald and Mark R. Leary. "Why Does Social Exclusion Hurt? The Relationship Between Social and Physical Pain." *Psychological Bulletin* Vol. 131, No. 2 (2005): p 202.
[28] Tyree, "Shame: A Hospice Worker's Reflections." p 91.

the dying are placed far from the hubs of activity, almost hidden at the ends of bleak corridors, under the pretext of protecting the other patients from a sense of hopelessness.[29, 30]

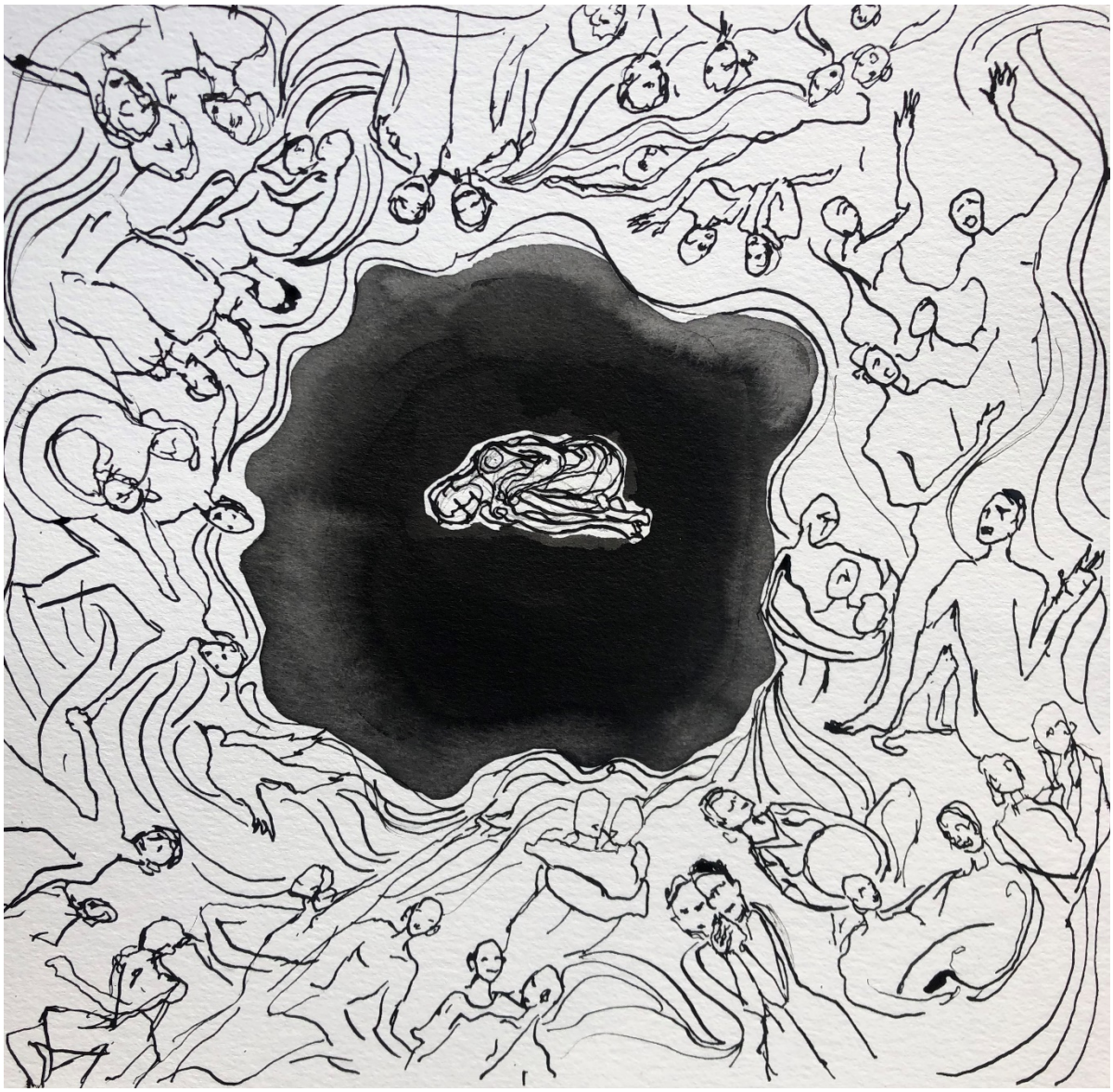

Figure 2: ISOLATION: to be separated, ejected from the fabric of life, of community, of connectedness.

[29] Verdeber et al. p 9.

[30] Annmarie Adams, "Home and/or Hospital: The Architectures of End-of-Life Care," *Change Over Time,* Vol. 6, No. 2, (2016) p. 258-9.

Figure 3: SEGREGATION: to be rejected by society. To no longer be seen, have worth, or to belong. The most painful thing to do to a human being.

Our inability to communally reframe our perception of a wholly natural process, and to question our culture's definitions of worth, has left us all hurtling towards the edge of a self-created abyss. It is no wonder that we would rather not acknowledge the end of life when we perceive it through such a barren lens. Considering that only 10-20% of us experience an unexpected death, most of us will have time to mentally and emotionally grapple with our own mortality, so why not reframe the inevitable in such a way that allows for the possibility of unforeseen beauty uniquely accessible within the final chapter? [31, 32]

What if we redefined worth to embrace ideas related to giving and receiving love, to being integrated into a community of people, to having earned wisdom through the convoluted pathways of life? What if age, ageing

[31] Miller and Berger. p xii

[32] "What really matters at the end of life," September 10 2015. B.J. Miller, YouTube TED Talk, video, 19;07, https://www.youtube.com/watch?v=apbSsILLh28.

and the process of dying became something we recognized and respected? Not only would this change the experience of dying, but it would also have repercussions for the family members and loved ones who support them. It would also result in architecture that reflects this underlying compassion, producing designs that are more open, visually and functionally engaged with the community: architecture that metaphorically opens its arms and supports connection within and without.

Current hospice design frequently reveals our latent collective fear of our own mortality- our impossible wish to avoid our own end, or that of those we love. Many hospices present an unobtrusive face to the community, one that is subdued, sometimes camouflaged in greenery, or disguised in a domestic typology (Figure 5).[33] As

Figure 4: BELONGING, SUPPORT AND INTEGRATION: to be seen, to have worth, to experience meaning, to be valued, to have a voice and choice.

[33] Verdeber et al. Innovations in Hospice Architecture. p 18.

Annmarie Adams points out about end-of-life facilities: "There exists a 'culture of silence' around death that we can read in these buildings types".[34]

Figure 5: Current hospices in Vancouver and surrounding suburban communities. Most adopt the residential typology and present an unobtrusive face to the community.

[34] Adams, "Home and/or Hospital: The Architectures of End-of-Life Care," p. 261.

In terms of interior observations, visiting a hospice has not been possible due to COVID restrictions, therefore I must make my observations of interior studies based on photographs and interviews. Below are images from three Greater Vancouver hospices. There seems to be a variety in funding access as some hospices seem far more generously supplied with interior and exterior space, amenities and quality of construction and furnishings than others. The ones pictured below do not represent the most luxurious conditions, which are the exception. It can be observed in many of the pictures that the typology wrestles between the institutional and the domestic, with aspects of both clashing together within each space. Some of the major issues that have emerged in the field of hospice architecture are privacy, acoustics, control, territoriality, access to nature, and accommodation for family members.[35] The examples below can be compared with the precedent examples of Section 3.

Figure 6: The Crossroads Hospice in Port Moody. Located on the upper level of a 4-storey residential building. The hospice provides a leading-edge level of care. The spaces appear functional however, it is difficult to mask the institutional aspect that they carry.

Figure 7: At the Irene Thomas hospice in Delta, special care has been poured into the ceiling as it is recognized that patients often arrive in a stretcher and the ceiling is a façade a hospice patient spends more time than most seeing. The corridor at the facility, while softened with carpeting, still exudes the air of an institution.

[35] Adams. p 250-251.

Figure 8: Reception and memorial table at Irene Thomas hospice.

Figure 9: Irene Thomas hospice: Private room with operable doors and access to the exterior. Common kitchen area and eating area.

Figure 10: Family Day Room and family overnight room at Irene Thomas hospice. Their website notes the importance of making the family as comfortable as possible so as to encourage them to visit frequently.

Figure 11: The laundry and supplies rooms at Irene Thomas hospice.

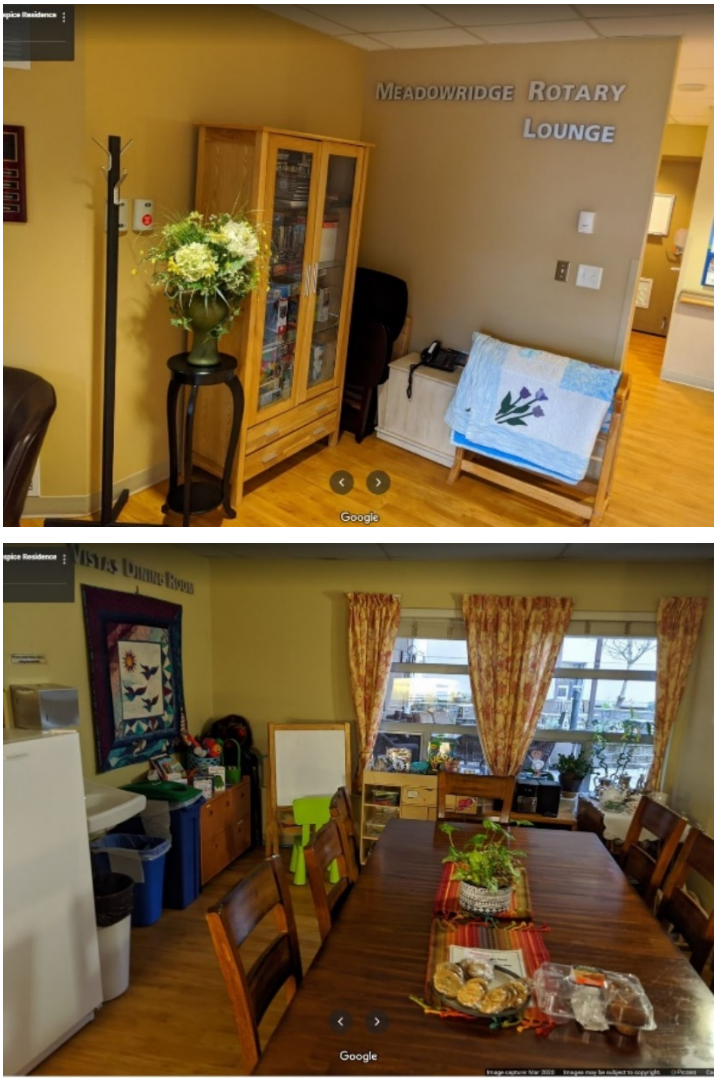

Figure 12: McKenney Creek Hospice Residence in Maple Ridge.

2.1 ORIGINS

The word *hospice* originates from the Latin word "hospitum", which means guesthouse.[36] The earliest found use of the word hospice is in relation to shelters along religious pilgrimage routes throughout Europe during the Middle Ages, where travelers could rest and replenish themselves along their journey. These refuges were run by a variety of religious orders, and payment for room and board could be paid or bartered for. If travelers became too ill to carry on with their grueling journey, these were the spaces where they were cared for until their death.[37] In the Christian tradition, the family had the principal role in nursing their dying family members. Death and display of the dead occurred inside the home, and grieving rituals varied, but centered around the family and the immediate community for centuries.[38, 39] As Europe industrialized, families moved from their places of origin and became disconnected not only from their churches and communities, but also from each other and the rituals and traditions that guided them through death and bereavement.[40]

The earliest hospice association on record in Europe was L'Association des Dames du Calvaire, founded in 1842 in Lyon, France by Madame Jeanne Garnier. As a widow and bereaved mother, she and her group of members in similar circumstances opened a home for the dying the following year. Though Madame Garnier died in 1853, her foundation carried forward her approach characterized by "a respectful familiarity, an attitude of prayer and calm in the face of death", and opened other homes for the dying in Paris and St Etienne in 1874, in Marseille in 1881 and 1894, Brussels in 1886, and Rouen in 1891. The association carried on opening other homes for the dying throughout France into the 20th century.[41]

In 1879, Our Lady's Hospice for the Dying at Harold's Cross, Dublin was opened and run by the Irish Sisters of Charity. This centre and other services provided by the order ministered to the deeply impoverished population within Dublin at the time and responded to the newly recognized contagion problem of combining "birth, life and death" within a singular hospital environment.[42] The Sisters of Charity opened other facilities to serve the dying in Australia in 1890, England in 1905, and Scotland in 1948. St. Joseph's Hospice, Hackney, opened in 1905, would eventually play an important role in the modern hospice movement of today.[43]

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[36] Verdeber et al. p 10.
[37] Verdeber et al. p 10.
[38] Verdeber et al. p 10.
[39] Elisabeth Kubler-Ross. *On Death and Dying.* (New York: Touchstone, 1969), p 19-20.
[40] Verdeber et al. p 11-12.
[41] David Clark, "Women pioneers in 19th century hospice care," End of life studies, University of Glasgow, April 8 2014, http://endoflifestudies.academicblogs.co.uk/women-pioneers-in-19th-century-hospice-care/
[42] Clark, "Women pioneers in 19th century hospice care"
[43] Clark, "Women pioneers in 19th century hospice care"

In 1891, Trinity Hospice was founded in London, and still operates as England's oldest hospice. Its close ties to the royal family, and their continued patronage, allowed the hospice to provide its care free of charge, expand its physical space in size and quality and grow in prominence. [44] At the beginning of the 20th century, the idea of the hospice was beginning to become a recognizable term.[45]

> "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."
>
> -Description at Our Lady's Hospice for the Dying at Harold's Cross, Dublin

In 1893, another important precursor to the modern hospice was opened; St Luke's Home for the Dying Poor offered 35 beds to those in the direst circumstances.[46] This establishment was eventually renamed "St Luke's, Bayswater", where the implicit policy of hiding death was manifested through the transfer of patients just prior to death to a private room near the door, so that none of the other patients would be confronted directly with the reality of their own mortality.[47] It was to this facility that in 1948, a young social worker named Cicely Saunders would come to work.

2.2 DAME CECILY SAUNDERS AND THE MODERN HOSPICE PHILOSOPHY

Cicely Saunders is considered the founder of the modern hospice movement and, "more than anybody else, was responsible for establishing the discipline and the culture of palliative care."[48] She was enormously innovative and her profound compassion for her patients drove her to break beyond the common practices of her day and forge

[44] Verdeber et al. p 12.
[45] Verdeber et al. p 12.
[46] Verdeber et al. p 13.
[47] Verdeber et al. p 13.
[48] Caroline Richmond. "Dame Cicely Saunders, founder of the modern hospice movement, dies." The BMJ. Accessed on December 18 2020. https://www.bmj.com/content/suppl/2005/07/18/331.7509.DC1

new approaches to patient care. She eradicated the prevalent belief that patients should attempt to be cured, no matter their physical, emotional or spiritual state, and that those who could not be healed represented a failure on the part of the treating physician.[49] She not only embraced that death was a natural part of life, but she also guided her colleagues to comfortably come to terms with that reality. She publicly disagreed with the common practice of lying to patients about their prognosis, and she altered the practice of pain management to prioritize patient comfort rather than irrelevant fears of drug addiction.[50]

Born in 1918, Cicely Mary Strode Saunders was born in Barnet Hertfordshire, into a wealthy family. After the outbreak of the war, she defied her father's wishes and pursued nursing studies, which she had to abandon due to back pain. She instead pursued social work and became what was then called a lady almoner in 1947. Originally an agnostic, she had a spiritual awakening that had an important impact on her life. In 1948, while working as an almoner at Archway Hospital, she developed a profound relationship with a 40-year-old terminally ill patient named David Tasma. During their brief and deeply intense relationship, they discussed the possibility that she might one day open a home for the dying that would impart a sense of peace to a patient's final days. David Tasma's death coincided with that of her father's, and that of a close friend which formed the catalyst for Saunders' to clarify her life's calling which would be to "build a home for dying people, where scientific knowledge should be combined with care and love."[51] Her intense desire to create change in patient care propelled her own doctor to encourage her to study medicine because he felt that she would have more clout as a physician. She chose to pursue this path and was accepted to St Thomas' Medical School at age 33.[52] Upon the completion of her studies in 1958 at the age of 39, she wrote her first article arguing for a new approach to end-of-life care, launching what would be a prolific writing career. In this essay, she boldly stated:

> "It appears that many patients feel deserted by their doctors at the end. Ideally the doctor should remain the centre of a team who work together to relieve where they cannot heal, to keep the patient's own struggle within his compass and to bring hope and consolation to the end."[53]

Saunders continued to pursue scholarly research throughout her work as a practicing physician. She studied pain management in the incurably ill, and developed her theory around total pain, which was that a terminally ill patient must be treated for the totality of their pain which consists of physical, mental, social, and spiritual pain.[54] As she developed her professional research, she pursued her dream of founding a hospice and devoted herself to a broad and in-depth study on the topic of death and dying, in which she was greatly impressed by the research of Swiss-

[49] Richmond. "Dame Cicely Saunders, founder of the modern hospice movement, dies."
[50] Richmond. "Dame Cicely Saunders, founder of the modern hospice movement, dies."
[51] Richmond. "Dame Cicely Saunders, founder of the modern hospice movement, dies."
[52] Richmond. "Dame Cicely Saunders, founder of the modern hospice movement, dies."
[53] Richmond. "Dame Cicely Saunders, founder of the modern hospice movement, dies."
[54] Clark, "'Total pain', disciplinary power and the body in the work of Cicely Saunders, 1958-1967." p 727.

American psychiatrist, Dr. Elisabeth Kübler-Ross, a pioneer in near-death studies.[55] In 1967, Cicely Saunders founded St.Christopher's hospice with 60 beds available to patients where she could put into practice her groundbreaking methods for pain management and her nonconformist approach to viewing death as a natural

> "So often, patients and families were told that 'there was nothing more that could be done' a statement that Dame Cicely refused to accept. Throughout her time at St. Christopher's her watchword was 'there is so much more to be done.'"[57]

part of life, rather than a failure of medicine.[56, 57] The success of St. Christopher's hospice has been replicated all over the world, and it continues to be a leader in the field. Dame Cicely was made a Dame of the British Empire in 1979 and awarded the Order of Merit in 1989.[58] Dame Cicely died in 2005 at St Christopher's Hospice.

2.3 RECENT HOSPICE DEVELOPMENTS

The context in which Dame Cicely's spearheading approach to end-of-life care was that of the modern and ever-growing mega hospital, steeped in biotechnical medicine. "In this culture to not get better- to decline, to die – is to fail ...popular culture inevitably isolates the sick, the dying, and the grieving."[59] In our post World War II increasingly industrialized world, thousands of modernist community hospitals, tertiary care medical centres, and nursing homes for the infirm and elderly were built all over the world, reaching new levels of scientific competence and efficiency. The cost of this however, was the creation of spaces that felt and looked more like warehouses, with interminable corridors, sterile institutional environments, and an atmosphere of anonymity for patients and their visitors.[60] The demand for something more aligned with the needs of the dying, that could perhaps allow for meaning and solace in their final days, buoyed the emergence of the Hospice movement, largely lead by Dame

[55] Richmond. "Dame Cicely Saunders, founder of the modern hospice movement, dies."
[56] Clark, "'Total pain', disciplinary power and the body in the work of Cicely Saunders, 1958-1967." p 731-32.
[57] Richmond. "Dame Cicely Saunders, founder of the modern hospice movement, dies."
[58] "Dame Cicely Saunders; Her Life and Work," St. Christopher's, Accessed on December 18 2020, https://www.stchristophers.org.uk/about/damecicelysaunders#:~:text=Dame%20Cicely%20was%20made%20a,that%20was%20offered%20in%20hospitals.
[59] Verdeber et al. p 14.
[60] Verdeber et al. p 14.

