I, Kevin Schreur, hereby submit this original work as part of the requirements for the degree of:

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in Architecture

It is entitled:
The Architecture of Dying:
Understanding the Role of Architecture in the Hospice Community

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Committee Chair signature: Vincent Sansalone
The Architecture of Dying: 
Understanding the role of Architecture 
in the Hospice Community

A thesis submitted to the 
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by

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Committee Chair: John Hancock
Abstract

‘The Architecture of Death’ is a misnomer. Tied to entrenched cultural beliefs that life is sacred and death the enemy and overseen by authoritative medical institutions, architectural endeavors in addressing the end of life claim to reference the entirety of the process of dying but invariably play themselves out through the vehicles of grief and bereavement. Death, however, is not merely an event that one must mourn, but rather a process that everyone must - and most certainly will - experience. The hospice care movement, founded just over 40 years ago, recognizes this process in three stages; Dying, Death, and Bereavement. Each stage is an equally important part of an individual’s experience, requiring a focus on personal counseling and palliative medicine with the intent of achieving a desired quality of life at the end of life. Hospice seeks to empower the dying patient with the authority to determine their own plan of care, but programs currently operate in environments that make it difficult, sometimes impossible, to provide necessary medical treatment or to ensure an individual’s expected and comfortable death. This thesis intends to illustrate that place and environment are as important to the stages of death and dying as they are to our means of grieving and bereavement, and will demonstrate that the missions of hospice care can be enabled and enhanced through built form. Culminating in the design of a hospice inpatient facility on a specific site in southern Massachusetts on Cape Cod, this thesis highlights the growing importance of the hospice care movement and provides successful examples of architecture meeting the needs of the hospice community.

To fully contribute to the process of dying we must ultimately rethink the architectural response to death, partnering with hospice and listening to patients in order to form ‘The Architecture of Dying.’

Kevin Schreur
This work is dedicated to:

Andrew and Edith Schreur, whose experiences inspired me to begin.

Paul Schreur and Greta de Jong, who have prodded, but never pushed.

Grace de Jong, whose life and death inspired me to finish.

-and-

My extreme thanks to the professors and staff of the School of Architecture and Interior Design, without whose guidance, support, and incredible tolerance this effort would not have come to fruition.
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Introduction

Dying can be a very difficult subject to discuss. On one level, we understand that death is a necessary part of the experience of living and that dying is a natural and expected process that we must endure. The death of a loved one is an event that will greatly impact our personal and social bonds, and our own experience with dying will be an important time in our lives as we bid farewell to the people and world around us. We know, too, that death is inevitable and that we therefore should not frame our reactions to it as a sort of struggle or battle that can somehow be won. But accepting the unavoidable outcome of death brings us face to face with our own mortality and the prospect of suffering great personal loss. Whether we are participant or witness, the realities of the dying process require us to endure a gradual decline of abilities, the visual deterioration of the body, or the emotional struggles of memory loss and dementia, not to mention the strain on social and familial relationships that can be triggered by any one of these possibilities. It is no wonder then, that our cultures keep the discussion of death and dying at arms length, postponing the pain of addressing end of life issues until absolutely necessary.

Similarly, architects are reluctant to comprehensively address the dying process. “The act of making a building is universally presented as a singularly life-affirming act, one of sheer hope, optimism, even joy. Architects are trained to envision that which does not yet exist in physical
The process of dying and the act of death profoundly contradict this deeply ingrained bias, making it difficult for an architect design for that which will not grow, but vanish. This is not to say that the profession of architecture does not address death in any meaningful way. On the contrary, a great deal of effort on the part of individual designers has gone into understanding and interpreting the significance of death in built form. This so called, ‘Architecture of Death’ can be classified into three basic categories; tribute, experience, and mourning.

Architectural ‘tribute’ focuses on the recognition of deeds and accomplishments, creating or preserving environments that exemplify the importance of a life now gone. Appreciation for the worldly contributions that one or more individuals have provided is immortalized in stone and steel. The category of ‘experience’ is best described as a visual, almost visceral reminder of the cause and process of death. Most often associated with acts of war or tragic accident, this category of architecture is employed to remind the public of the cost of death through a retelling.
or reliving of events, highlighting the importance of life and memorializing those that have passed. Architectural spaces of ‘mourning’ encourage personal reflection and meditation and provide a place to grieve over the loss of loved ones. Illustrated by these three categories, the ‘architecture of death’ provides important and effective strategies to help individuals come to terms with loss, but it still falls prey to the bias of designing spaces for thriving communities and individuals. In short, it only serves the process of bereavement - of memory, suffering, and grief - and not the process of dying or the act of death. It is architecture after life, not architecture at the end of life.