Cicely Saunders. But the movement was slow to progress. In 1976, only 3 hospices existed in the United States as demonstration projects in Branford, Connecticut, Boonton, New Jersey, and Tucson, Arizona.[61]

The hospice movement was by nature continuously at odds with modern medicine which was perpetually advancing its scientific capacity to perform feats of medical triumph over illness. "A death-denying culture was in evidence in which the fact of human mortality was regarded increasingly as a private, rather distasteful matter – even a taboo."[62] As mentioned above, the establishment of St Christopher's Hospice was the first modern hospice in the United Kingdom, but the movement gathered speed more quickly there than in the United States. By 1977, the United Kingdom had over thirty inpatient hospices, whereas the United States only had two.[63] The movement was gathering momentum however, as an increasing number of articles on the topic were being published, and in 1985, five models of hospice care had emerged in the United States:

1. The freestanding autonomous hospice.
2. The freestanding hospice with a hospital affiliation.
3. The specialized Palliative Care Unit (PCU) within an acute care or long-term care facility.
4. Roving hospice care teams for patients in scatter-bed configurations within these two types of institutions.[64]
5. Programs providing exclusively at-home care.[65]

Yet as forms of operation were emerging, the word "hospice" was still understood mainly as a philosophy rather than linked to certain architectural style or typology. By 1985, hospices in the U.S. finally had to meet guidelines set out by the Joint Commission for the Accreditation of Hospital Organizations, which lead to an early formation of basic spatial and design requirements.[66] Programs closely integrated spatially and functionally with hospital care were predominant, with the architecturally independent hospice accounting for only approximately 10% of hospice programs in 1983, which by then totaled over 1000 and included at-home care models.[67]

In 1996, the number of operational or planned hospices in the United States had reached 2,531, and the number of patients treated in hospice care in 1994 had increased by 25% over the previous year.[68] Additionally during that year, one out of every seven deaths from all causes in the United States had been treated by a model of hospice

[61] Verdeber et al. p 15.
[62] Verdeber et al. p 15.
[63] Verdeber et al. p 15-16.
[64] Scatter-bed configuration, or the scattered bed model, is when inpatient hospice care is provided in beds in hospitals contracted with hospices.
[65] Verdeber et al. p 16.
[66] Verdeber et al. p 16-17.
[67] Verdeber et al. p 17.
[68] Verdeber et al. p 17.

care.[69] The hospice care movement had increasingly gained traction in the public's mind and by 2000, it was becoming generally accepted that the mega-hospital acted in many ways against an ideal atmosphere of health and recuperation. The hospice has been claimed to be the "first genuinely postmodern *healthcare* building type of the late twentieth century" because of its "utopian" nature, standing apart from the sterile and industrial hospital ethos and instead amplifying a human-scaled and holistic approach to patient care.[70] The hospice provided spaces lacking in the modern mega-hospital: rooms for grieving, flexible and informal transition spaces to allow for privacy and a moment of self-composure, spaces for non-denominational spiritual reflection, healing and meditation gardens, overnight accommodations for family members, counselling rooms, family-friendly libraries, and an assortement of therapy rooms such as water-, art, and music-therapy.[71]

Despite these post-modern and innovative developments materializing within the hospice, the exterior architecture generally took on forms that catered to the fear expressed by several American neighbourhoods towards the presence of a new hospice- especially those that served patients suffering from HIV/AIDS.[72] Hospices became "anti-monumental", and blended into their surrounding neighbourhoods in an attempt to be as unobtrusive as possible.[73] In support of this design approach, some describe it as a way for the dying and the bereaved to blend into their neighbourhood and thereby feel that they belong to it rather than standing apart.[74] But it can be honestly stated that in the financially over-stretched world that is healthcare, additional costs for innovative or expressive architecture become difficult to consent to when it comes at the cost of needed healthcare equipment, programming or additional staffing, and it is unfortunate that design is often undervalued and sacrificed in the balance sheets. It is a general trend in hospice design to gravitate toward an affinity with the home, in part to reject the anonymity of the mega-hospital, and in part to offer a sense of comfort and familiarity to the patient when they most long to be in their own home. Many of the early hospices were in converted houses, which aligned with the understanding that most patients would prefer to die in their home.[75]

The research on hospice architecture is minimal and many questions remain to be answered - questions such as: What are the different architectural requirements for a hospice palliative care facility when compared to other typologies such as home, the nursing home and the hospital? What is its ideal size, occupancy ranges and placement within the context of the community? How does such a facility relate to the nursing home, the local hospital, and the surrounding community?[76] Some of the major concerns for hospice architecture that have

[69] Verdeber et al. p 17.
[70] Verdeber et al. p 17.
[71] Verdeber et al. p 17.
[72] Verdeber et al. p 17.
[73] Verdeber et al. p 18.
[74] Verdeber et al. p 18.
[75] Adams. p 251
[76] Adams. p 250.

emerged are privacy, acoustics, control , territoriality, the accessibility of nature, and accommodations for family members.[77] With such a close enmeshment of the residential, domestic typology with palliative hospice design, it is important to question the assumptions around this; "home" doesn't universally translate to a place of "warmth, comfort, nourishment, parental love, and intimacy". For some, the middle-class residence may represent instead a place of repression, loneliness, violence, or financial hardship.[78] The palliative hospice is still in its infancy and the typology is still undetermined; now is the moment to question current practices, be imaginative in the achievement of its most fundamental objectives, and to be as innovative as the care practices that occur within.

[77] Adams. p 251.
[78] Adams. p 252.

3.1 URBAN HOSPICE

Architect: NORD Architects, Copenhagen, Denmark
Location: Copenhagen Denmark
Date: Completed in 2016
Site Size: 0.60 acres
Inpatient Beds: 16

This urban-situated hospice is unusual in Denmark in that most hospices are usually located in rural communities. Rural settings create a challenge for urban families who would like to make daily visits to their ailing family member. This is what led the client, The Deaconess Foundation to create the Urban Hospice. This center is part of a larger redevelopment master plan for a 10-acre medical center in the wealthy residential area of Frederiksberg, in Copenhagen. This new hospice replaced an older, obsolete facility. The Urban Hospice is 24,000 square feet, is modest in scale and at the request of the client, speaks quietly to the surrounding context. It is located across the street from the historic neo-Gothic original teaching hospital. The warm reflective glow that emanates from the

Figure 13: The Urban Hospice by NORD Architects in Copenhagen, Denmark.

zinc-alloy brass façade creates an intrigue that is balanced by the modern muteness of the design. Together, the form and the materials produce a building that sits amicably and comfortably within its residential surroundings. The narrow urban lot made it especially challenging to carve out outdoor and natural space, however the architects elegantly defined many varied outdoor spaces for rest and tranquility. Inside, the feelings of comfort are generated using natural materials combined with a bright and airy atmosphere. Without imitating a residential home, the elements of comfort are expressed using light, volume, and the use of natural materials that create a harmonious ambience. This creates a more universal feeling of warmth since "home" and "house" carry different meanings for everyone and may not always translate to feelings of security.[79] However, in this modern hospice, the pleasures of natural light, natural materials and generous volumes merge to convey a pure sense of welcome. The negotiation between shared communal space for social support and belonging, and private contained space for personal suffering, grieving, or respite, is balanced fluidly and with the utmost simplicity (and thus clarity) in this design.

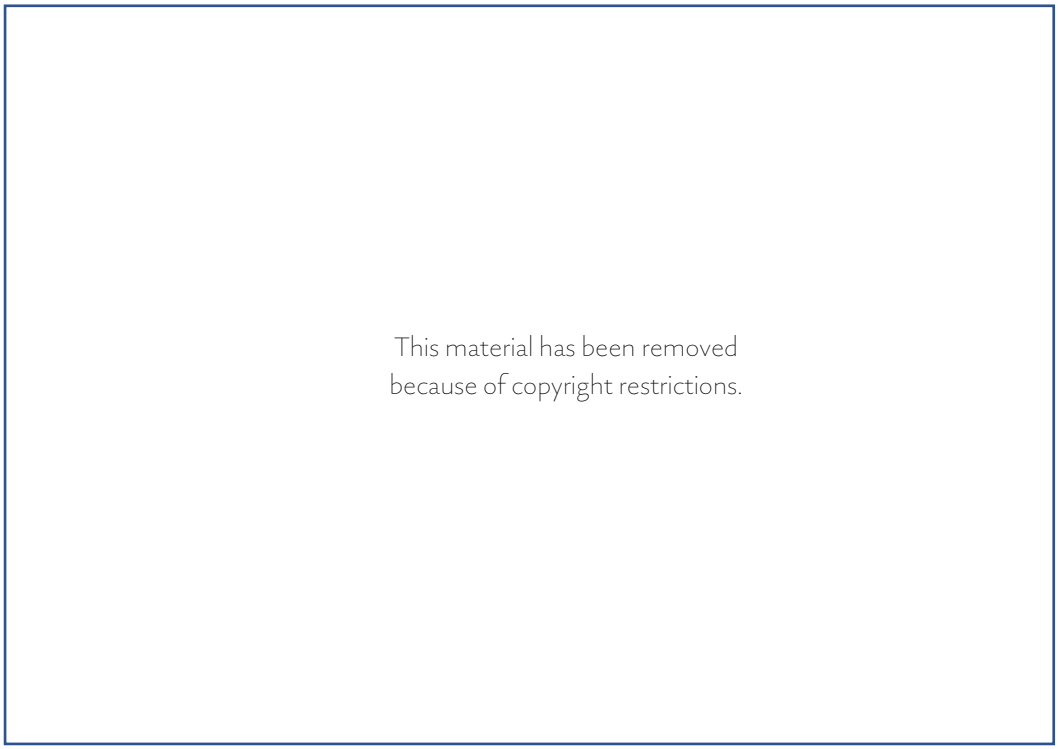

Figure 14: The Urban Hospice Site Plan

[79] Adams, p. 252.

Relevance:

This project is not only the same typology as my intended design project, but also one of the most coherent, successful and honestly expressed examples of the hospice typologies that I have encountered thus far. It is meaningful that the project is located within the city because most people dwell in urban centres today. Through this, the project addresses the importance of providing the terminally ill person with access to fresh air and as much nature as is possible under the considerable constraint of a confined urban lot. If access to nature, air and tranquility can be achieved elegantly under such challenging circumstances, it can surely be achieved under more generous nature and spatial conditions. The emphasis placed by the client and the designers on the inclusion of the hospice within the urban fabric begins to express the increasing acceptance of death within our culture- and if not, it might begin a dialogue around the topic that could enhance our open-mindedness to the subject.

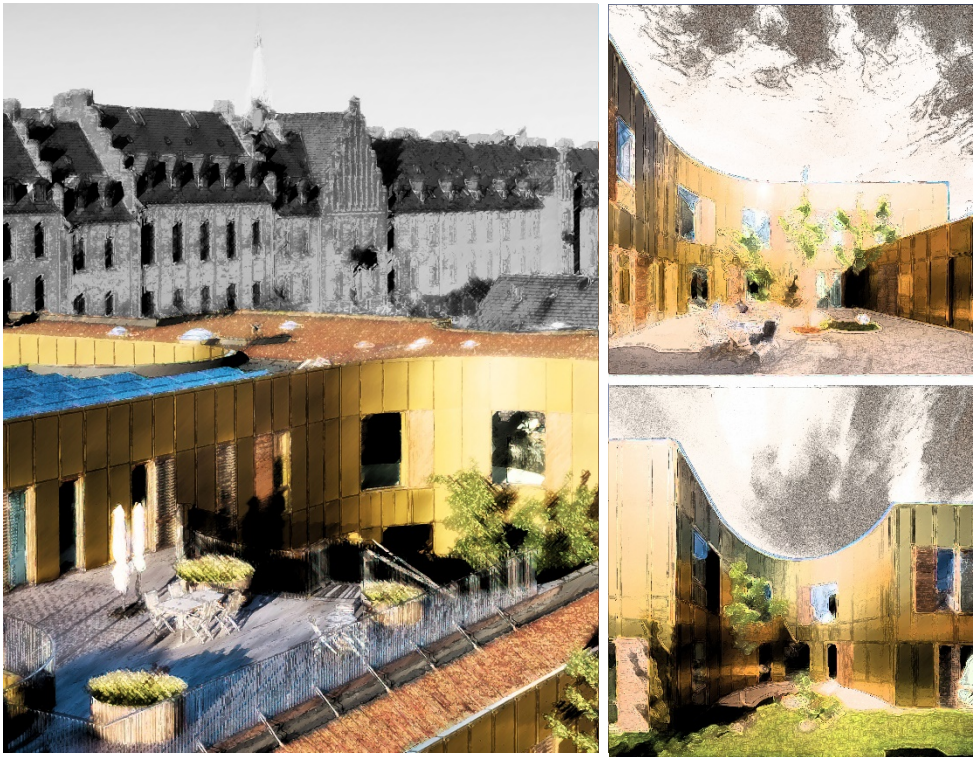

Figure 15: Immersed in an urban environment, the Urban Hospice manages to create moments of connection to nature in its small alcoves, courtyards, and terraces.

Figure 16: Urban Hospice Level 1 & 2 Floor Plan

Figure 17: View of the double height central common living area.

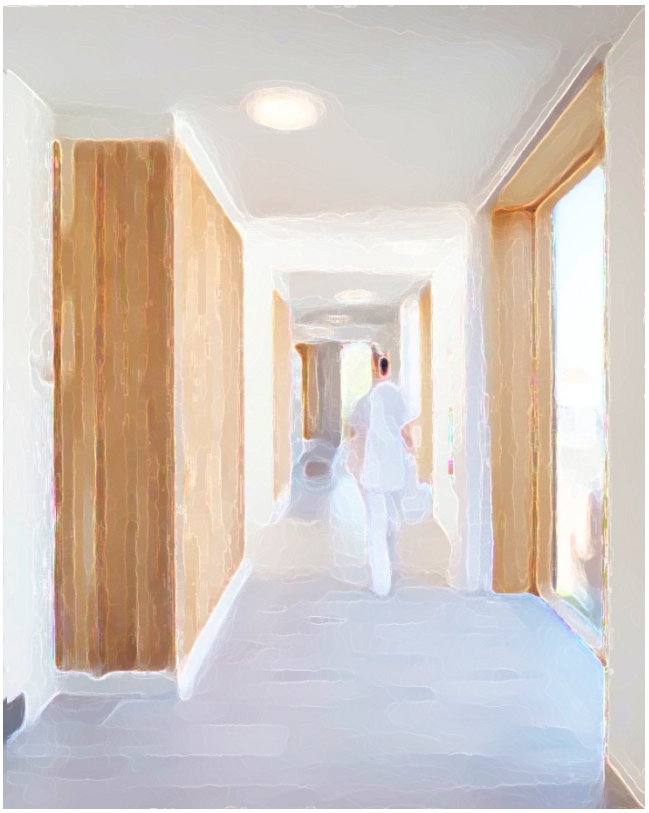

Figure 18: Corridor leading to patient rooms, second level.

Figure 19: Windows follow the curve of the building and apertures are accentuated with wood.

Figure 20: Patient rooms have large windows and operable glass doors leading to terrace.

Figure 21: The curves of the building frame the sky.

3.2 TSURUMI CHILDREN'S HOSPICE

Architect: Junichi Katase/TAISEI DESIGN Planners Architects and Engineers, Tokyo, Japan
Location: Osaka, Japan
Date: Completed in 2016
Site Size: 6.5 acres
Inpatient Beds: not an overnight facility

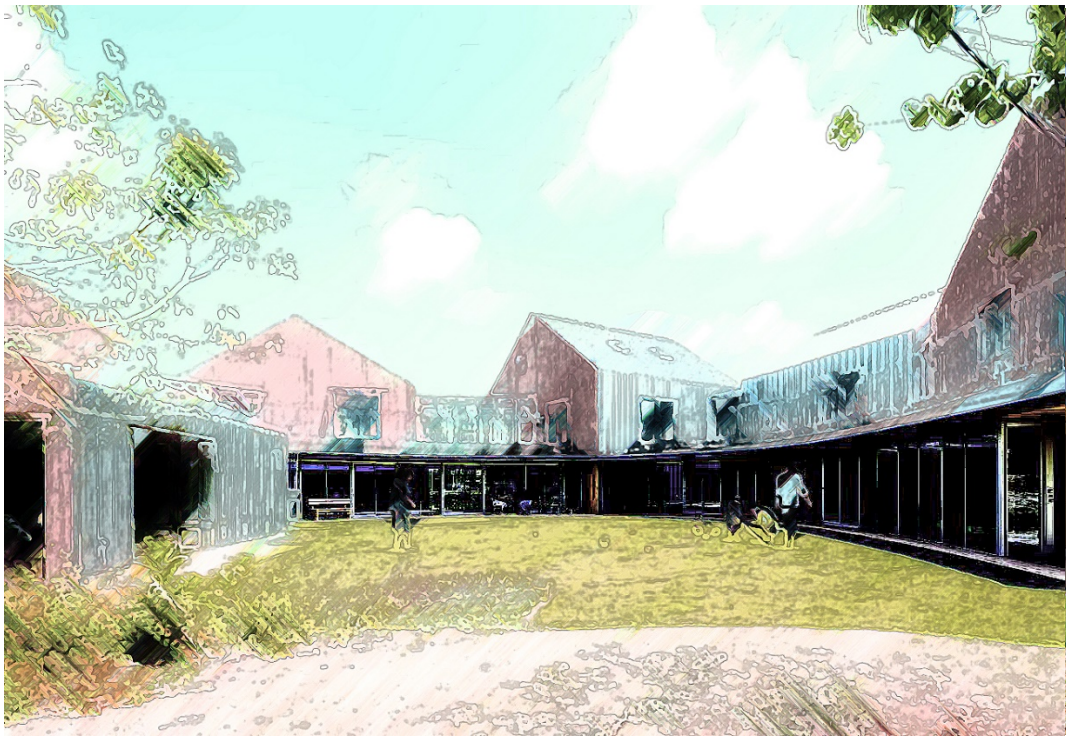

Figure 22: The Tsurumi Children's Hospice wraps around a central garden where families can spend time together with their children.

The hospice philosophy has advanced considerably in Japan, however the country did not at the time of this facility being built have an overnight child or adolescent end-of-life care facility. The Tsurumi Children's Hospice in Osaka was the first day-only pediatric hospice for children and adolescents in Japan. Located 20 minutes by subway from the centre of the city, the hospice acts as a "waystation" between home and hospital, offering spaces for daytime napping, outdoor play, hydrotherapy, café/kitchen, music therapy, crafts, and children's play space. It is a place for children and their families to come together with others experiencing similar challenges and to find belonging and support. The form of the building consists of several small "houses" gathered together in a semicircular arc enfolding a green open space at its heart. The individual houses each have a distinctive niche and are interconnected by enclosed hallways and an overhanging covered porch. The

outdoor space is distinguished into four distinct zones: the community square, playtime hill, the community garden, and the cultivation forest. The space is modeled in a similar way to Maggie's Centres in the U.K. (daytime support centres for cancer patients). The rooms within the gathered buildings provide young people with terminal illnesses and their families with a place to share in quality time with friends in family away from home and hospital. While no physicians are present within the space, nurses, physical therapists, social workers, and volunteers (including teachers) are on hand to support the children and their families. While this building is not an adult residential hospice facility, it is an example of architecture that engages clearly, honestly, and emphatically with the human experience of grief and loss.

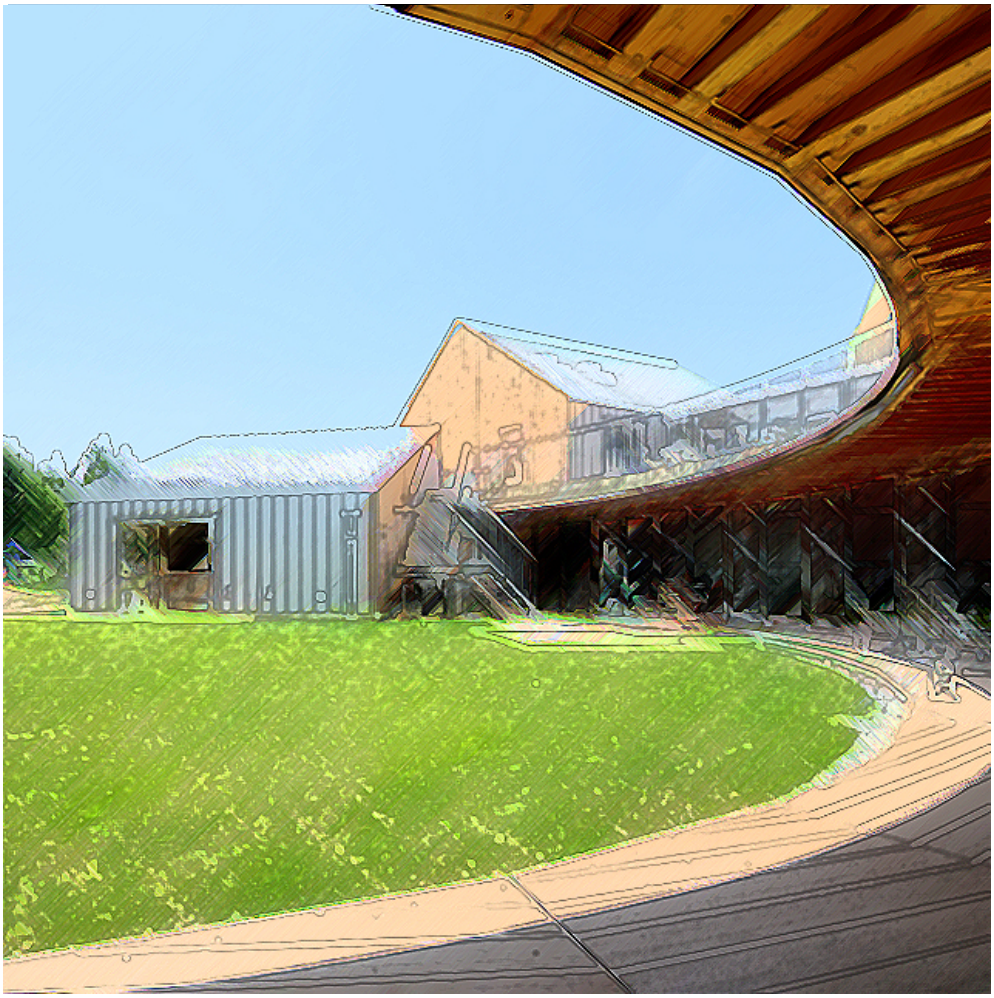

Figure 23: The deck connects the interior open spaces to the garden at the center buildings, inviting visitors to explore the exterior spaces.

Relevance:

The building demonstrates several moments of fine attunement towards the psychological, emotional, and physical states of the children and their families who visit the centre. While being sensitive and supportive to their pain through a pared down and calming atmosphere, it still expresses comfort, togetherness, and moments

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Figure 24: The generous property size allows for a variety of gardens for the children and their families to enjoy.

of joy. By offering many places of exploration and discovery to children, it declares the belief that life is worth living until the time of death, and not any time sooner (paraphrased from the mandate of Cicely Saunders, commonly held as the founder of the modern Hospice). The gathering of buildings expresses the togetherness that is fostered within the spaces of the complex. The playfulness of the forms through irregularity and grouping along a path echoes the simplicity of childhood without leaning on motifs of amusement park colours or jarring cartoon-like motifs. Children are liberated and at home when exploring in nature and this complex eloquently combines the delight of outdoor play with the comfort of shelter and belonging. It is this provision of joy and of support, and the delicate attentiveness to the needs of the dying person and their family, especially during their most difficult moments, that I would like to have guide my design process. A second important element of this design relevant to my project, is this hospice's ability to provide comfort without pretending to be a home or "house". It is neither institutional or falsely a residence, and yet by using natural materials, simplicity, natural light, and volumes that befit the use of each room and feel neither overly cramped, nor exaggeratedly inflated- that the spaces create a feeling of warmth, calm, and tranquility. Since this space is only a day-centre, the presence of

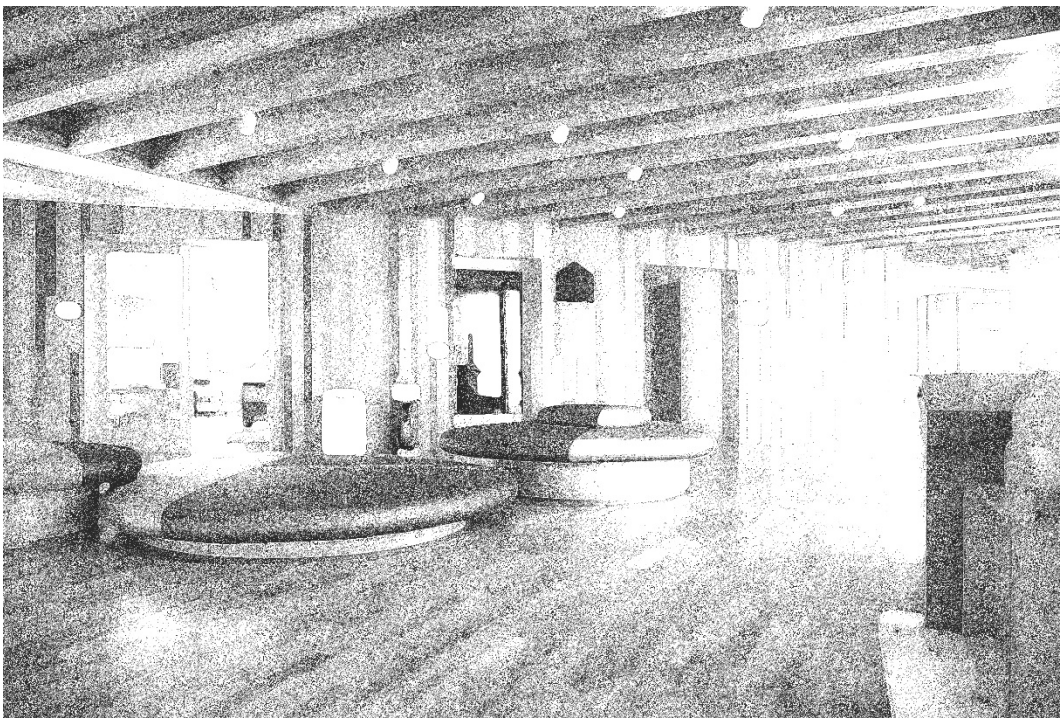

Figure 25: Tsurumi Children's Hospice Interior. The individual houses are interconnected- each has a unique function and the space between forms circulation and common gathering space.

highly private space is limited, however, the facility still offers a fluid combination of communal space to foster supportive connection, and "away" spaces, to allow for a private setting down of physical and emotional burdens.

Figure 26: Between the buildings of the Tsurumi Hospice are semi-private niches. Services at the hospice are free, and there are plans to open a 24-hour care facility nearby.

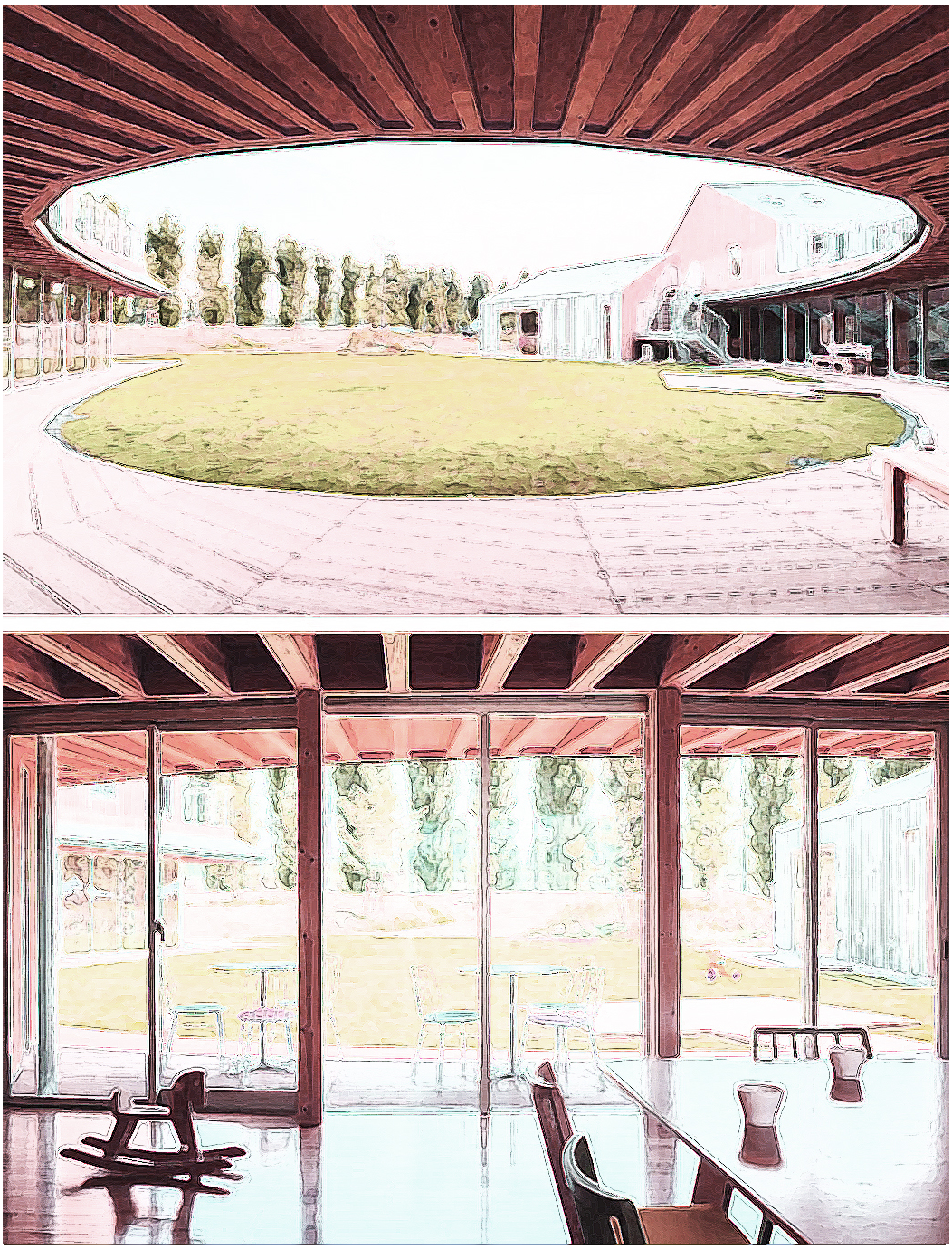

Figure 27: The curved form allows for clear sight lines which help with orientation (above). The floor to ceiling glass on the main floor floods the spaces with natural light, subdued by the overhang, and additionally blurs the edges between the interior and the exterior (below).

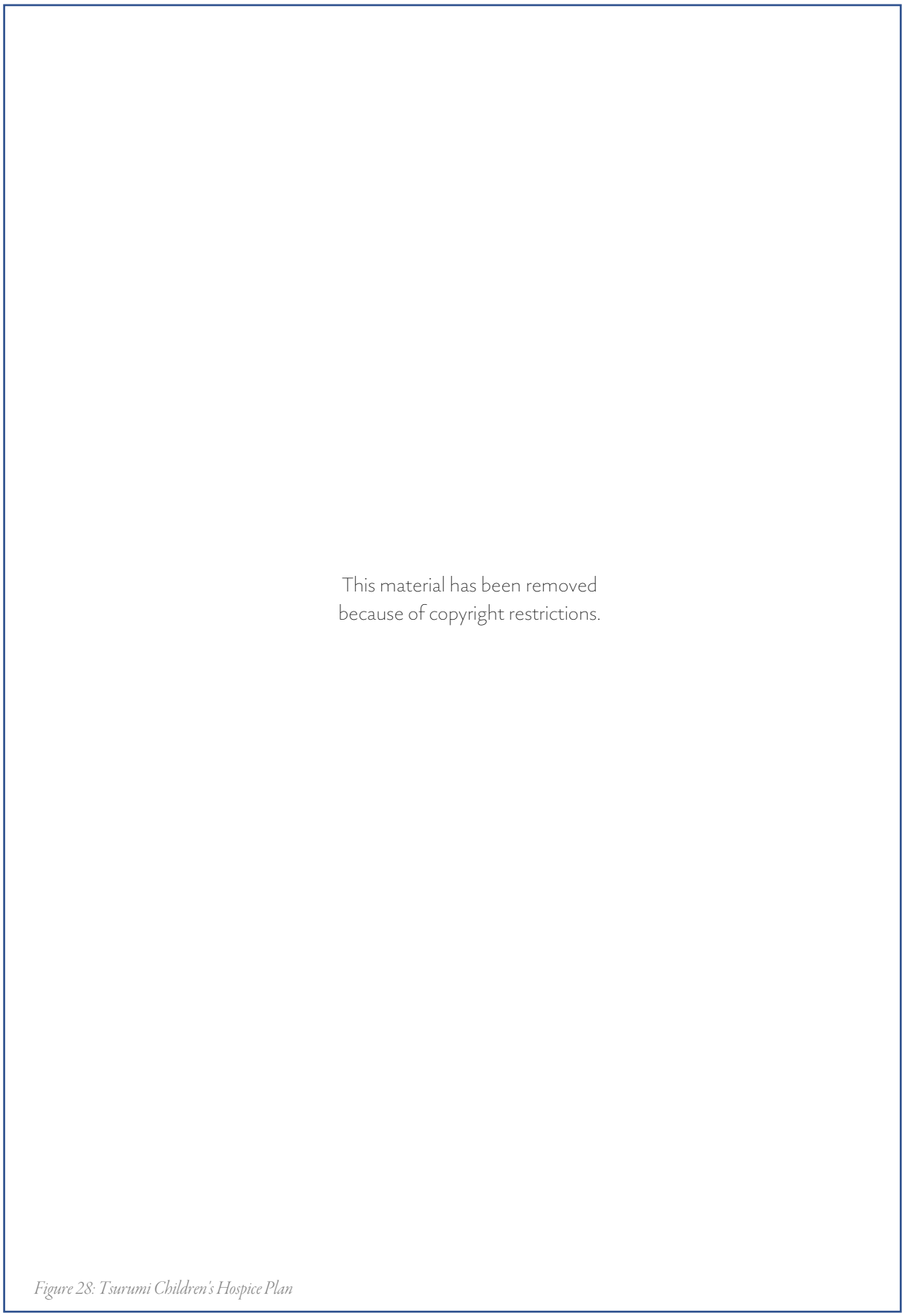

Figure 28: Tsurumi Children's Hospice Plan

Figure 29: The hydrotherapy room above and nap spaces below support care for patients and caregivers, respectively.

3.3 MAGGIE'S CENTRES

Who was Maggie?

Maggie Keswick Jencks was a landscape architect in Edinburgh, Scotland, when she was diagnosed with cancer in 1993 for the second time. She decided to fight her illness and take an active role in her own treatment. By educating herself as much as she could in alternative health practices, she could apply those that would support the aggressive treatment her care team were prescribing. She came to believe quite strongly that this move from "passive victim to active participant" was the most important step she took in dealing with her illness.[80] Another important insight for Maggie was how confronting and paralyzing it was for the new cancer patient to suddenly be flooded with endless and difficult-to-understand information about their disease. There was no aid or guidance in how to best navigate the labyrinthine and infinite avenues of information related to cancer once the patient was left alone with their diagnosis. Maggie's own experience with this, in addition to her familiarity with the many waiting rooms and hospitals which became a regular part of her life, led her to decide that cancer patients needed something better. In 1994, during an eighteen-month remission from cancer, she wrote a 'patient perspective' on the impact of diagnosis and recurrence at the request of her doctor with whom she was in close contact throughout her treatment. The result, *A View from the Front Line,* was in large part a piece about the different alternative avenues which she explored and that supported her own health, focusing mainly on nutrition and nutritional supplements to boost the immune system. She expounded her belief that it wasn't so much what she did exactly to support her own health, but the fact that she was taking an active role that mattered. After her remission, Maggie then began to devote herself to developing her ideas on what kind of help she and other people with cancer needed. What

Figure 30: Maggie Keswick Jencks at Portrack, Scotland. From "A View from the Frontline".

[80] Keswick Jencks, Maggie. 1995. *A View From the Front Line.* London: Maggie Keswick and Charles Jencks. p 2.

emerged was that cancer patients needed a welcoming place near the hospital, with an office and library- a place where a patient could be supported and empowered. Maggie was a strong believer in the ability of buildings to uplift people, and with this founding belief, the plan for "Maggie's Centre" began to evolve. She modeled her centre partly on examples of patient support centres in the U.S., such as the Wellness Foundation in Santa Monica. With a clear image for the centre she had in mind, she was able to persuade the hospital administrators at the Western General Hospital to go ahead with the first cancer caring centre. In 1995, she hired Edinburgh architect, Richard Murphy, to convert a small stable building on the hospital grounds into a flexible space for the centre to operate. By April of 1995, Maggie's cancer had returned, and she knew her time was limited. She wrote a 'Blueprint' – a mission statement - which outlined the centre's principal philosophy and what it would do:

> "It would offer information, psychological support, advice on nutrition, exercise and relaxation therapies. Each person visiting the centre would be helped to find his or her own best way of coping with the disease. There was to be no 'right way'. The centre was to be a haven, where the range of use would extend from a cup of tea you could make yourself in a friendly kitchen to attending weekly support groups led by a clinical psychologist."[81]

Maggie died on July 8th, 1995, one year before her first centre was built. This first drop-in day centre, named after her, continues to thrive and has been so successful that the organization went on to open 24 centres throughout Scotland , the United Kingdom, and internationally in Hong Kong, Tokyo, and Barcelona, with more centres currently in development.[82]

> "Feeling alone, as if set adrift in a leaky boat on a violent and hostile sea, numbs the mind and lets in despair."
>
> -Maggie Keswick Jencks

In Maggie's essay *A View from the Front Line,* she makes some compelling observations. She notes how unwelcoming the hospital waiting room environment is, especially considering the shaken emotional state of the patient. She points out how the overhead neon lighting, the lack of nature views, and the uncomfortable seating all contribute to worsening the patient's spirits.[83] Overall, Maggie expressed that this message adds up to saying: "How you feel is unimportant. You are not of value. Fit in with us, not us with you". She had the boldness and

[81] Keswick Jencks, Maggie. *A View From the Front Line.* p 4.
[82] "About Us," Maggie's, Accessed on December 17, 2020, https://www.maggies.org/about-us/how-maggies-works/our-story/
[83] Keswick Jencks, Maggie. *A View From the Front Line.* p 21.

the courage to question: "Why shouldn't the patient look forward to a day at the hospital?"[84] Maggie was imagining a place of support, of togetherness, a place to find much needed guidance and information. She was beginning to dream of the cancer centres she would birth the ideas for.

Maggie also recognized the value of feeling in control, for patients to feel that they are able to set their own course, and to support their sense of confidence and resourcefulness.[85] She eloquently captures the philosophy manifested in the Maggie's Centres in her claim: "Above all what matters is not to lose the joy of living in the fear of dying."[86] This resonates closely with Cicely Saunders' care philosophy that "you matter because you are you, you matter to the last moment of your life".[87]

[84] Keswick Jencks, Maggie. *A View From the Front Line.* p 22.
[85] Keswick Jencks, Maggie. *A View From the Front Line*. p 27.
[86] Keswick Jencks, Maggie. *A View From the Front Line*. p 23.
[87] Miccinesi, Guido, Augusto Caraceni, Ferdinando Garetto, Giovanni Zaninetta, Rafaella Berte, Chiara M Broglia, Bruno Farci, et al. "The Path of Cicely Saunders: The "Peculiar Beauty" of Palliative Care." *Journal of Palliative Care* 2020 Vol. 35 (1) p 5.

Maggie's Centres and Maggie's Dundee, Scotland

The United Kingdom's Maggie's Centres are renown worldwide as a series of innovative, award-winning, small scale buildings designed by some of the world's greatest architects.[88] These drop-in day centres for cancer patients and their families to gain practical, emotional and social support have designs that tend to stand-out, and be attention grabbing; they take on an architectural presence reticent of larger, monumental buildings such as museums, and therefore create quite a contrast to the traditional hospice building typology which tends to be set in an inconspicuous domestic style.[89] Though they are all situated near or adjacent to existing National Health Service hospitals with cancer treatment facilities, the Maggie's Centres operate in "joyously non-clinical environments that could easily be described as architecturally stunning: bold, beautiful, uplifting, challenging, welcoming, the antithesis of drab and oppressive".[90] The design brief for the Maggie's centres is exceptional

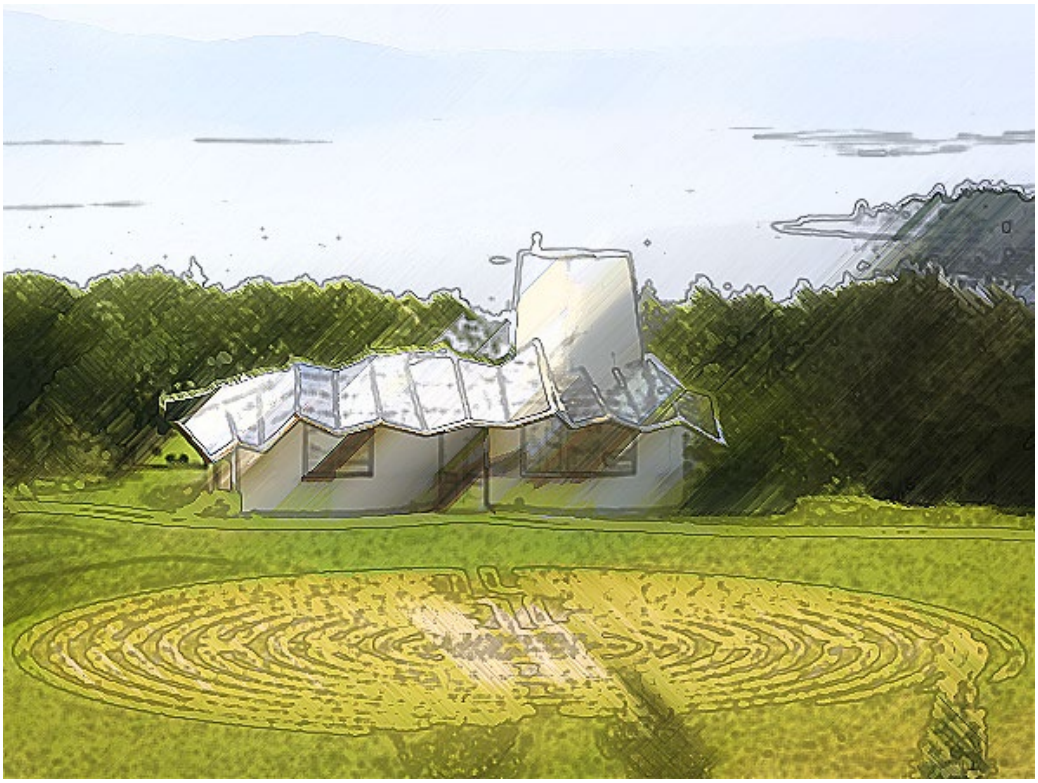

Figure 31: Maggie's Centre Dundee, Scotland. Designed by Frank Gehry of Gehry and Partners. The Tay Estuary is visible in the distance and in the foreground is the Labyrinth Garden designed by Arabella Lenox-Boyd.

[88] Adams, p. 253.
[89] Adams, p. 253.
[90] "The Best of Biophilic Architecture – Maggie's Centres," Workagile, Accessed on on December 18, 2020, https://workagile.co.uk/the-best-of-biophilic-architecture-maggies-centres/#:~:text=Twenty%20years%20later%2C%20the%20roster,2011)%20and%20Norwegian%20design%20powerhouse

Figure 32: Maggie's Centre Dundee, south façade. Designed by Frank Gehry.

because it asks the architects to create spaces that invite certain emotional responses. In the words of Maggie's late husband, Charles Jencks, who had carried on the foundation in his wife's honour until his death in 2019: "We have learned to be more ambitious about what we ask for. We want more than functional spaces. A building which has quality makes you feel valued. We believe that kindling curiosity and imagination is fundamental to feeling alive, and we want this spirit embodied in our centres. We choose architects who have the imagination, the confidence, the ability and the understanding to respond to such a brief."[91] The architects who have designed Maggie's centres include Pritzker Prize-winning designers such as Frank Gehry, Zaha Hadid, Richard Rogers, Kisho Kurokawa, OMA and Snøhetta.

[91] Adams, p. 253.

The first Maggie's Centres were renovations of existing buildings or existing oncology units. In 2003, the first free-standing Maggie's Centre in Dundee, Scotland, designed by Frank Gehry opened. The building was designed as a day centre for cancer patients undergoing treatment at the neighbouring Ninewells Hospital, or other hospitals nearby. It is located at the margin of Dundee City, looking out towards the Tay Estuary. The building was designed with the occupants in mind, consisting of four interconnected spaces, which is a common feature to all the Maggie's Centres: an arrival area and main lounge, an open welcoming kitchen, an informal sitting area, and a library.[92] As is the case with most of the Maggie's Centres, the scale is "residentialist", and it acts as "both a visual and functional antidote to the nearby hospital."[93] Important features of this, and in fact all

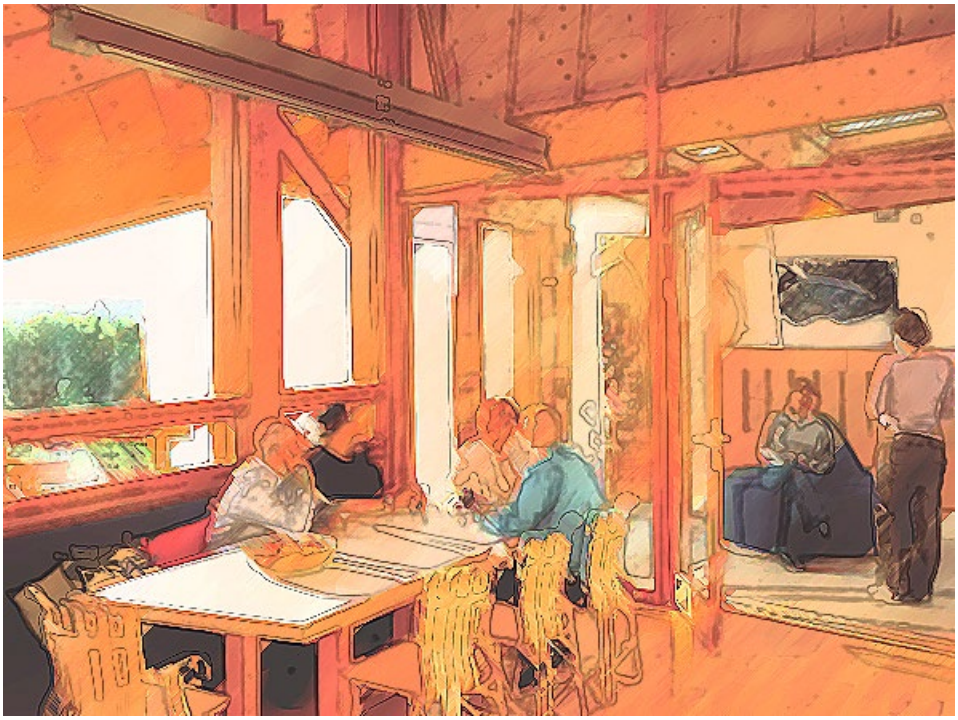

Figure 33: Informal sitting area extending from the kitchen and arrival area in the Maggie's Centre, Dundee. Guests are invited to sit and linger to create an open atmosphere that invites connection.