How we will be remembered is certainly an important concern in the final days of life, but so is the fear of isolation and the loss of control. Countless stories from healthcare professionals, patients and families recount the importance of the role that built environments can play in providing a desired quality of life to the dying individual. One often encountered tale speaks of the terminally ill patient, lingering in the hospital environment, listless and disengaged who, upon moving to a more home-like environment, miraculously regains a vested interest in living their lives to the fullest.

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until the end. A discussion between healthcare professionals recorded in the book, *And A Time To Die*, exemplifies this story as they pondered over a recent change in behavior of a particularly stubborn and cantankerous patient. Suddenly, the patient was smiling, more alert, sitting up in bed and cooperating with medical and physical therapy staff. They could not attribute the positive improvement to any one factor until one of the nurses identified that he had recently been moved to a private bedroom with larger windows that was closer to activity centers.\(^3\) Another story recalls the unwavering attempt of a dying patient to alter the hospital room in which she knew she would be spending the rest of her days. Her efforts created considerable controversy with the medical staff and in the end, she was allowed, begrudgingly, to keep a bedside lamp. “People have commented that it makes the room look softer, homier. And I’m glad for that, but that’s not why I got it. I got it because I wanted to have some control over when the light went on and off in my room! I thought that was a pretty bare minimum of autonomy, of quality of life.”\(^4\)

Architectural efforts to engage the bereavement process and to assist those who must find ways to cope with loss are laudable and necessary, but the process of dying and the act of death are woefully underrepresented by the architectural profession despite the apparent need for appropriate environmental responses. This thesis intends to demonstrate how architects can push past their professional and cultural biases against death to fully

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4 Kaufman, *And A Time To Die*, 271
engage in the human experience through the practice of an architecture, not of remembrance and grief, but of an ‘Architecture of Dying.’

This effort cannot be undertaken alone. Dying is a complex process, unique to the individual and full of unexpected requirements that the architect, a relative novice at providing healthcare services, has little knowledge of. Design of environments at the end of life must then be conducted in coordination with those who have unquestioned authority over the dying process. A brief overview of cultural approaches to the issues of death and dying will reveal who has been entrusted with this authority and how that authority has changed hands over the years. This thesis will illustrate that the late 20th century has seen the beginning of a new shift in authority, placing the mandate for appropriate built environments for the dying back into the hands of the individual patient.

Putting the patient in control of determining their own plan of care, however, can place an enormous burden on them and their families at an already stressful period of time. Hospice, a philosophy of care developed by Dr. Cicely Saunders in the 1960’s, seeks to relieve this burden by offering medical knowledge, around-the-clock physical support, and bereavement counseling, all while upholding the authority of the individual patient. Employing palliative medicine, a field of medical practice focusing on pain relief and symptom control rather than curative treatments, hospice
acts as the arbiter of a patient’s plan of care, ensuring a desired quality of life at the end of life. This thesis will demonstrate how, through providing the hospice community with a built form intended specifically for terminal care, architects can finally deliver environments appropriate for the end of life. Analyzing the precedents of the panoptic hospital and the characteristics of prospect and refuge found in personal residences, this document will draw out the benefits of both the hospital and the home as ideal elements for use in the design of modern hospice facilities.

The culmination of this research will lead to the architectural design of an independent, inpatient hospice care facility located in south-eastern Massachusetts on Cape Cod. Site analysis will be conducted with thorough exploratory methods demonstrating the importance of its residential context, its dynamic variability, and its existing content. Analysis results will serve as further inspiration for generating design methodology and processes intended to inform the final design outcome of a proposed hospice unit. In the end, the objective of this thesis is not to mandate an ideal form nor to tie hospice care to a particular built environment, but to stand as one of hopefully many examples that showcase how architects can enhance and improve the quality of life at the end of life through an ‘Architecture of Dying.’
Chapter 1: A Place For Dying

Recognizing that the built environment can play a critical role in ensuring a quality of life throughout the processes of dying and death, it remains puzzling as to why the architectural profession has not taken a more active role in the study and design of spaces for the terminally ill. When architects do choose to address the topic at all, their focus appears to be turned entirely towards the healthy and thriving. Rather than addressing all three stages of death - dying, death and bereavement - the ‘architecture of death’ instead creates environments intended solely on assisting bereavement practices. We could attempt to explain this seeming lack of attention by laying the blame at the feet of our cultural relationship with dying, as even the idea of serious thought about the dying process is often seen as a social taboo. It is understandable that the physical and emotional strain that death takes on ourselves and our families is actively avoided, and none can be blamed for not making its discussion or debate a high priority in their daily lives. The individual does not desire to be reminded of death constantly through their communities or their environments, so it follows to reason that there may be little demand for architecture to address the stages of dying and death simply because the individual and our culture on the whole does not wish to address them.

Researcher Tony Walter, however, challenges the assumption that individuals are so fearful of dying that they willingly blind themselves to it's
occurrence or shrink from discussions of the end of life. In his book *The Revival of Death* he points out that, while we claim death is not talked about at all in our society, even in 1987 when death-studies were still relatively new, over 2,350 books had been published in the United States on death and dying. Walter argues that reasoned, thoughtful and knowledgeable discussion has clearly been taking place and individuals have certainly taken interest in understanding the process of dying. The question therefore really isn’t one of express interest or avoidance of the topic, but is rather one of power and authority over both the topic and the reality of its subject matter. The book demonstrates how, over time, the individual has surrendered their own authority over the process of dying to organizations and institutions with more extensive experience and more empirical knowledge about the human body and spirit. As these institutions matured and changed throughout the centuries, the authority shifted hands accordingly, affecting changes in public and private participation in the dying process. Chronicling these changes serves to illustrate how our modern attitudes towards dying and death have developed and highlights the beginning of another shifting of authority; one that encouragingly seems to be putting that authority back into the hands of the individual.

### 1.1 A Dying Authority

In the past, death has been considered somewhat of a mystery. The causes of terminal illness and aging were not clearly understood and the individual was relatively powerless to stop their progress regardless. Death

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came frequently, sometimes quickly, and people lived with the realization that it could strike anyone at any time in their life. Everyone knew death and were, if not comfortable with, at least familiar with its effects. It may be romanticizing the issue to claim that our forebears had a more gracious acceptance of death and dying, but as the cause and the reason for the occurrence of death remained a mystery to the individual, people put their effort into administering to the needs and relief of the dying, attempting to make the transition from life to death comfortable rather than attempting prevention for the living.

The purveyor of the great mystery of death could only be God himself, since the earthly world was at a loss for explaining the ‘how and why’ of the dying process. From the 15th century to the 17th century, religion was the only institution that could offer any insight for the public on the origin and ultimate purpose of death and, as such, became a focal point in the distribution of

Figure 1.7 “Death and the Maiden” sketch. Hans Baldung Grien, 1515

Figure 1.8 16th century engraving, depicting death as a companion to beggars and nobles alike.
information about the process of dying and a resource for those seeking counseling when death touched their lives.⁶ Strong humanitarian objectives and moral codes of religious practice encouraged religious institutions to reach out to communities and offer not only spiritual support but physical aid wherever possible, which led to the creation of the earliest forms of medical support environments; churches and monasteries operating as hostels and care centers where anyone might find a place to stay or recover while journeying or on pilgrimage. With the capability to address both the mystery of death and the physical needs of the dying, Religion became one of the first absolute authorities over the dying process.

All this changed in the late 1680’s with the dawn of the Age of Reason. Specifically, it is the advent of statistics and the study of

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⁶ Walter, The Revival Of Death, 9
mathematical probability that began to chip away at religion’s claim to
authority. With the tools to study population trends and observe correlating
factors between environments, activities, and health, there began to be the
literal demystification of death. Though reasoned and calculated studies
could not give predictions, it was nevertheless possible to follow the trail of
death and to categorize it. The physical context of dying had at last become
comprehensible and quantifiable and provided more accurate and
actionable answers than religious institutions were able to supply. The age
of reason shifted the frame of discussion from sin and fate to science and
probability. “Exit the good death, enter the normal death. Exit the bad
death, enter the abnormal death.”

Growing interest in the rationalization of death opened the
opportunity for the bureaucratic formalization of the dying process.
Governments and organizations could step in and begin to mandate or
forbid certain medical practices and require investigations into the causes
and circumstances of a death, to the point where modern law could not
allow a death not to be rationalized. This formalization was a drastic
departure from traditional experiences and rituals and was often at odds
with the desires of grieving relatives and relations, inadvertently pushing
the process of dying further from the emotional and spiritual capabilities of the
individual. The erosion of community and religious authority leads to a loss
of tradition and hence to a heightened sense of uncertainty and insecurity in

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7 Walter, *The Revival Of Death*, 9
8 Walter, *The Revival Of Death*, 9
the face of death. Unable to trust traditional sources, people began seek out a new voice for information and guidance.