Maggie's Centres, is the legibility of the space; upon entry, clear sight lines to the other main common spaces are provided, allowing the visitor to gain an immediate orientation and to support their sense of being in control. These navigation features are intentionally counter to the typical anxiety-inducing experience of orientating oneself in a typical institutional or hospital building. A generously-sized country style kitchen conveys a

[92] Verdeber et al. p 45.
[93] Verdeber et al. p 45.

universally understood sense of welcome, and visitors are invited to help themselves to a hot cup of coffee or tea. These details are deliberately designed elements in the Maggie's philosophy, all acting in harmony to orchestrate a sense of ease and belonging. At the Dundee Centre, the sitting areas are bathed in natural daylight and invite

> "...place and space do make a considerable difference to how people feel. An imaginative environment is liberating. (...) A building has done a good job if it even lifts your spirits for a brief moment. If it creates spaces which make it easier to be with other people, by creating a comfortable balance between public and private, which make you feel safe but at the same time stimulate your imagination without your even noticing that such a thing is going on, then it has done even more."
>
> -Marcia Blakenham
> Friend of Maggie Keswick Jencks and
> founding trustee of Maggie's Centres

guests to linger and possibly engage with one of the professional support workers.[94,95] The professionals in the Centres listen and only advise and guide if asked, however, they do not instruct.[96] The informality of the architecture is intended and supports the philosophy of openly and warmly welcoming the visitor, and at the same time, allowing the visitor to determine the ways in which they will best be supported.[97] Spaces and seating are designed in a strategic way to allow a new visitor to watch a group activity from a slightly setback standpoint, or to engage if they feel propelled to, in the most fluid and unobtrusive way. This supports Maggie's intention that there would be no "right way", encouraging each patient to take control of their care. As is true for hospice patients also, having the ability to control the course of one's care is of enormous psychological importance- especially at a time when so much control in life has already been lost.[98] In the words of the authors of *Innovations in Hospice Architecture,* Stephen Verderber and Ben J. Refuerzo: "Gehry's Maggie's Centre provided innovative design: versatile and expandable spaces, an open arrangement with few 'closed cells', and no corridors,

[94] Verdeber et al. p 45.
[95] Keswick Jencks, Maggie. A View From the Front Line. p 31.
[96] Keswick Jencks, Maggie. A View From the Front Line. p 30.
[97] Keswick Jencks, Maggie. A View From the Front Line. p 30-32.
[98] Vanderpool, p 851.

signs, or clinical overtones. In these respects, it expressed, architecturally, principles extremely similar to those expressed in progressively designed residential hospices."[99]

Figure 34: The informal sitting areas in the Maggie's Centre in Dundee are bathed in natural light. Orientation becomes easy with interconnected common spaces.

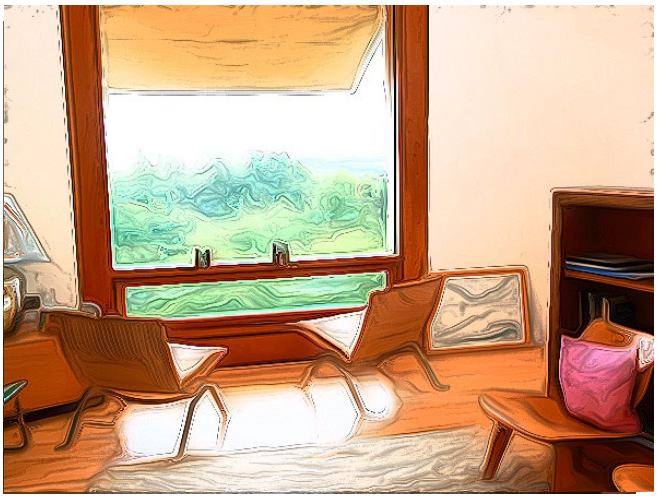

Figure 35: View out toward the Tay Estuary from the tower.

[99] Verdeber et al. p 45.

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because of copyright restrictions.

Figure 36: Maggie's Centre Dundee by Frank Gehry. Plans: Level 1 and 2. The circulation is informal allowing for immediate orientation and eliminating the bleak and daunting corridors of typical institutional health care buildings.

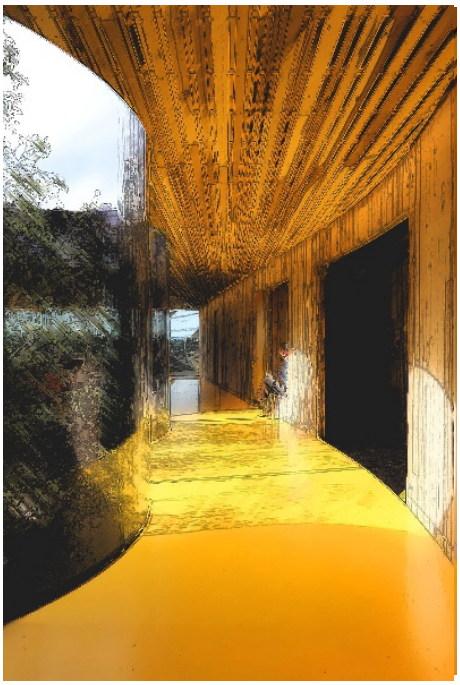

Figure 37: A sampling of Maggie's Centres capturing the lively, vibrant, and welcoming atmosphere.

4.1 PROGRAM INTEGRATION

My goal is to imagine a way that design can further the aims of the hospice philosophy; to alleviate the "total pain" of death and dying, not only for the person dying, but also for their loved ones. I want to imagine an alternative to shame and isolation and visualize how a life event as momentous and natural as dying can happen in a way that fosters as much support, consideration, and meaning as possible. Progressing forward from research to synthesis, my aim is to explore the ideas of belonging and integration as they relate to the hospice on three scales: The urban fabric, the community, and within the hospice space itself.

Figure 38: A program map showing activity hubs and the idea of programs meeting to create a more profound integration of the hospice into the physical and social fabric of the community. Beginning at the top in a clockwise direction, a Drop-In Day Centre for Bereavement Support, the Hospice, a Café/Luncheonette that could be linked to the local farmer's market, and the Community Centre for the Arts. In the middle, a shared courtyard or greenspace allows for visual and auditory connection, welcoming the sounds of music and voices, and the vitality they share to enliven the space. Greenery and a water feature will contribute a sense of grounding and replenishment to the centres and the larger community, inviting people to enjoy the outdoor spaces.

On the scale of community, integration can be created through mixed programming. By grouping together community activities that can relate harmoniously to one another, there is an opportunity to merge the social fabric of the neighbourhood with the hospice. Through my explorations of the psychological landscape of grief and the often-experienced shortage of support through the long and arduous journey of bereavement, a Drop-In Day Centre for Support Through Grief in the spirit of the Maggie's Centres would be a natural addition to

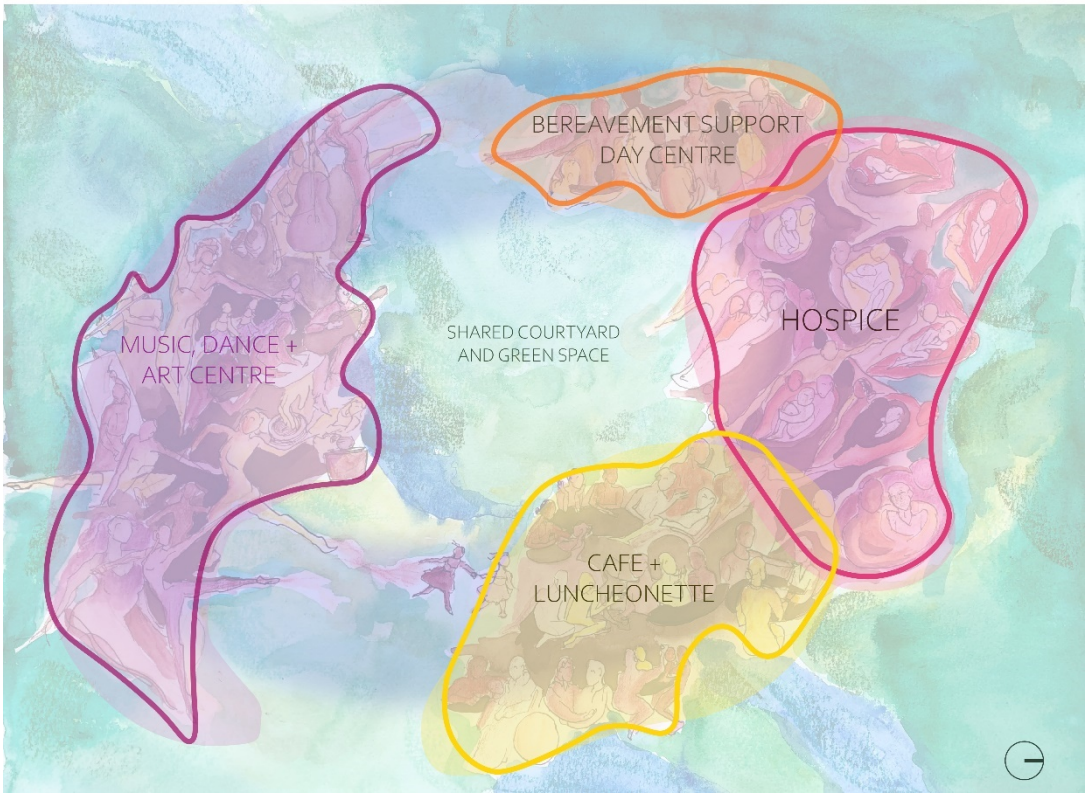

Figure 39: From people to spaces: the previous drawing becomes a launching point to define physical spaces and their relationships to one another, answering the question, how can architecture best serve the needs of the community and the stakeholders.

the hospice.

As a balance to the reflective atmosphere of the hospice, a Community Centre for Art, Music and Dance would be a place of expression. The core essence of the arts is to translate the experiences of living into languages that are universally understandable. A centre for the arts could reach out to the hospice not only to provide grounding and relief through art therapy, but also for the therapeutic experience of music. By drawing community members of all ages who share a fondness for the arts to the site, the hospice becomes embraced by a

vibrant community presence. While the design of the hospice will provide autonomy of choice for users to select privacy when desired, the option to choose one's level of engagement, whether only through watching across the garden courtyard, or engaging in an activity will be up to each individual to choose.

Figure 40: The mixed program within the site space to show the preserved greenery and the integration with the local community.

And finally, a Cafe or Luncheonette would provide a lively and casual place for gathering for not only the patients of the hospice and their families, but also for visitors of the Day Centre, the Arts Centre and the larger community. The integration of programs with the hospice expresses a strong position of belonging.

As for the specifics of the hospice program itself, early research on the spatial requirements of the hospice has led to the assembly of the following table of programmatic space:

4.2 HOSPICE PROGRAM

	Detailed Demands		Architectural Response
Domain	Function	Quantity	Detailed Demands Regulations, form, technique
Main Space			
	Entrance and reception	1	*Must welcome, assuage fears, anxiety. Be a strong expression of belonging, safety, security, and serenity.*
	Wardrobe	1	
	Washroom facilities		
	Storage		
	Shared Gathering space for eating and living	1	*Express comfort through the senses: through the auditory, olfactory, and kinesthetic experience. Communicate a welcome greeting and a relaxed atmosphere.*
	Smaller Dining Room	1	*For meals where a family may choose to eat privately together.*
	Music Space	1	*Auditorily linked through the shared spaces and the private rooms to create an invitation for connection, empathy and belonging through the universal language of music.*
	Storage for musical equipment	1	
	Shared Kitchen	1	*Large, practical, warm, and accessible. It must invite participation, togetherness. It is effectively the heart of the centre.*
	Children's Nook	1	*A space for children to feel right-sized, secure and belong with tasks, activities and objects that speak to and are interesting to them.*
	Creative space	1	*Communal, accessible, light-filled, inspiring with views onto nature and space to create or simply be near the creative activity- provide the choice to participate or watch.*
	Storage for creative materials	1	
	Individual Rooms (including private bathrooms)	20	*Warm, practical, functional, communicating a sense of serenity, comfort, and peace. A connection to nature visually, physically and auditorily. Linked through the auditory and olfactory senses to the shared space, music space and kitchen. Must move away from the institutional feel of the hospital room without resorting to a false domesticity.*
	Private Consultation Room	1	*Warm, gentle, kind, connected to nature, offering respite. A space to collapse and be supported.*
	Physical Treatment Room	1	*While the body is still alive, there are still ways to care for the body which creates a sense of comfort, pleasure, joy. Physical touch, cleaning, bathing,*
	Hydrotherapy Room	1	

			and caring are primal needs that every human needs.
	Family Guest Room	2	*Provide comfort and warmth, respite, and calm for multiple ages. Be accessible. Have visual and physical access to nature. Natural materials.*
Employee Area			
	Workstations / office space	4	
	Print and copy room	1	
	Formal meeting room	1	
	Informal meeting room	1	
	Journal archive	1	
	Break room	1	
	Storage	1	
	Toilet facilities	1	
	Changing Room	1	
	Kitchenette	1	
Other			
	Laundry and linen room	1	
	Room for caretaker	1	
	Remote warehouse and garbage	1	
	Supplies delivery	1	
	Technical/plant room	1	
Sacral space			
	Ceremonial space	1	*Not specific to any one religion but capturing the essential essence of the ethereal. Simplicity, light, silence, warmth.*
	Conversation room	1	*If a space could be a balm, a cocoon. An expression of belonging, support, comfort, with a connection to nature.*
Exterior			
	Sacred space for reflection and meditation	1	*An intimate space with sounds of water. Offering privacy through the creation of smaller nooks created by carefully selected plantings.*
	Children's play area	1	*Interactive, engaging, can be touched, can be climbed on, can be explored, and yet also offer clear sight lines for parents.*
	Outside eating area for warm weather	1	*Flexible in size- can feel right sized for a larger group without feeling too large for smaller groupings. Provide sound privacy for conversations and sheltered from traffic noise- perhaps with the sounds of water. Access to sun and light but also offering shelter during the heat of summer.*
	Exterior gathering place	1	

5.1 CHOICE OF SITE

The current hospice in the small suburban community of Port Moody is in a central location, however its presentation is anonymous and its integration into the urban fabric is lacking. It is across the street from the local Eagle Ridge Hospital, which is convenient, but it is situated inside a multi-level residence, on one of the upper levels. There is only a small sign indicating its presence, but otherwise, the entire building appears to be one of many multi-level residential housing developments present in the area.

Figure 41: Pioneer Memorial Park looking southward from Ioco Street.

My proposed site is informed by the painting I created (right) depicting how dying can be a supported, accepted and embraced process, not only directly by the support team, but also on the larger scales of integration into the community and ideological societal acceptance. The site I have selected is currently a moderately treed green space in the centre of the community called Pioneer Memorial Park. The park is located between the commercial and social hub to the east and the civic and recreational centres to the west, and is slated for development. It is connected to a network of waterfront paths and trails, has extensive access to transit, and is a 5- minute walk to skytrain. The forested condition of the site is an asset as well and would be protected as much as possible to benefit from the restorative effect of nature in the community, and as a place of respite.

Although integration with nature is an important aim of my design, it is more important to reflect the intent to thoroughly integrate the hospice in the community. While there are many possible sites in Port Moody that would offer a complete immersion into nature, they would begin to set the hospice into an increasingly distant "out of sight, out of mind" locale- a move that I strongly want to avoid. Instead, I would rather offer a central location for the hospice and creatively strive to preserve and even enhance the nature that envelopes the building as is exemplified in the Urban Hospice discussed in my Precedents section. This would enrich the city centre with a verdant vibrance that everyone could enjoy, without banishing the hospice.

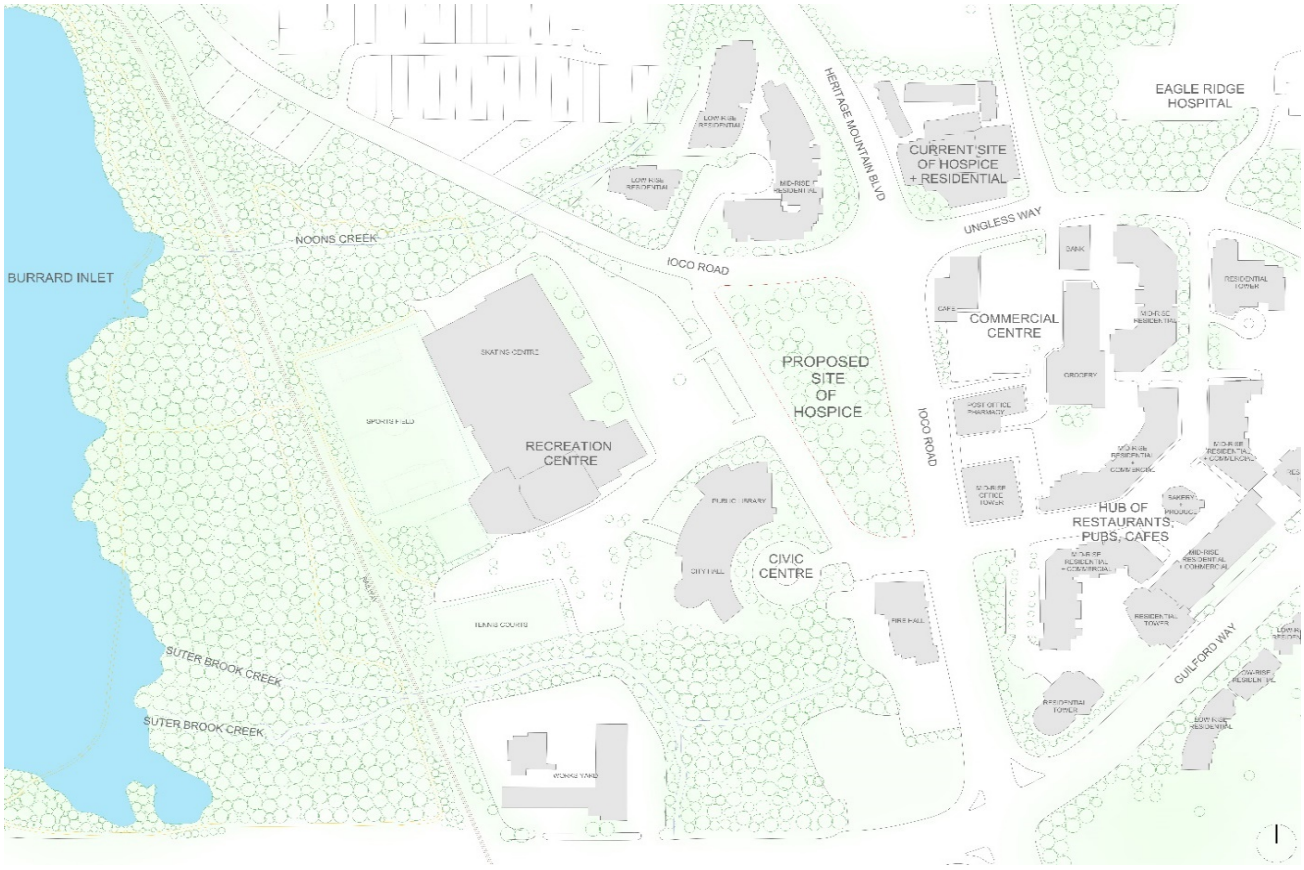

Figure 42: Context Map of Port Moody city centre. The proposed site is located in the centre of this map. The ocean and seaside parks and trails are located to the west. The city centre is a central hub of commercial and civic activity. The city has made it a Point to be a walkable place and is generously treed.

Figure 43: View northwards with Pioneer Memorial Park (the proposed site), to the right and the entrance to the recreation centre to the left.

Figure 44: View southwards of Pioneer Memorial Park at centre-left and the entrance to the recreation centre to the right.

Figure 45: The Program diagram within the proposed site showing the preservation of greenery on the site and the integration within the community.

Though this central location experiences a higher exposure to traffic noise, the principle of integration takes priority. Most importantly, it has been noted that when life has become highly limited as it does towards the end of life, having visual and auditory access to the rhythms of daily life can provide a connection to the surrounding world and a bridge to the cycles, sounds and paces of the community, adding a backdrop of connection to the more immediate links made within the hospice.[100]

[100] Cecilia Hakanson and Joakim Ohlen,, "Connectedness at the End of Life Among People Admitted to Inpatient Palliative Care," American Journal of Hospice & Palliative Medicine, Vol. 33, 1 (2016) p 48.

5.2 SITE TOUR

Figure 46: View towards the east from the northern edge of the park, with the site of the current hospice in the 4-storey building at left.

Figure 47: Looking Southward from the Northern-most part of the park.

Figure 48: View to the southwest from the northern edge of the park.

Figure 49: The Crossroads Hospice Labyrinth Healing Garden in Pioneer Park with the library and city hall across the street to the west.

Figure 50: From the centre-east of the park, view to the southeast towards the commercial hub of Port Moody.

Figure 51: View to the southwest with the library and city hall across the street to the right.

Figure 52: From the centre-west of the park, view towards the northwest and the rec-centre across the street.

Figure 53: From the centre-east of the park, view to the east towards the commercial hub across the street.