Advancement of scientific knowledge about the body and its functions and the development of more sophisticated medical technology offered a comprehensive and unbiased view of the dying process. The 18th century therefore saw the role of medicine step up to fill the void and provide absolute authority over death. The role of the doctor changed from that of the learned advisor to the sole distributor and author of medical care. Medical practice became less attuned to caring for the ill and more obsessed with understanding the illness itself. Individuals no longer mattered as the human body had become “objectified, no longer a person, but a constellation of objects to be subjected to medical scrutiny.” A doctor’s word became law where it pertained to medical treatment. The patient’s own experience of his or her body was literally inferior to the objective knowledge of the doctor. Right up to the 20th century, the medical institution has retained its authority over the process of dying.

An Experiential Divide

However, the objectivity of medical science and a preoccupation with the purely mechanical or chemical functions of the body introduced a disconnect between the individual and the authority of science. Dying has always been seen as a human act, from the perspective of the individual. It has been a time to acknowledge faults, give personal advice, receive spiritual assistance, to dispose or distribute goods and valuables, and then

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9 Walter, *The Revival Of Death*, 13
An individual’s experience with dying incorporates emotional, mental, social, and spiritual components, reaching far beyond the “constellation of objects” that medical science can address. The needs of the patient and the capabilities of the authority have begun to diverge.

Ironically, it is the medical institution’s own effectiveness at understanding the body and curing its ills that has widened the gap. Medicine has increased the average human lifespan to nearly 80 years, and by allowing us to live longer we have had the opportunity to form many more relationships and stronger ties to family and friends. A truly multigenerational family is now the norm and not the exception. Emotional bonds and community ties are stronger than ever, and it is the degradation and eventual loss of these relationships now combined with the degradation of the physical body that are the primary concern of the individual. This split between experience and authority has come to a head in the mid 20th century with the public rise of individualism leading to the questioning of culture and established institutions. It was clear that the publicly available languages for talking about death did not tally with private experience and could not help make sense of the feelings of the individual, their family or friends. The authority of medical science over the dying process had begun to erode, just as the authority of religion had.

We find ourselves today in yet another transition period. While modern society has placed it’s trust not in tradition, but in expertise, we are beginning to question if authority is now better represented by the

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11 Walter, 23
individual self. Figure 1.10 displays a table from “The Revival of Death” that outlines the roles, relationships, and responsibilities undertaken by the three main authorities; the ‘traditional,’ based in the community and spoken with the language of religion, the ‘modern,’ based in privacy and spoken with the language of the doctor, and the ‘neo-modern,’ based within the self and spoken with the language of self. ‘The will of God,’ or ‘doctor’s orders’ no longer epitomize who is in control of the dying process, and it is personal experience, quality of life, and individual choice that governs...
modern day attitudes towards death. The Individual, wielding tradition and expertise as tools for their own use, is now the ultimate authority over the dying process.

What this research has shown is that whoever has control of knowledge and authority over the dying process has the greatest influence on how issues at the end of life are approached and controls, directly or indirectly, all aspects of the process. This includes the demand for and realization of environmental design for the terminally ill. Framed as an issue of power and not of desire we can see that there have been few architectural forays into the personal and humanistic vantage points of the dying process because the individual has not, until now, had the ability to request it. In fact, architects most certainly have been designing environments in which people experience the three stages of dying, death, and bereavement, but the demand for such spaces has been in the hands of the medical institution.

Design priorities and requirements of doctors and medical practitioners pertain to their own needs and mandates, which are specific to understanding the body and treating illness and are not necessarily in step with the personal needs and mandates of the patient. As we move forward into the era of individual authority, architects must recognize that the needs of the patient must come before the needs of medical staff or religious counseling. We need not abandon the lessons that have been learned from former partners in the design of terminal care environments, but we must look for new partners that can assist us in creating spaces that speak to the personal and emotional experience of the dying process.
1.2 The Case For Hospice

In the last 40 years there have been drastic changes in how we talk about and view death and dying. No longer sufficiently explainable by traditional religious or modern medical procedures, the new picture of death is a personal one, facilitated by palliative care, focused on reaffirming life experiences, and administered and coordinated by the dying individual themselves. However, if the traditions of religion and community provide little instruction, can we trust that, as individuals, we will know how to determine our own exit from this world? If we cannot place our trust in those with expertise about the body, how can we be assured that our physical care will be administered as we would direct it?12

Guidance on these and many other questions, can be found in the emergent branch of medical practice known as Hospice Care. Based on the pioneering work and life experience of Dr. Cicely Saunders, Hospice lies in step with the public mandate to return authority to the hands of the dying patient while recognizing that the individual may not always be capable of acting on that authority. The goal is not to take over the dying process for those who are unable to

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12 Walter, Revival of Death 3
do so themselves, but to be a support mechanism, a knowledge resource, and a competent arbiter for the patient and his or her plan of care.