6.1 GP2 METHODOLOGY AND AIMS

My principal aim for GP2 is to create a Residential Hospice Design which includes a set of other programs integrated to various degrees of considered proximity with the hospice. In addition to the physical design, I will develop a set of Guidelines for Integration that explore how social belonging can be supported and even fostered by design on different scales. These guidelines may also serve the spheres of long-term nursing homes and palliative care units.

A considerable portion of my research on current hospice care in Canada points to an integrated palliative approach to care in our immediate future. This means that to reduce governmental health care costs, and to align with the majority of people's wish to die at home, we need a care system that is available to patients on a sliding scale of support. It must have a single point source for communication to avoid breaks in patient follow-up and to help develop a sense of familiarity. I imagine that home-care and residential hospice care could be linked with the home-base of a roving home-care team being physically integrated with the residential hospice. If residential hospice care becomes needed, patients and their families may already be familiar with the team if the two forms of support are united. Additionally, this configuration may streamline supplies and staffing, further reducing the load on our healthcare system- an endeavour we must take seriously when we consider the demographic trends of our population (refer to section 1.2). These ideas would need further research to determine their validity, as would the specific space requirements for an integrated roving end-of-life palliative care team.

Within the context of program mixing, is there a way that one of the programs integrated with the hospice can help to fund the hospice? In Canada, residential hospice care programs are still at least 50% funded by charitable donations.[101] One of the main issues that have emerged with the Hospice Typology is overnight accommodation for family members, and for certain cultures, it is important that as many family members as possible are present at the time of death, creating a requirement for larger accommodation.[102] Is there a way to merge these two needs together through a space that can function as overnight accommodation for family members when needed by the hospice patients, and be rented out in the model of an Airbnb accommodation when not in use by the hospice? The idea of creatively and concurrently solving the issues of hospice funding and accommodation provision deserves further exploration.[103]

And finally, on the physical level of designed space, the three main areas of research I plan to delve into are:

[101] Canadian Hospice Palliative Care Association, "Hospice Palliative Care in Canada."
[102] Adams, p 251.
[103] Ideas emerged from conversation with Steve DiPasquale on December 18, 2020.

- Biophilic design,
- Phenomenology and sensory design, and
- Environmental psychology.

Though the three can be considered and studied separately, they all share the common thread of focusing on the neurological experience of space. I am fascinated by this domain where design and biology converge and learning how to create a specific emotional and physical response within the mind and body of a visitor will further enable me to serve the needs of the program, in this case the hospice, in a way that is sensitive to the nuances and details of spatial experience.

Biophilic design has been proven to have a significantly calming effect and has been successful in stress reduction for patients in a residential hospital environment.[104] Phenomenology and sensory design seeks to activate the senses to gently draw the visitor out of the cyclical turbulence of their thoughts and into the immediate presence of their physical body. Design that purposefully stimulates more than only our visual sense can bring us to into the present moment in a similar way to conscious breathing and other such mindfulness practices.[105] The result can be an increased sense of calm, and in some cases, an invitation to step into a higher, almost spiritual level of consciousness- like the experience of walking through a beautiful forest, or an awe-inspiring cathedral.[106] The mind is brought swiftly into the present and it can be felt as an awakening experience. At the very least, design that purposefully enhances the delights of our auditory, olfactory and kinesthetic senses can simply elicit the purest feelings of comfort and pleasure- feelings that are sorely needed during the turbulent period of illness and dying.[107] As an example, this process could involve accentuating the acoustics of the hospice in such a way to allow music to drift into the rooms of patients, allowing them to choose whether to engage with the activities of the common room, or to remain in the privacy of their own space. The comforting smells of baking and cooking are pleasures that reach our oldest sense and can be enjoyed even when other capacities have been lost.[108] Materiality is also a significant way to convey comfort and warmth, and the use of natural materials have been shown to have a calming effect through sight and touch.[109]

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[104] Beth Altringer, "The emotional experience of patient care: a case for innovation in health care design," *Journal of Health Services Research & Policy, Vol 15, No. 3* (2010) p 174-177.
[105] Juhani Pallasmaa, *The Eyes of the Skin.* (West Sussex: John Wiley & Sons Ltd. 2012)
[106] Steven Holl , Juhani Pallasmaa, and Alberto Perez-Gomez. *Questions of perception: phenomenology of architecture.* (San Francisco: William Stout, 2006).

[107] Barbara Erwine, *Creating Sensory Spaces: The Architecture of the Invisible.* (New York: Routledge. 2017)
[108] Miller, "What really matters at the end of life. YouTube TED Talk"
[109] Laura Ann Dammarell, "Residential biophilia: creating a nature based home for better psychological Health," (Master's thesis, Iowa State University, 2019), p. 14. https://lib.dr.iastate.edu/cgi/viewcontent.cgi?article=1245&context=creativecomponents

Finally, environmental psychology closely examines the physical, mental and emotional responses of human beings to their surroundings, further reinforcing the potential positive impact that can be had from thoughtful, considered design.[110]

By studying design in this scientific way, and integrating this with an artistic, intuitive approach, I think I can use the whole range of my abilities to create a space that can elicit a sense of serenity, that can communicate a message of caring and belonging, that visitors enjoy being in, that is also practical and functional, and that overall can help to act as a counterbalance to the persistent tumult patients and their loved ones may be experiencing during the end-of-life stage.

[110] Stephen Kaplan and Rachel Kaplan.. "Creating a larger role for environmental psychology: The Reasonable Person Model as an integrative framework." *Journal of Environmental Psychology* Vol 29, (2008) 329-339.

7.1 ESQUISSE

Figure 54. Esquisse capturing the publicly shared safe haven within an urban centre.

This early esquisse lead my vision and depicts the hospice as a sanctuary within an urban context, welcoming the community to experience moments of visual and physical connection through windows and the crossing of paths. Through this interweaving, the unknown that fuels our collective fear and taboos surrounding death can begin to be dismantled. The natural process of death becomes normalized, and the shame and isolation experienced by the dying and their caregivers are alleviated. Rather than shunning people at their most vulnerable, the community surrounds them. It is an expression of belonging, support, and compassion.

7.2 URBAN INTEGRATION

Figure 55: Events and services within walking distance of the site increase vibrancy, vitality and pedestrian traffic.

Multiple studies were conducted on the site and the surrounding area which confirmed the vitality, access, and functional benefits of being located in the heart of an urban centre. The proximity of events such as the weekly farmer's market, and important services such as Eagle Ridge Hospital, pharmacies, and commercial services within a one block radius not only help to serve patient needs, but also those of caregivers and staff, and create an important vibrancy around and within the site.

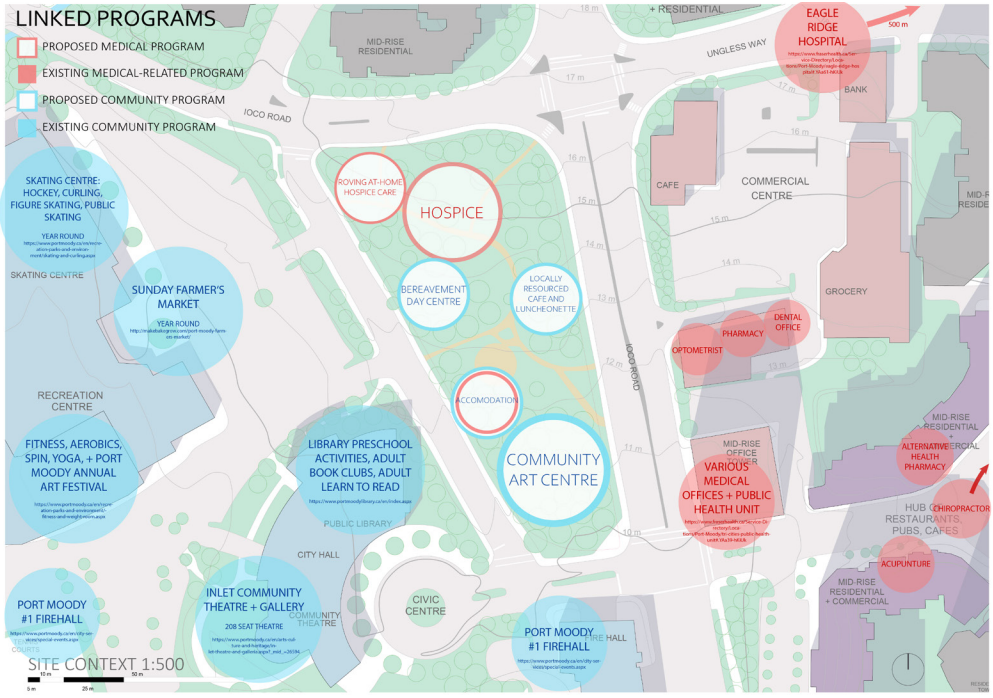


Figure 56: Community and health-related services support social connection and ease access to necessary professionals and prescriptions. The hospital is within a two-block radius, supporting access to palliative physicians.

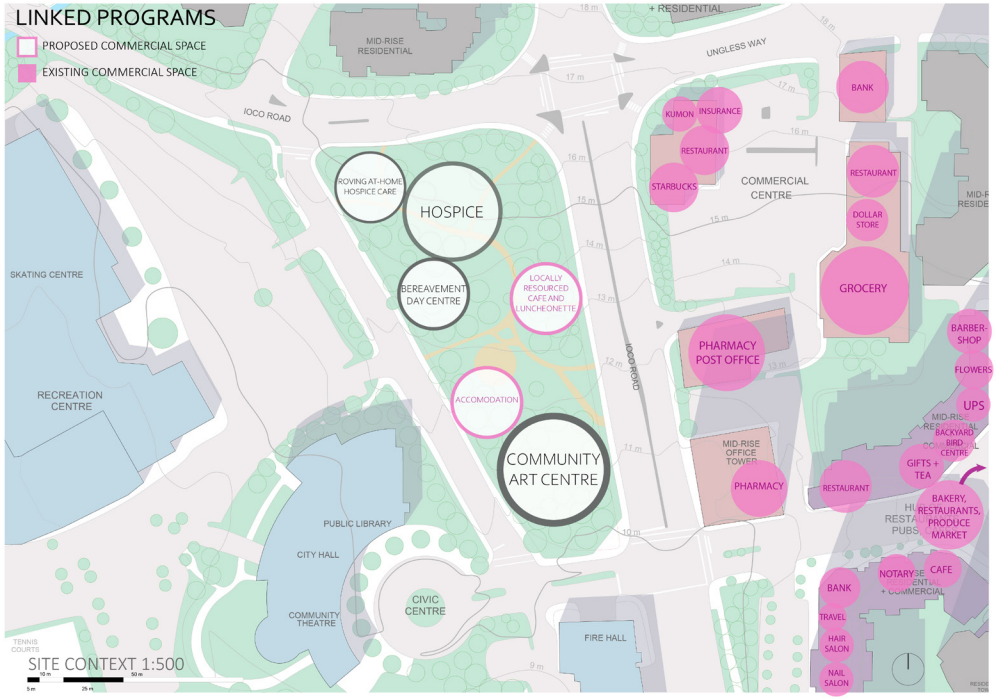


Figure 57: Commercial services support the daily needs of family members and staff. The convenience and functionality of the integrated hospice increases family members and loved one's ability to visit patients.

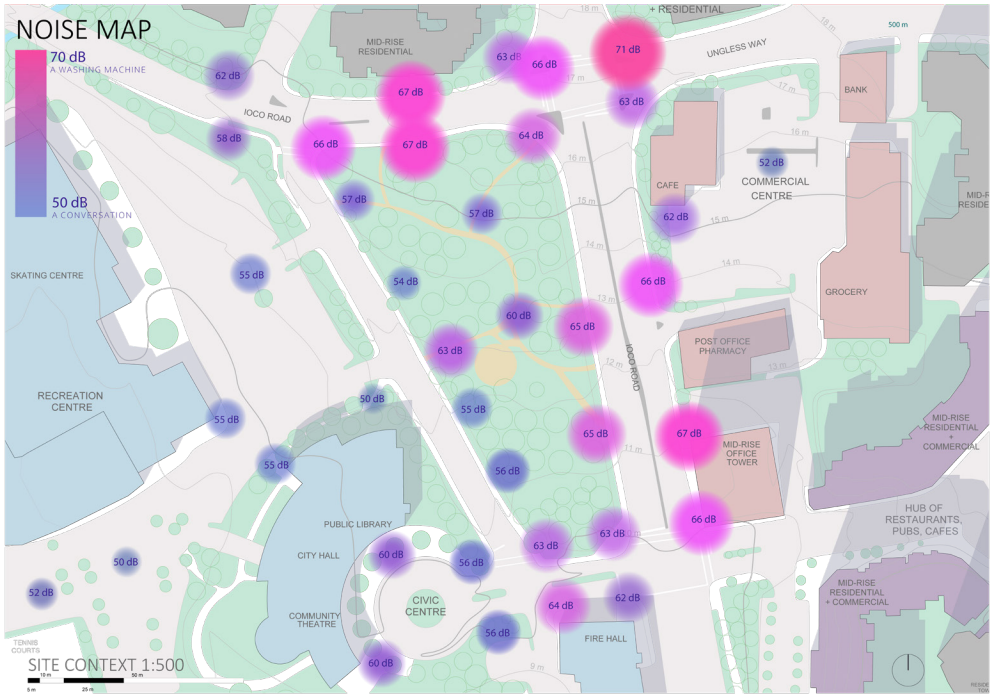


Figure 58: Sound studies on and around the site reveal that noise levels are much more manageable than originally expected for an urban locale.

Figure 59: Several bus routes and 5 minutes walk to sky train increase accessibility for visitors of all ages and abilities. Commuting becomes simplified for staff and reliance on personal vehicles is decreased.

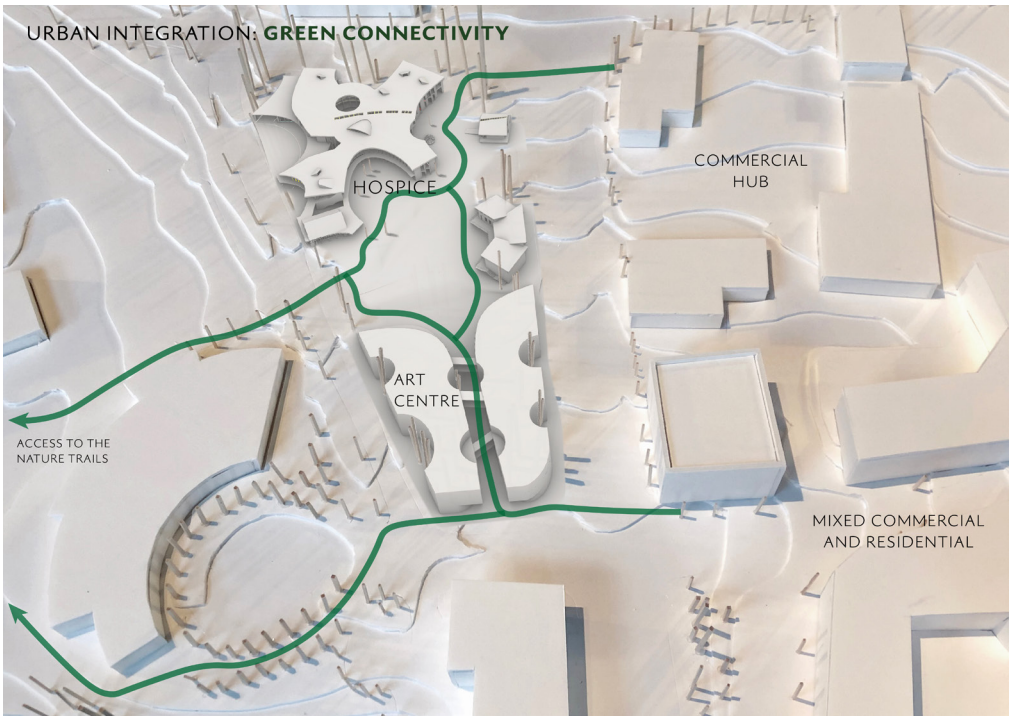


Figure 60: Access from the urban scape to the waterfront forested trails is unimpeded and flows through gardens, past the proposed hospice and art centre.

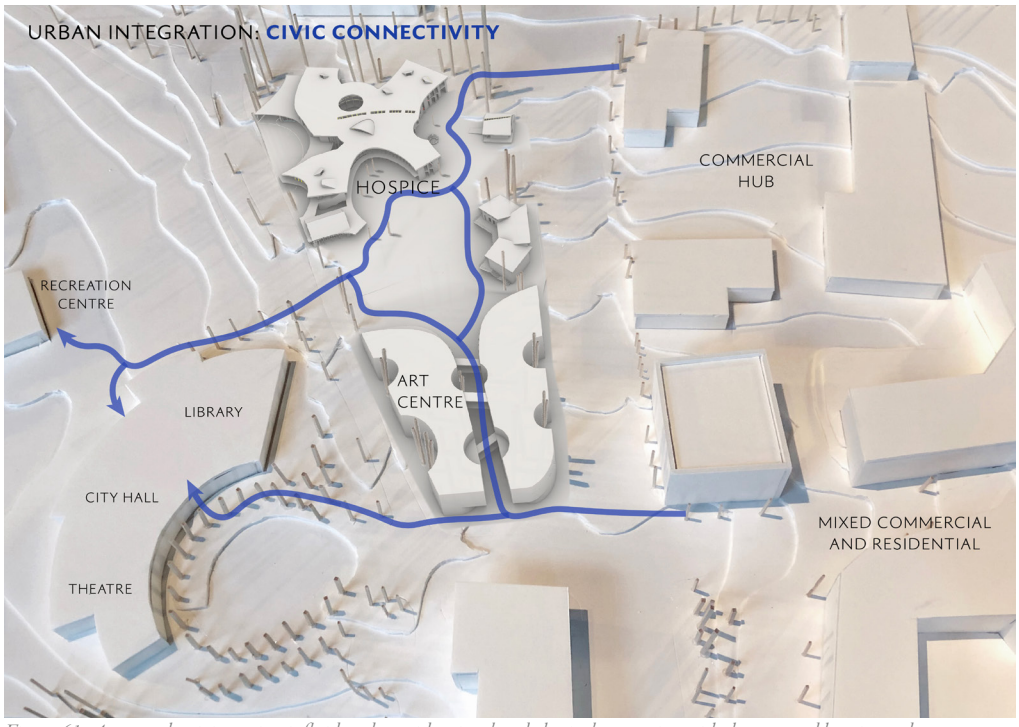


Figure 61: Access to the civic services is fluid and provides visual and physical connection with the proposed hospice and art centre.

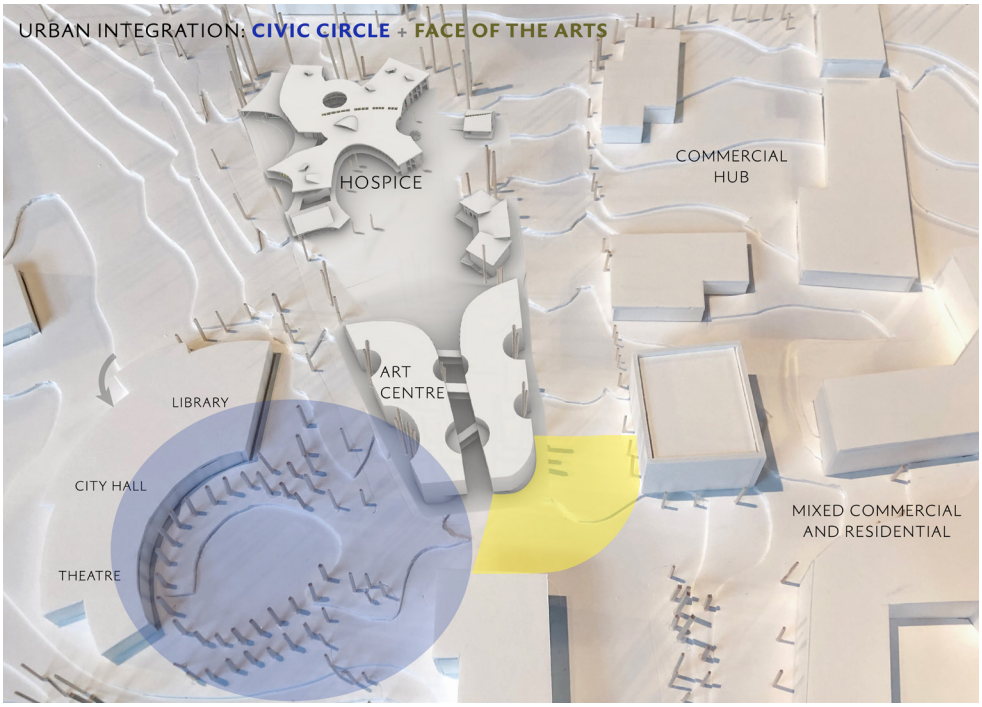


Figure 62: The proposed art centre completes the civic circle composed of the community theatre, city hall and library. The art centre projects a face of the arts outward into the community- which supports Port Moody's identity as 'The City of the Arts'.

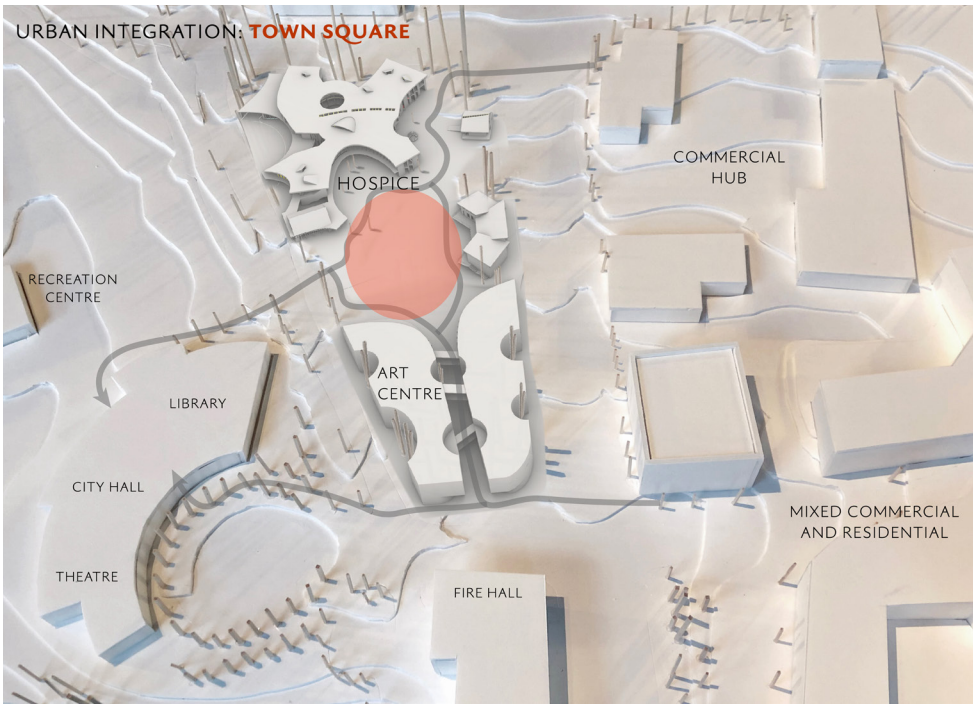


Figure 63: The centre of the site effectively becomes similar to a European style town square: a green and vibrant centre for the community.

7.3 SITE INTEGRATION

FORM MAKING ESQUISSE

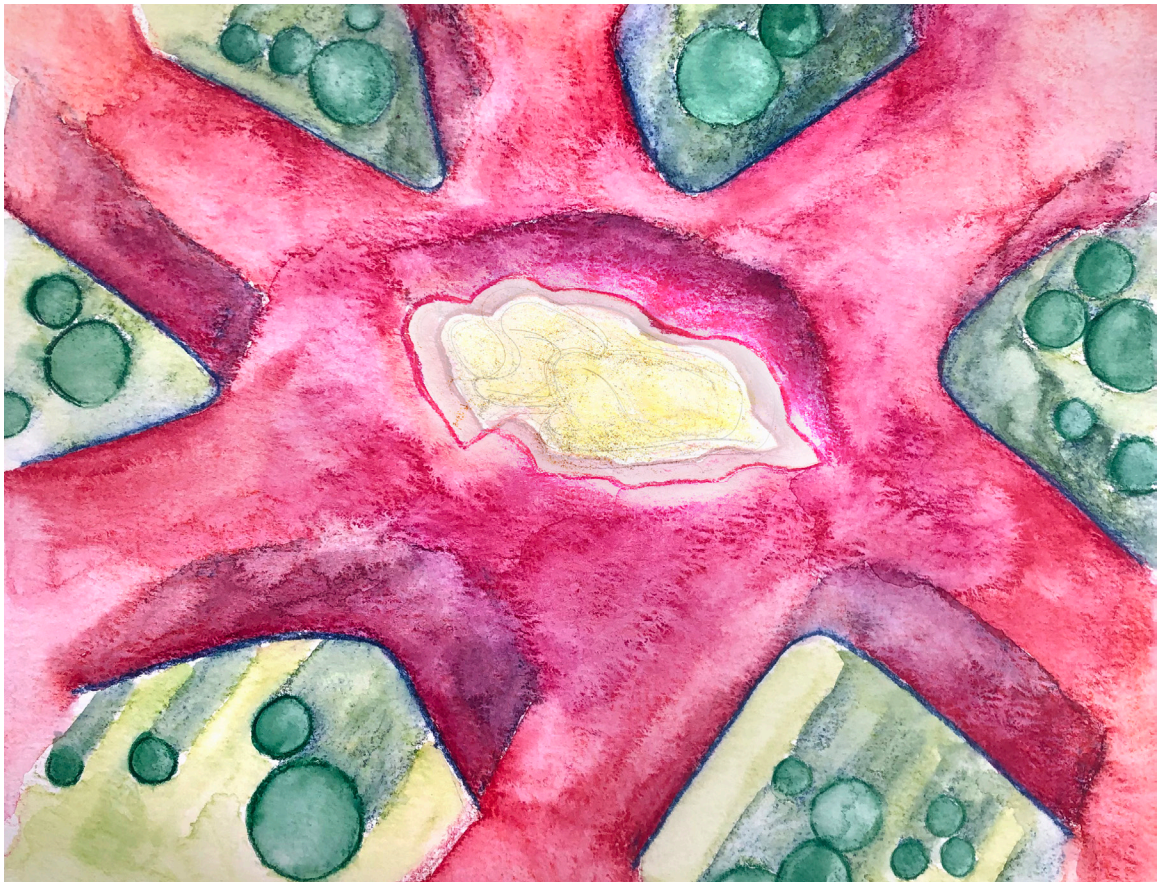
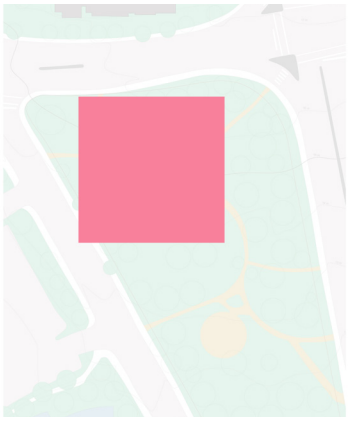


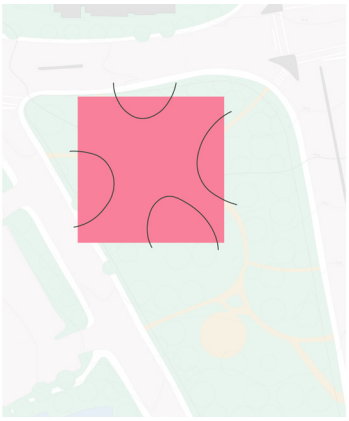
Figure 64: Form-making esquisse with patient at centre.

This form-making esquisse is a combination of abstraction and plan view, and expresses the tension between connection and privacy. By making outwardly reaching arms, privacy alcoves are created in the spaces between, offering privacy and a connection to nature. The arms in turn, reach out to the community, providing touch points- both visually and physically- allowing for integration on the scale of the site.

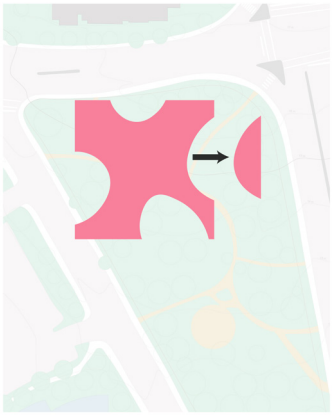
FORM MAKING PROCESS



The estimated space required by the hospice is 3000 m^2, seen above as one square, level on the site.

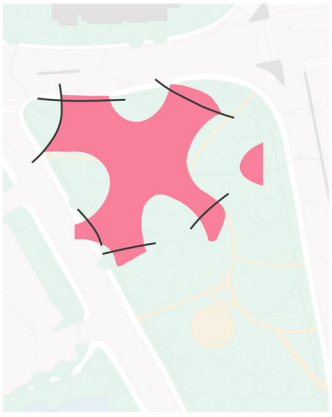


Alcoves are cut out, allowing arms to remain wide enough to include a patient room and a coridor. Patient rooms are extensively large- approximately 6 x 7 m, because they are in fact family rooms.

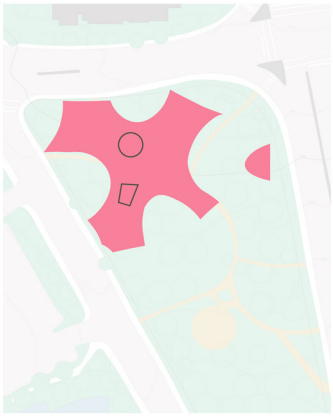


One of the removed alcoves is moved to the east to become the sanctum, allowing the publice exterior pathways to flow through the hospice spaces.

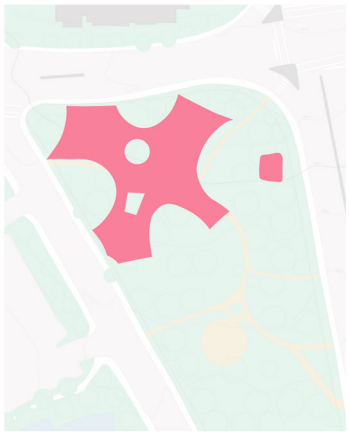
The four remaining arms extend toward the city fabric to connect at the site's edges.



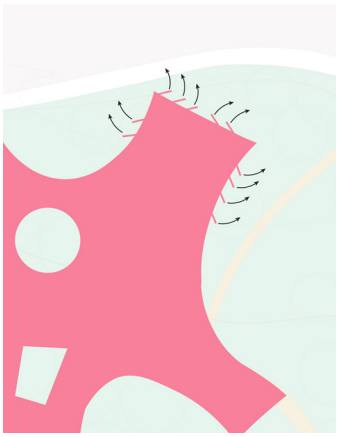
Each arm receives a clean cut to present a clear face to the surrounding community.



Two courtyards are cutout to allow natural light and garden views into the building.



The size of the courtyards is determined to be large enough to allow a tree to grow, but not larger than 9 m: the approximate limit to easily recognize someone's face.



To navigate the tension between openness and discretion, the openings pivot like opening eyelids, allowing light and views towards the alcoves and their gardens, but also providing a sense of privacy.

Figure 65: Form-making process diagrams.

SITE INTEGRATION THROUGH PROGRAM MIXING

Figure 66: Esquisse capturing program mixing between the hospice and the arts.

To create integration on the scale of the site, I have paired the hospice with a program that is naturally sensitive to the profound and meaningful role of the hospice. As a balance to the reflective atmosphere of the hospice, a Community Centre for Art, Music, Dance and the Writing Arts would be a place of expression. The core essence of the arts is to translate the experiences of living into languages that are universally understandable. A centre for the arts can reach out to the hospice not only to provide grounding and relief through art and music therapies, but also for the affirming experience of the telling and hearing of stories. By drawing community members of all ages who share a fondness for the arts to the site, the hospice becomes embraced by a vibrant community presence that is interwoven into the daily rhythms of the hospice.

Figure 67: Programs in plan on the site- early sketch.

In addition to the Art Centre, the site will include a café and accommodation available for use by the hospice patients' family members and loved ones. Both programs would add vibrancy to the site and support the hospice.

The hospice itself consists of three parts: the main in-patient hospice, a headquarters for local at-home hospice care, and a bereavement support centre. These three facets of the greater hospice centre further integrates the care the hospice provides on a time scale, and streamlines support to patients and families.

7.4 BUILDING INTEGRATION

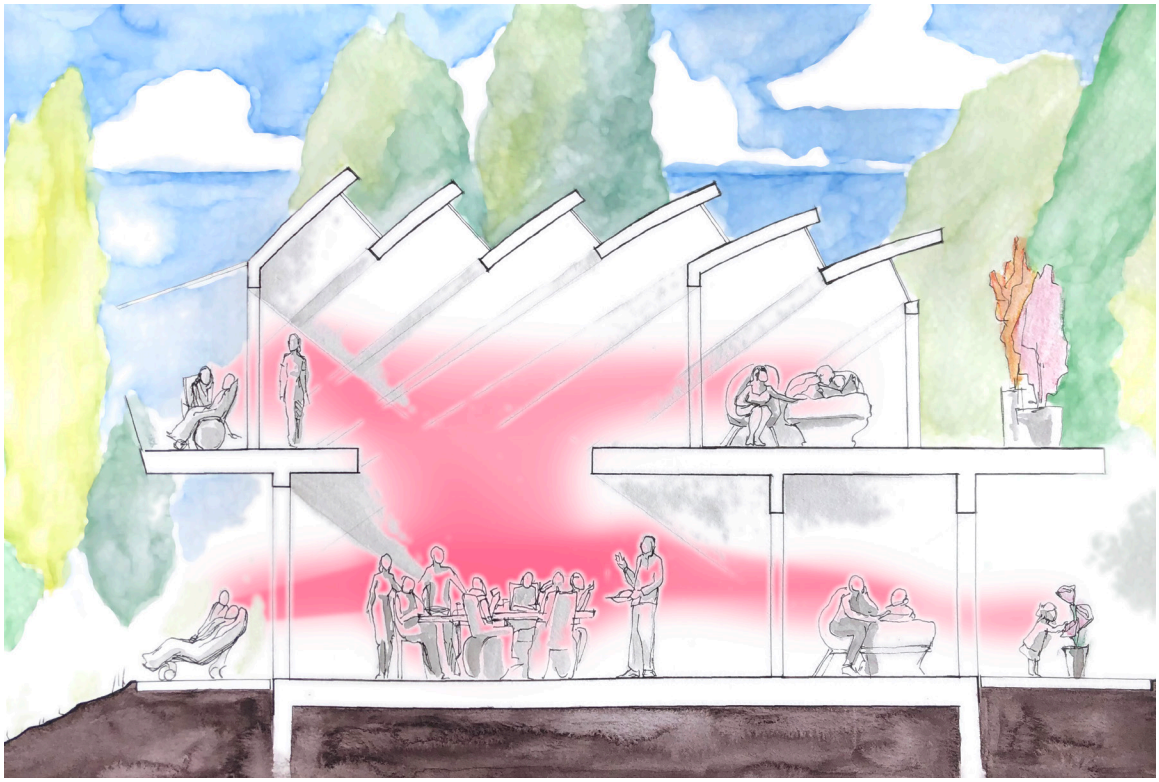


Figure 68: Building scale integration is achieved through visual, auditory and olfactory connection. Patient rooms have visual connection to the double-height shared gathering space- a space that includes the kitchen, the dining and lounging areas.

On the scale of the building, integration is created through sensory connection. Private rooms are visually and auditorily linked to the shared central gathering space. Patients have a large variety in mobility- some are bed bound so visual and auditory connection matters even more. The shared space is important also for families needing support and understanding.

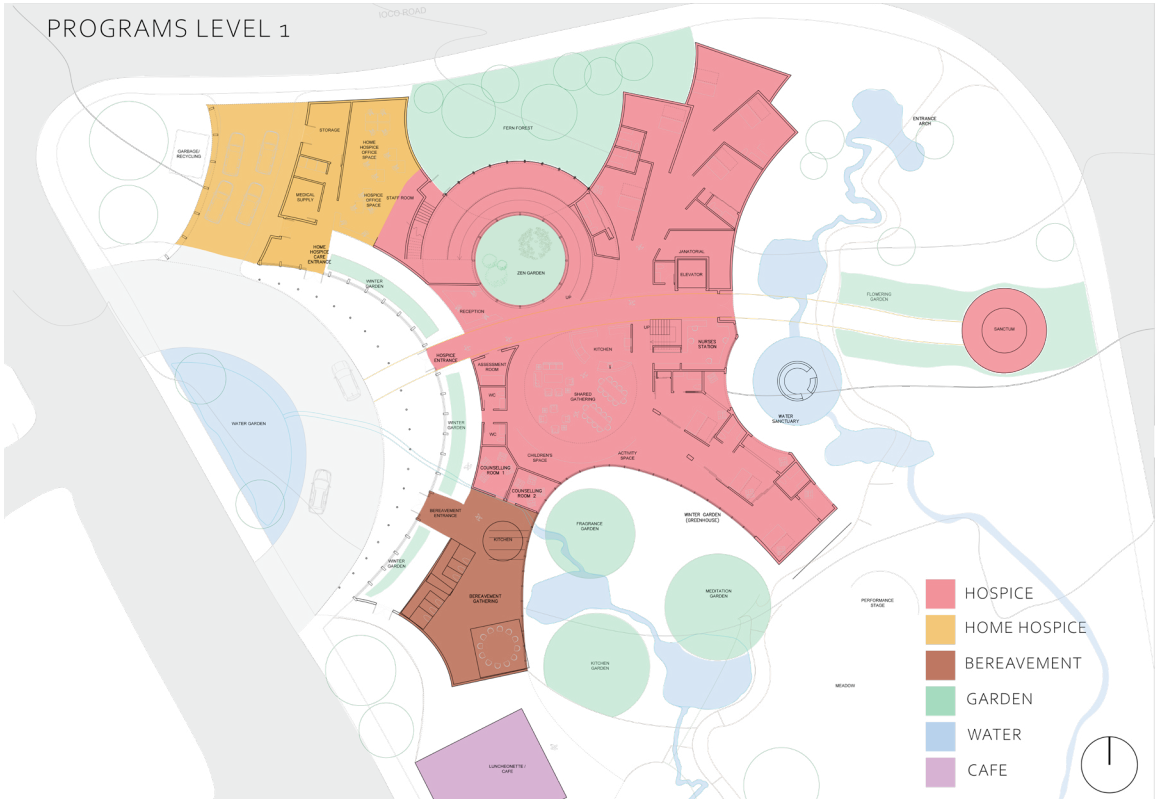


Figure 69: Program Distribution depicting the various arms of Hospice Programming- Level 1. In red, the main in-patient hospice centre, in yellow, the at-home hospice care centre, and in brown, the bereavement centre. The at-home hospice care is placed at the north west corner of the lot, for ease of their vehicular access. The Bereavement Centre is located at the south end, the most closely connected to the public and the café, to create a visual and physical invitation to the centre and the supportive public services they offer. The inpatient hospice care is placed between the two, offering a degree of privacy while maintaining opportunities for visual and physical connection.

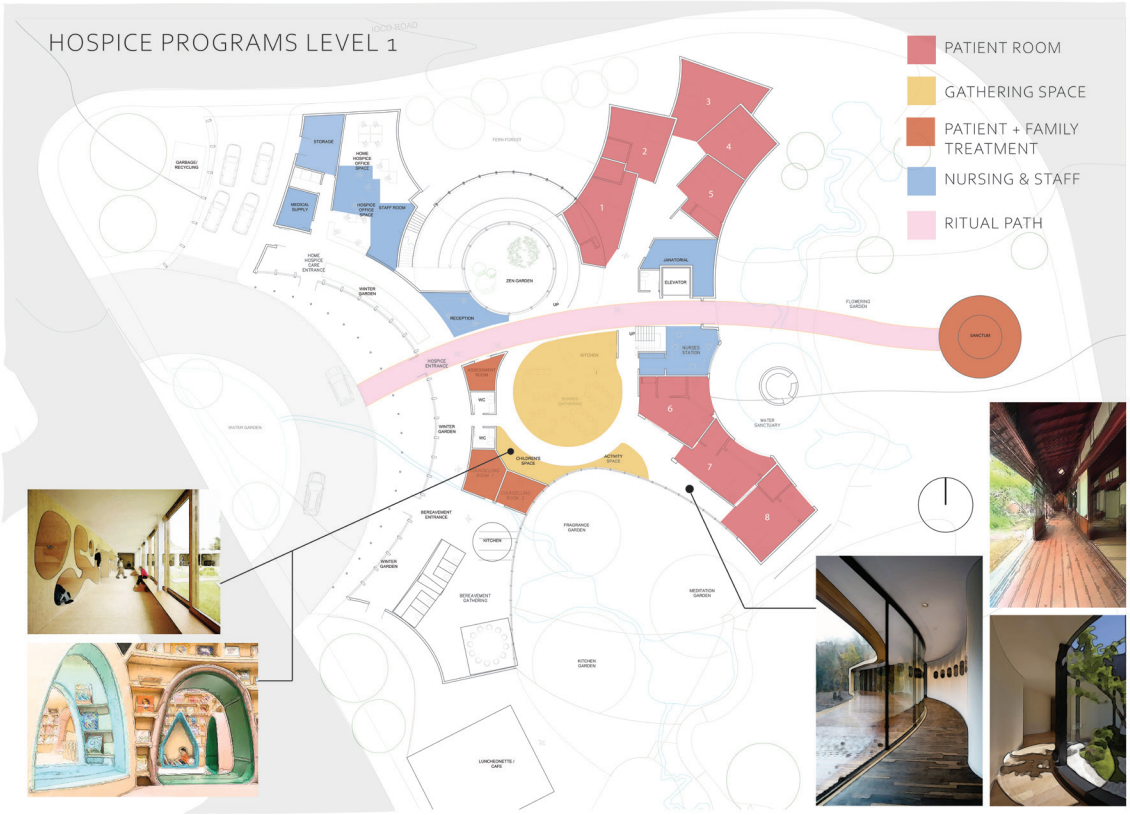


Figure 70: The hospice offers a 17 bed inpatient centre- one of the largest currently in Vancouver. This plan shows the breakdown of the in-patient hospice centre. The central shared gathering space, which includes the main kitchen, dining and lounging areas, is shown in yellow, inluding a right-sized play area for children. In red, the patient rooms project along the north-east and south-east wings. In pink, the ceremonial pathway connects the sanctum to the east with the entrance to the west. Its gently curved form invites one to walk forward in order to discover what lies ahead.

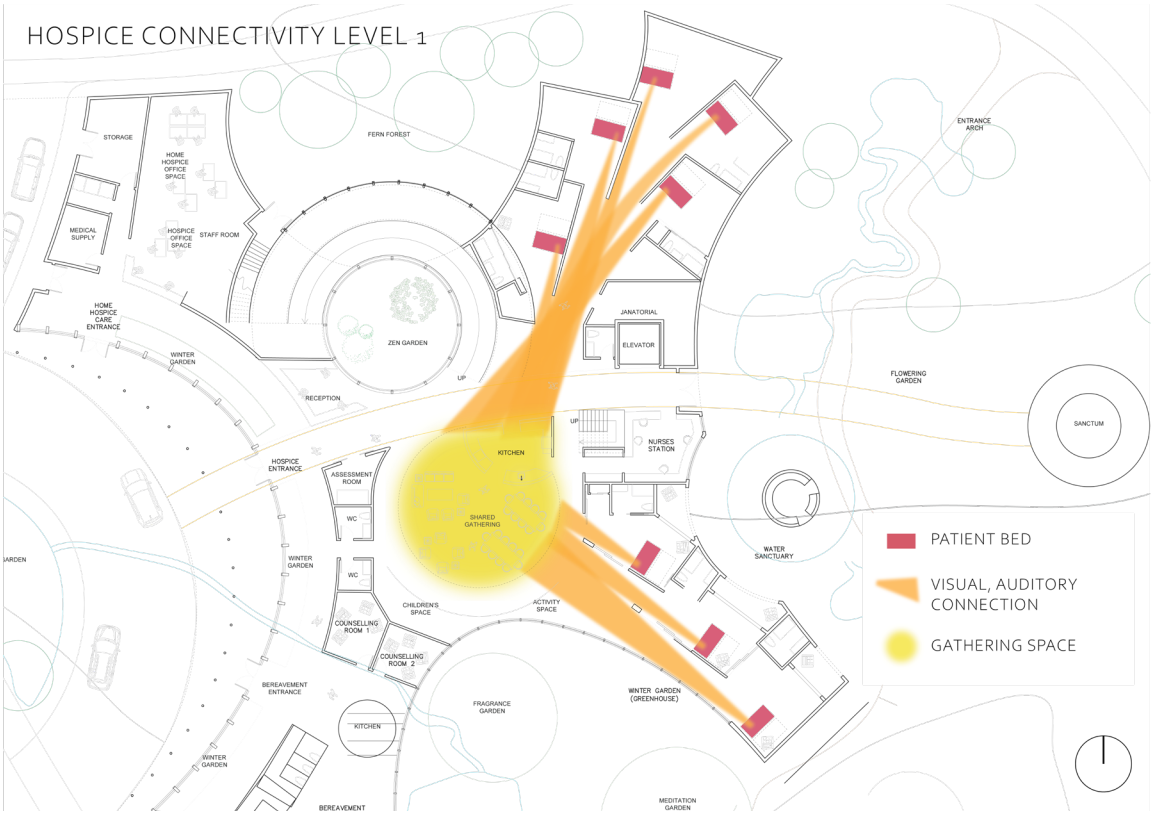


Figure 71: The first level in plan shows how each bed (represented as a red rectangle) is visually and auditorily linked to the shared gathering space in yellow. This was the principle driving force behind the layout of the interior. The auditory connection matters because hearing is the last sense to leave us in the process of dying.

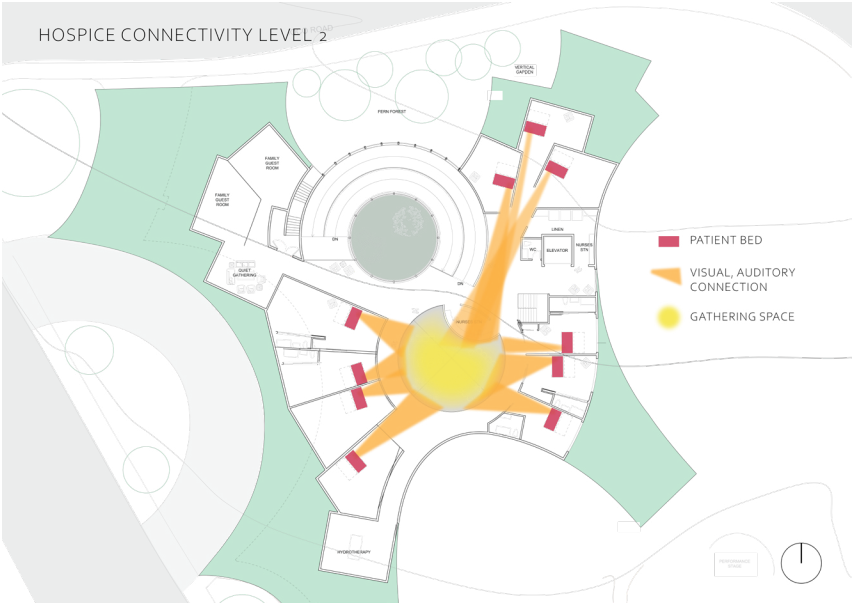


Figure 72: The second level plan also provides each bed with clear lines of connection to the central gathering space open below. An additional benefit to this layout is the ease and efficacy with which nurses can maintain a visual link to all their patients. Balance between privacy and connection is achieved through a combination of Japanese style sliding doors and more conventional swinging doors.

Figure 73: An enlarged view of the south-east wing of level 1. Each patient room has clear views into the main gathering space, in addition to sliding doors that can open between rooms. Each patient room can open to their neighbour's room to enable connection for patients who may be bed bound, but not always in the company of visiting guests.

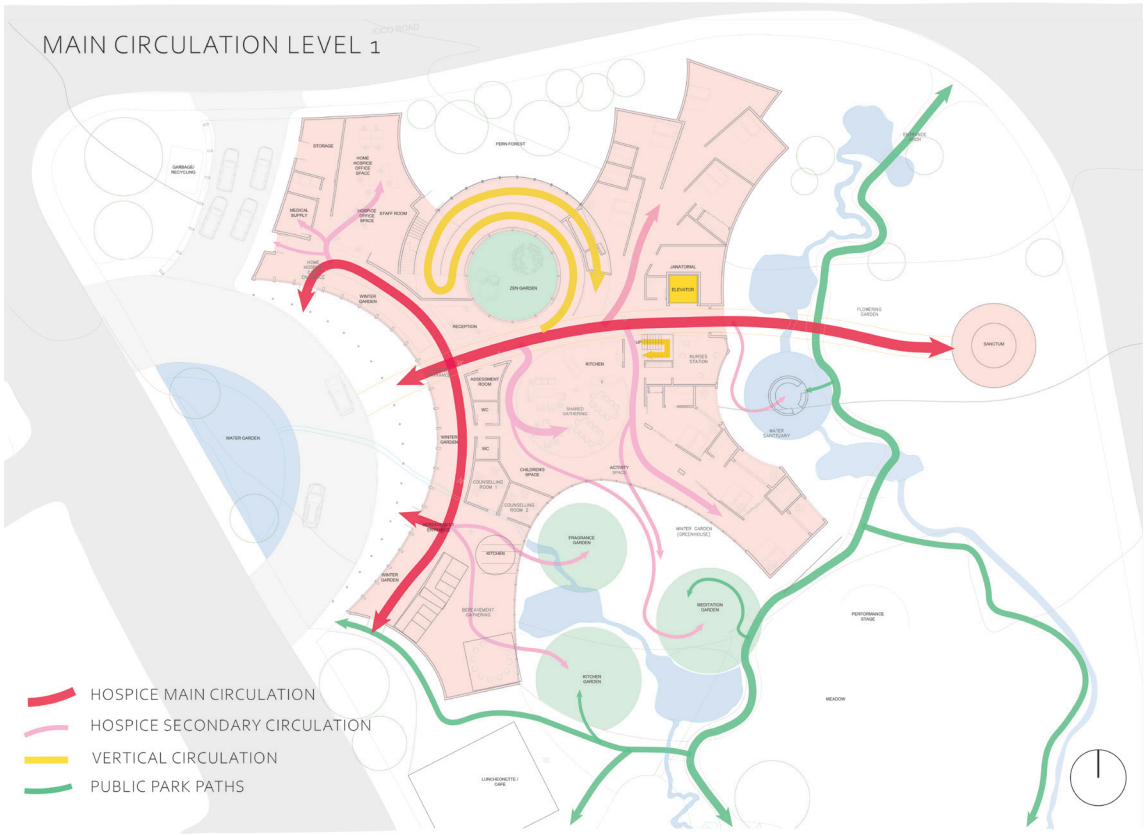


Figure 74: This diagram illustrates the flow of circulation through and around the building. The primary arteries of circulation shown in red, flow from north to south, connecting the three facets of the Hospice centre, and from east to west, between the in-patient hospice entrance and the sanctum. Secondary arteries in pink branch from the main circulation along the wings of the building. The public exterior paths in green intermingle with hospice circulation in the distinctly designed gardens- such as the water garden shown on the next page.

Figure 75: The meditation pod in the water garden where patients and their families can cross paths. Gardens by nature increase our sense of calm, and foster an enhanced embodiment which increases emotional awareness. This increased sensitivy will support positive interaction between the hospice patients and their families, and the public.

Figure 76: This illustration captures where the ceremonial path, lined on both sides by the flowering garden crosses with the public path. Curves in the public path allow for a slowing down of pedestrians to be sensitive to what can at times be especially meaningful moments in the life of the hospice. Visual openness such as this invites reflection and perspective, and dares to dissolve the secrecy we maintain around death.

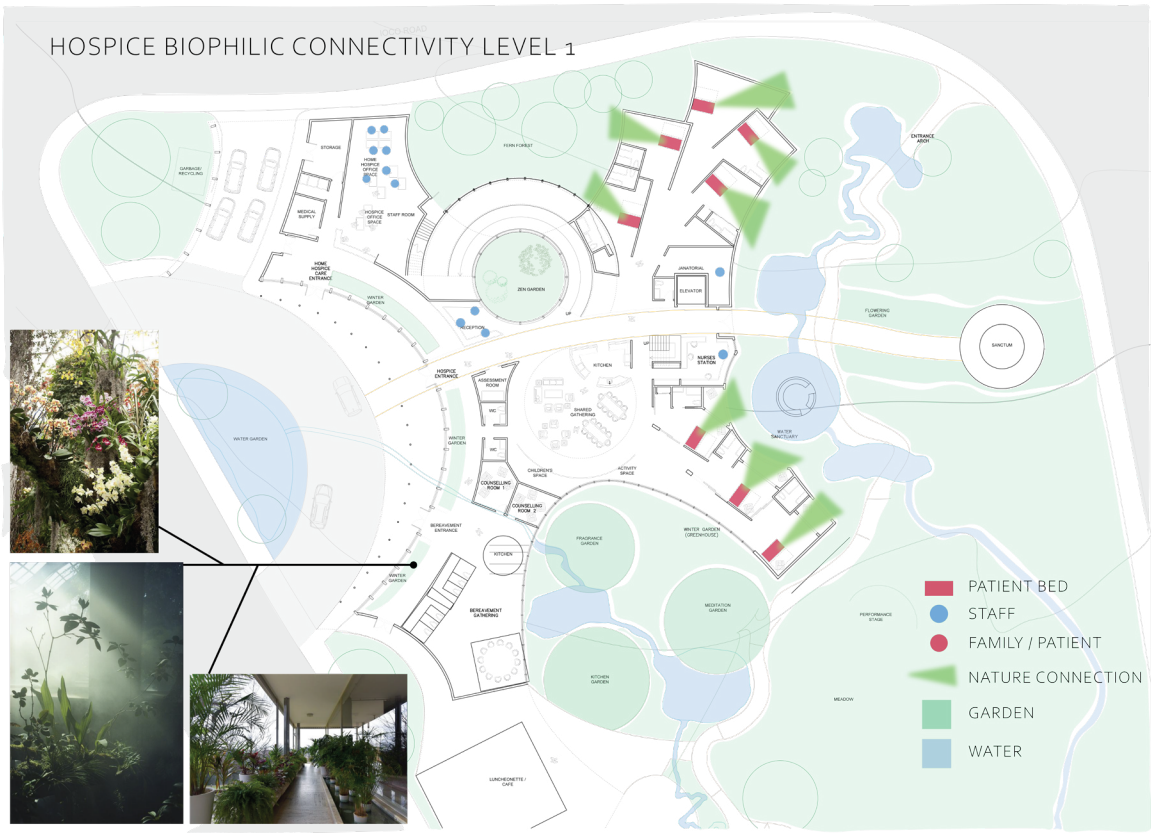


Figure 77: This diagram highlights how each patient bed, depicted in red, has a clear visual connection to nature and garden views. A water feature that runs southward through the site provides east facing rooms with the calming sound of a flowing stream. A winter garden that runs the length of the glazed entrance alcove provides the centre with flowers during the winter months, and a lush interior garden year-round.

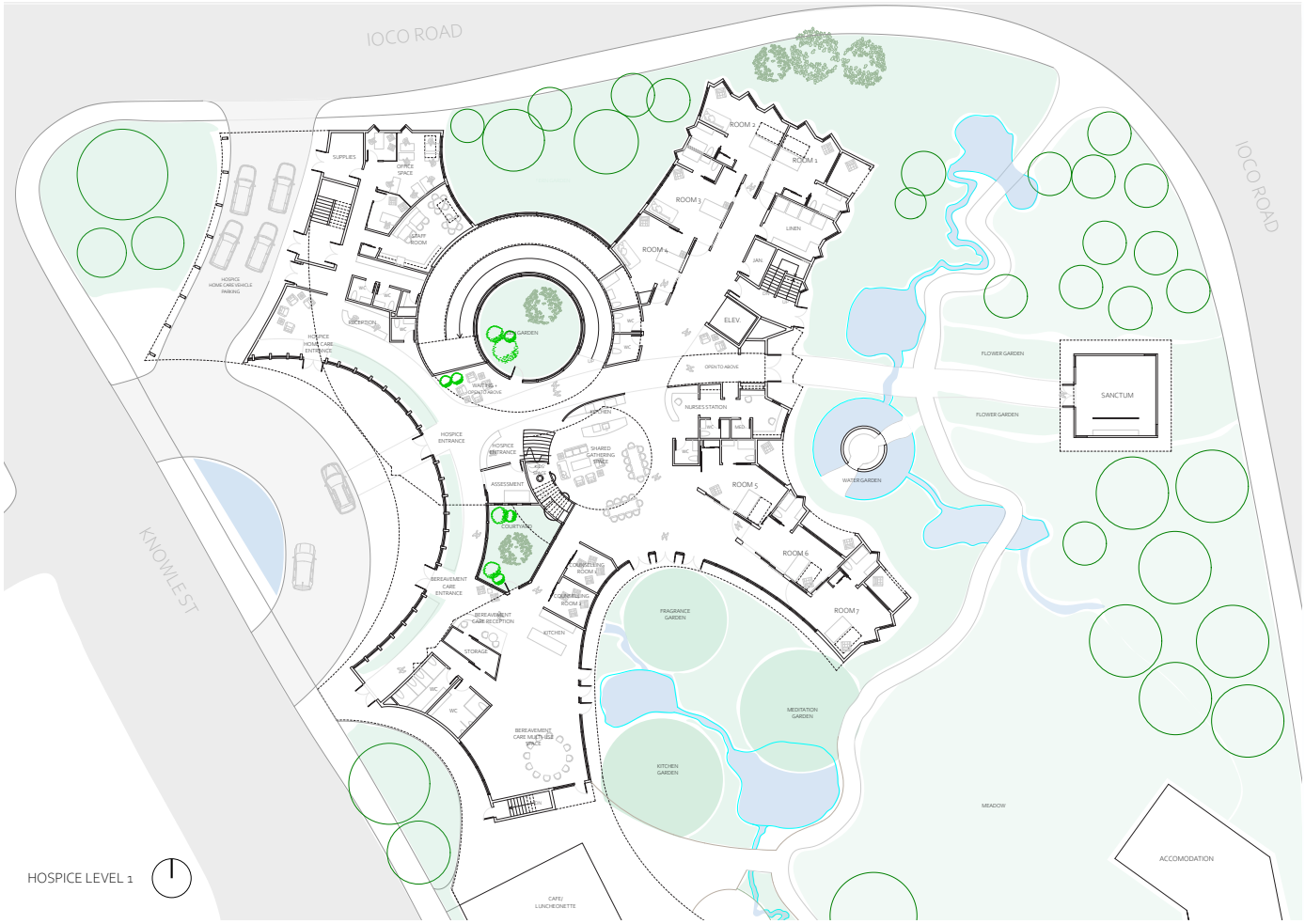


Figure 78: Hospice Level 1 Plan

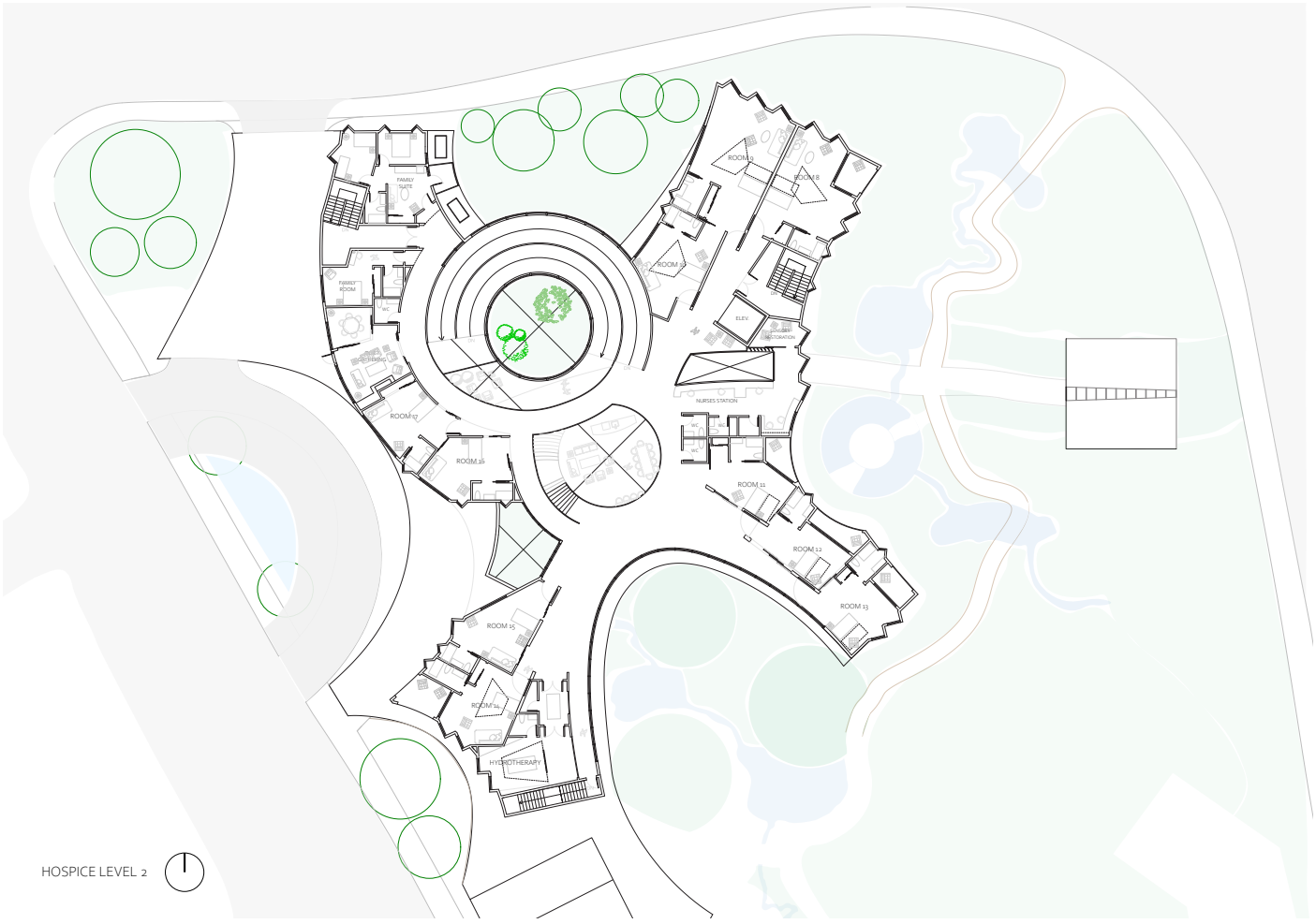


Figure 79: Hospice Level 2 Plan

7.5 RENDERS

Figure 80: A view of the Hospice from the centre of the site- looking north-west to the meditation garden, the kitchen garden and the café. The water feature becomes a place for play for children while parents and caregivers enjoy a conversation. Hospice patients and their families can view the activities of the gardens and central meadow from their rooms, remaining visually and auditorily linked to the rhythms of the day.

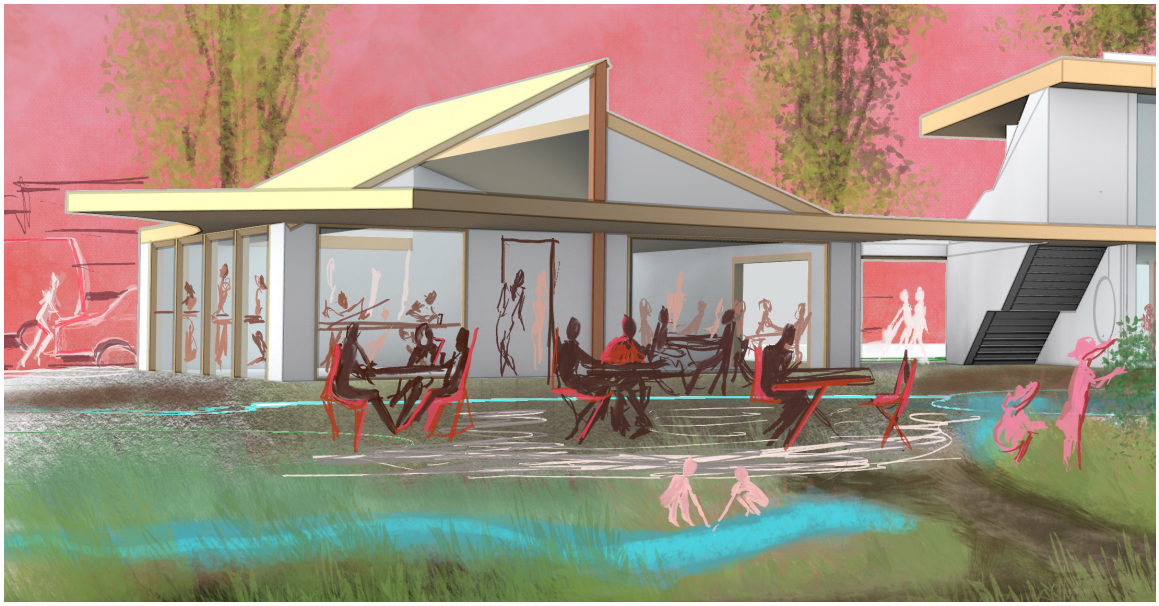


Figure 81: A detail of the render above showing the cafe and link to the street life.

Figure 82: A detail of fig. 78, depicting how patients can be visually connected to the rhythms of the community. These visual and physical connections (at the gardens), also allow the public to better understand the workings of the hospice. This allows the process of dying to become normalized and less taboo.

Figure 83: The entrance alcove opening its arms to welcome the community. The natural materials of the building in addition to the gentle curves express a warm and engaging presence. The entrance aims to be receptive and accessible, without following an institutional, nor a domestic typology.

Figure 84: A detail of fig. 81 captures the winter garden in the glazed entrance alcove and patients' visual access to the community that surrounds the hospice.

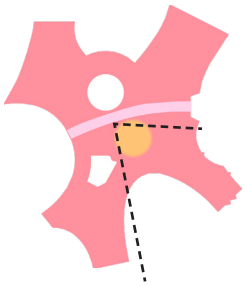
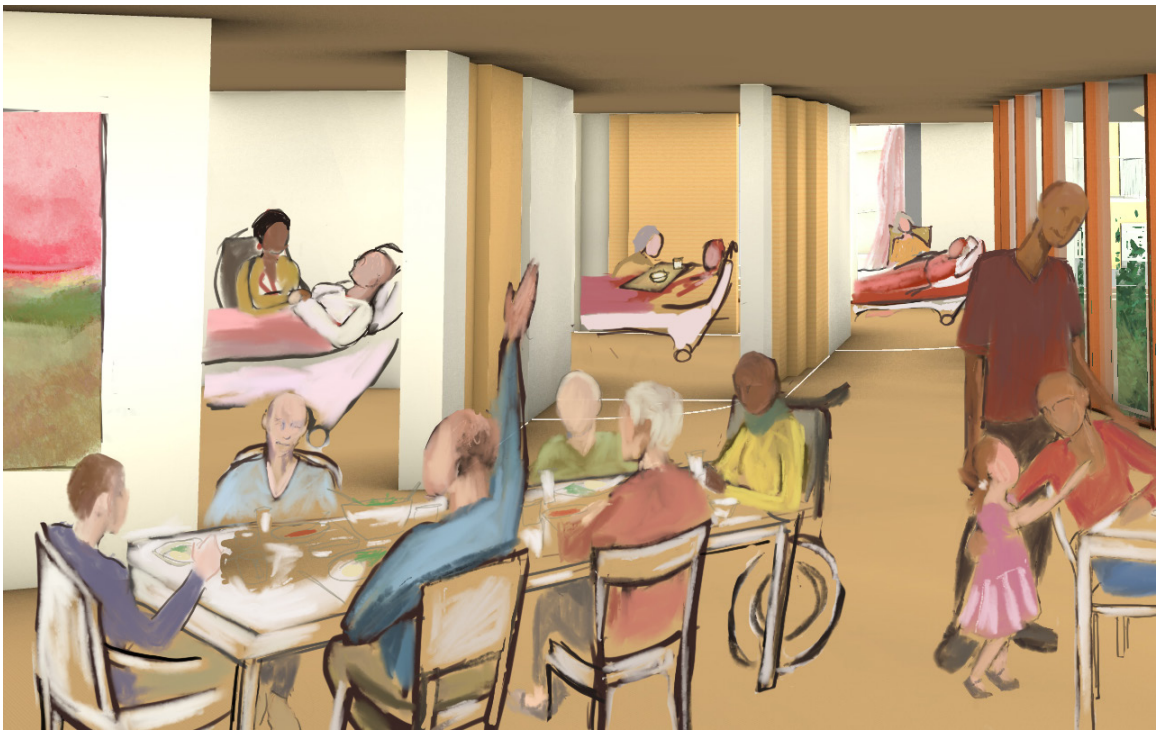


Figure 85: The main gathering space includes the kitchen, the main dining and lounge areas, as well as the children's space. All patient rooms fan from this central hub. Generous glazing visually links the space to the shared meadow at the centre of the site, and the accommodation and Art Centre beyond are within sight. Art by patients and students of the Art Centre abounds.

Figure 86: Each patient bed is visually and auditorily connected to the events in the main gathering space.



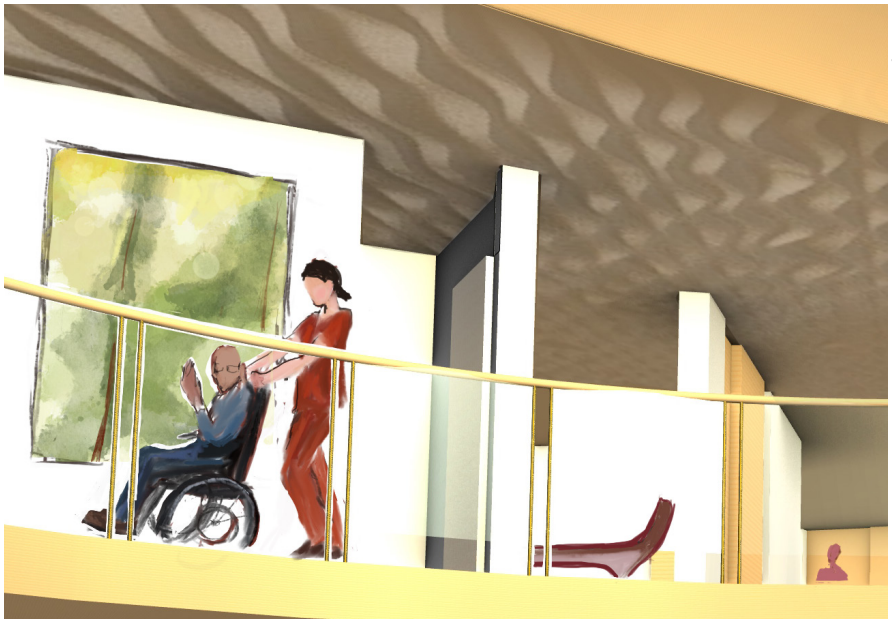


Figure 87: The acoustics of the generous and airy space are softened with felt acoustic panels.

Figure 88: The central kitchen is used to make all the meals for the facility. To further integration with the community, youth from the local highschool could participate in the making of the evening meal as part of their leadership or volunteer course work.

Figure 89: Furniture is light and designed to be moveable to allow for the easy inclusion of wheelchairs.

Figure 90: The children's space offers visiting children a rightly proportioned space to play while parents visit.

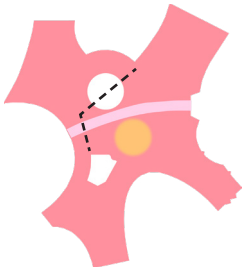


Figure 91: The flower ceremony is inspired by the Zen Hospice in San Francisco. When a patient at the hospice dies, their body is brought through the building along the ceremonial path as they leave. Caregivers, loved ones, and other patients share a moment of silence and can place flowers upon the deceased as an act of respect, kindness and recognition. Here is the view from the hospice entrance reception, along the ceremonial path. To the left you can see the zen garden courtyard, around which wraps the ramp to the second level. To the far right you can see the second courtyard through the patient assessment room. The skylights above follow the ceremonial path, offering a rhythmical pace in the repetition of their deep wooden beams and glass. The second level curves in the opposite direction to allow visual access to the path and courtyard garden below, in addition to creating a visual connection between the ground level path and skylights above.

Figure 92, 93: Details of fig. 89 illustrating the flower ceremony.

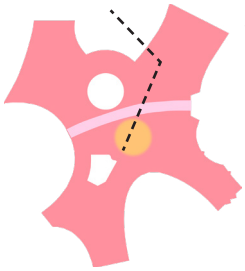


Figure 94: Each room offers a gentle, controllable connection to the sounds and rhythms of the community in addition to views of the alcove green spaces. The days in the hospice can be long and isolating- being able to watch the rhythms of the day in the community provide patients with an important connection to the world around them.

Figure 95: The alcoves offer each room direct views of gardens and nature, with the bustle of the community just beyond.

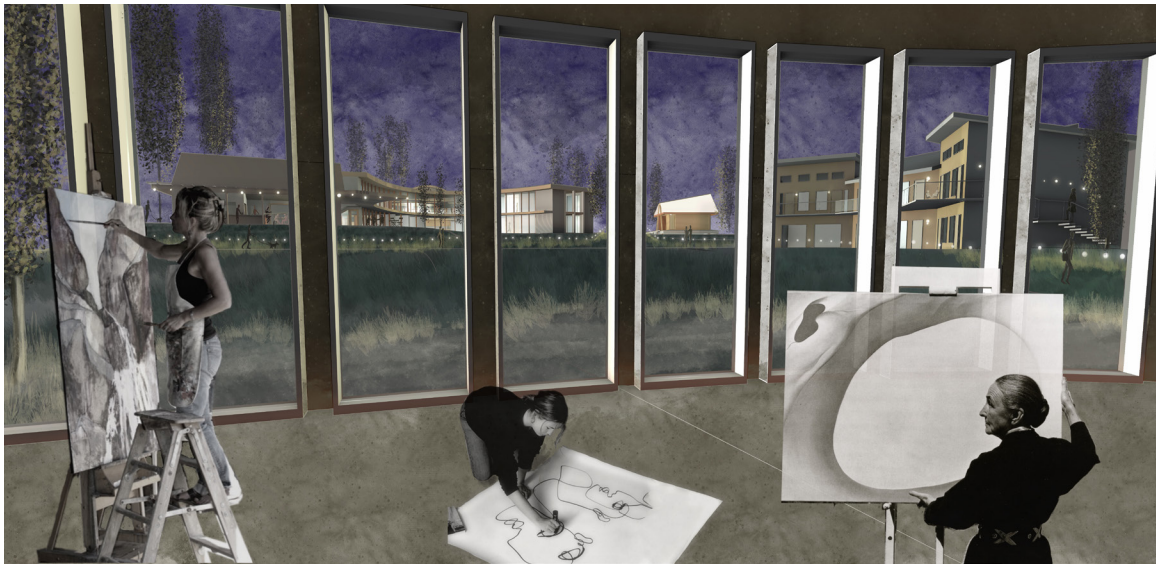
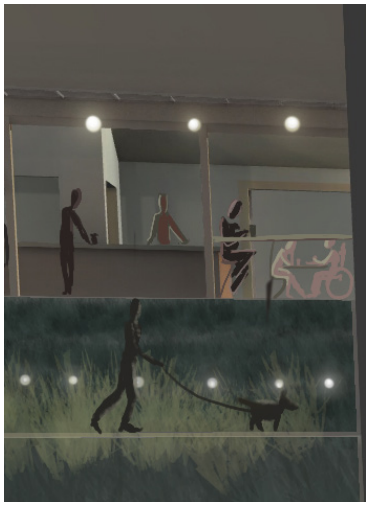


Figure 96: The meadow is lit at night to create a welcoming space for evening walkers, café customers, and art lovers. Across the meadow, the sanctum glows in the night- it is a flexible space that is sacred, but not necessarily religious in nature. It can be used for ceremony, washing, or prayer and meditation. The accommodation at right offers studio, one and two bedroom spaces available to the families of hospice patients, or to the larger community for short term stay when not in use. The evening liveliness of the art centre and its community night classes pairs well with the hospice, which also remains peacefully active at night.

Figure 97, 98: Details of the cafe at night with the hospice beyond.



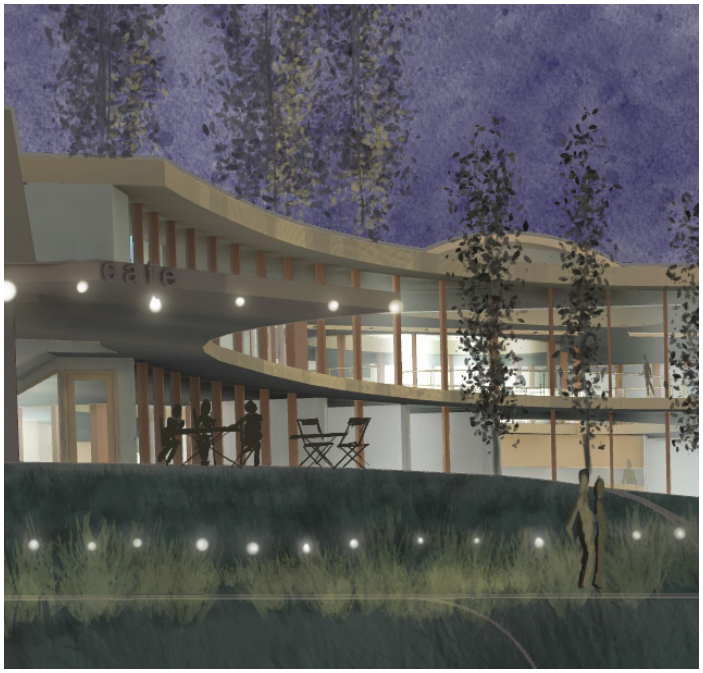


Figure 99: The green space at the heart of the site is lively with the art centre to the left, city hall and the library across the street, and the café next to the bereavement centre on the right. The hospice displays artwork made by students of the art centre, patients and community members.

Figure 100: Pathways on the grounds provide a gradual transition between the urban-scape to the east and the forested nature trails to the west. .

Figure 101: The café serves the hospice, art centre, rec centre, library, city hall, and nature trail users. Its connection to the meadow and the activities that happen there such as the farmer's market, music performances, and community events, enliven it further. The water feature offers children a place for creative and imaginative play while parents enjoy a moment to relax.

Figure 102: The kitchen garden provides vegetables and herbs for the café and hospice. Kids, youth, and adult gardening classes run by the rec centre across the street allow people of different ages to connect with the hospice patients, their families and the caregiving staff.

Figure 103, 104: With a light-filled space, beautiful nature views, and a modern open kitchen, the bereavement space is flexible and can be used for art shows, music performances, staff meetings and training.

Bereavement can be a multi-year process. Friends and family can have difficulty understanding or knowing how to be supportive and the assistance derived from the centre can offer the backing needed during the largely misunderstood grief process. The centre's proximity to the café and street act as an informal welcome to those who may be in need of its services.

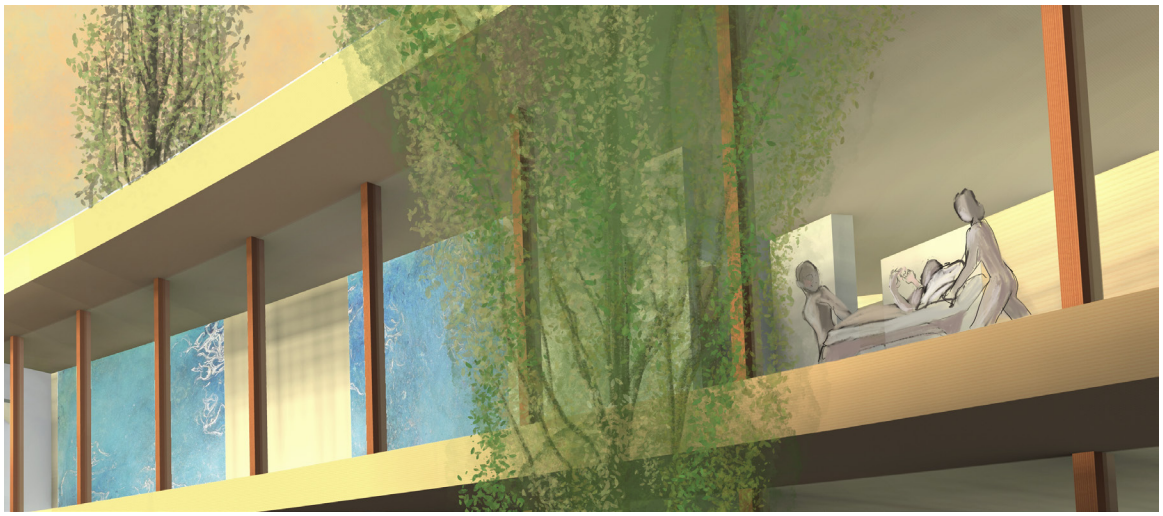


Figure 105: A patient is looking forward to a morning bath in the hydrotherapy room, which claims the best view in the building: west -facing on the second level, it provides views of Burnaby mountain. The poured resin slabs (in blue) offer a magical- otherworldly play of light in the hydrotherapy space when morning light shines through them. They are created by students in partnership with the art centre across the meadow.

Figure 106: The form of the art centre is opened into two halves, connected through glass-sided bridges. The effect of this is a visual invitation from the south up to the meadow. Looking north from the southern edge of the site, the hospice is visually framed by the two halves of the art centre.

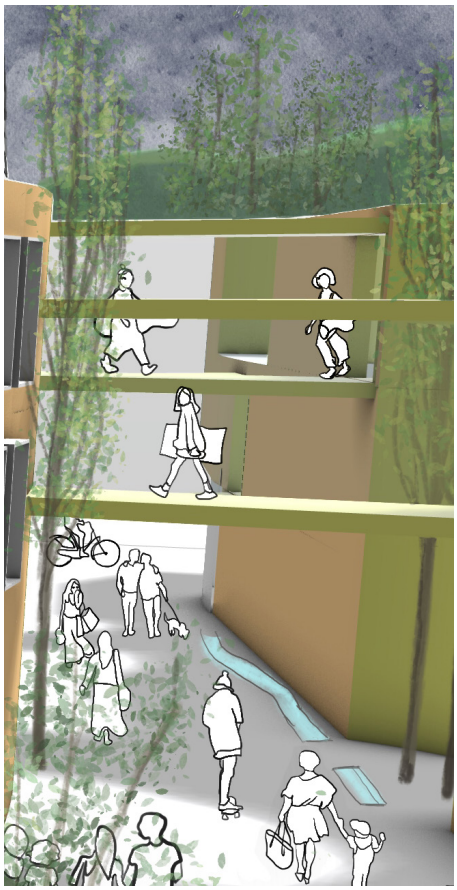


Figure 107: The bridges show the activity and vitality of the art centre and allows the users of the art centre to have clear views of the meadow and hospice to the north, and visa versa- where the hospice patients can take in the buzz and vibrancy of the art centre.

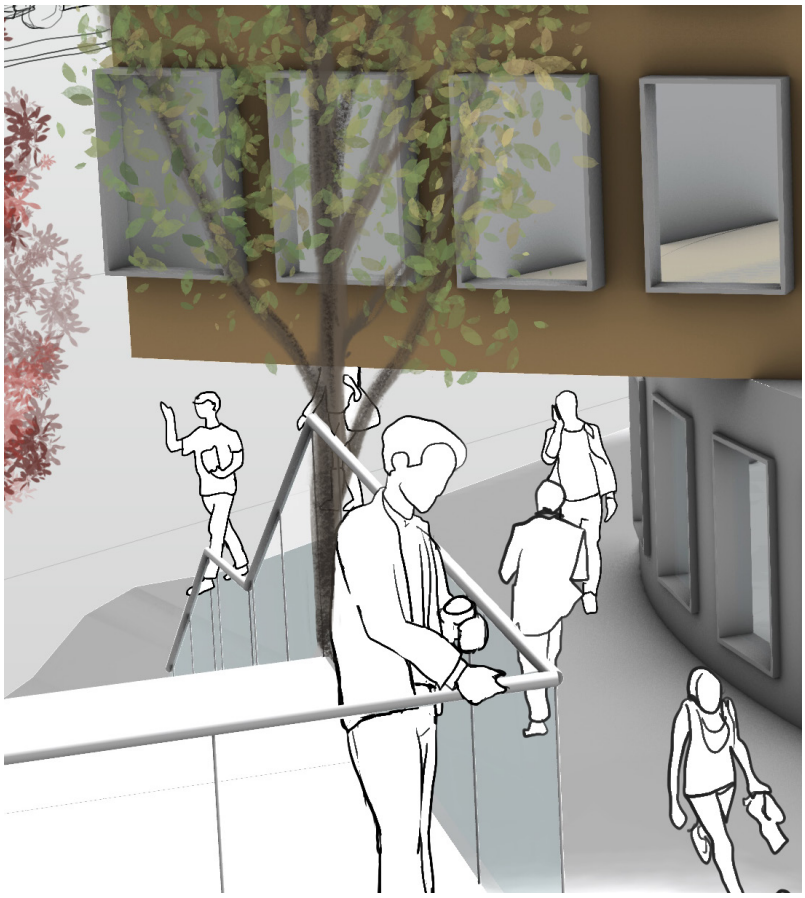


Figure 108: The ground level of the art centre curves into the site, creating a physical invitation and visual sightlines to the meadow and hospice beyond. The face of the second and third level extends to the street front, providing a sheltered overhang for pedestrians entering the site.

Figure 109: Large windows result in a strong visual connection between the public and users of the art centre, creating a warm, creative and playful atmosphere on the site.

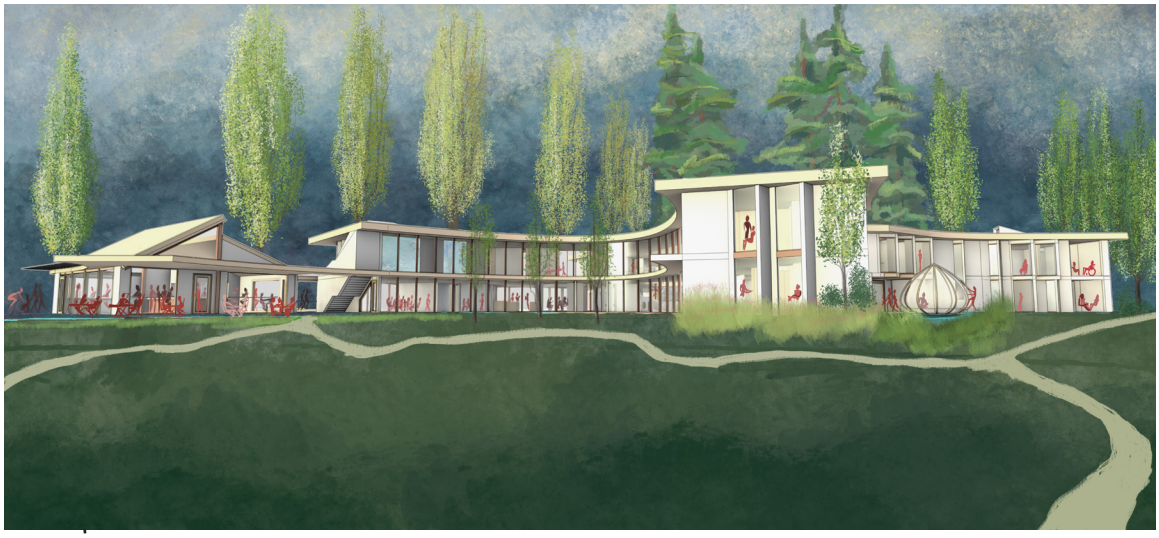


Figure 108: This final render, showing the hospice as seen from the accommodation, looking across the meadow, shows its open, welcoming atmosphere, that enlighten us on the compassionate work of the hospice, and help to dismantle the fears, the unknown and in turn the taboos around dying.

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