What began as a solitary medical center for the dying in 1968 has now become a legitimate and globally recognized branch of medical practice, inspiring the advancement of palliative medicine and end of life studies, defining the philosophy of care for the dying and strongly advocating for a quality of life at the end of life.

Here at last is the partner which architecture seeks if it is to participate in the process dying and not just bereavement. Hospice acts as the liaison between the individual and the architect, translating the authority of the patient, the wishes of their families and the requirements of their caretakers into inspiration for the design of environments at the end of life. However, within the hospice community there is a debate about what role architecture should play in the spectrum of hospice care, fearing the negative stigma applied to contemporary nursing home environments. The case must then be made that architecture can and should play an active role both in the process of dying and in the language of hospice care.

Hospice Mission

Hospice is a program of care that recognizes the importance of all stages of death; the process of dying, the event of death, and participation in bereavement. The primary intent of any hospice program is to neither prolong life nor hasten death, allowing the natural course of the decline of the human body to take place and to relieve painful conditions through palliative medicine and close personal counseling. “This philosophy of
care recognizes that every person deserves to live out his or her life with respect and dignity, alert and free of pain, in an environment that promotes quality of life....Care is focused on the whole person - body, mind and spirit - with an understanding that serious illness profoundly impacts not only the patient, but the family and loved ones as well.”

**Ethnicity and Diagnosis of Inpatient Clients**

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<td>0.5% Indian, Pakistani, and Bengali</td>
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<td>0.1% Chinese</td>
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<td>1.2% other</td>
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**Figure 1.12** Table describing ethnicity and diagnosis of inpatient hospice facilities.

Despite an encouraging and uplifting message that promises in-depth personal attention and sensitive, well reasoned care, hospice programs often have to combat a number of popular myths that themselves create barriers to hospice. One such myth is that hospice is only for people with cancer. While a significant majority of patients do suffer from cancer, hospice programs are dedicated to giving care at the end of life, however one might come to it. figure It is not uncommon to find patients with HIV/
AIDS, Alzheimer’s, cardiovascular, neuromuscular or any other number of chronic diseases along with those who have simply reached a venerable age and whose bodily systems have begun to shut down. Other myths revolve around hospice only serving the elderly or only serving dying individuals. Hospice has a family-centered concept of care, which “focusses as much on the grieving family as on the dying patients.”\(^\text{14}\) Whether those patients are young or old, hospices make their services available to anyone touched by death.

The biggest myth of all is that hospice is used only when there is no hope left. To the contrary, hospice workers teach that understanding and acceptance of the dying process is not an act of submission to fate, but a an opportunity to live life as fully as ever until the end. “The gift of hospice is its capacity to help families see how much can be shared at the end of life.”\(^\text{15}\) While each individual program has its own way of phrasing their mission, every one of them promotes ‘Death with Dignity’ not hopeless resignation. A general set of rules governs how any hospice program approaches the care of its patients.\(^\text{16}\)

1. **Life is not prolonged, and death is not hastened:**

Extraordinary measures to keep an individual alive simply for the sake of being alive does not guarantee a quality of life and often contradicts the notion of death with dignity. Similarly, hospice is profoundly against the


\(^{15}\) Baird & Rosenbam, *Caring for the dying* 29

\(^{16}\) Baird & Rosenbaum, *Caring for the dying* 53,62
premature cessation of life, though it has always and will likely continue to be involved in arguments over euthanasia.

2. *Comfort is a means to an end:*

Hospice programs are highly aware that their purpose is not solely one of palliative medicine. Their goal is to honor the patient’s life and mark the significance of its end. While the relief of physical pain is a necessary part of this process, the end-goal of hospice care is to assist the dying patient in realizing their own concept of a ‘good death.’

3. *The patient and their family form the unit of care:*

It is important to patients that they not feel abandoned, and it is important to family members that they not be excluded from the physical care and comfort of their loved ones. To this extent, hospice programs encourage both patient and family to participate directly in decision making, confirming the authority of the patient and sharing the power *and* powerlessness of each patient’s plan of care. In the end, the hospice exists to support the patient and their family, providing them choices, means of communication, and complete engagement in the process of dying.

**History of the modern Hospice**

The modern hospice movement is widely recognized as the direct result of the tireless work of Dr. Cicely Saunders. As a young social worker in the British healthcare system, Saunders was stationed at St. Joseph’s hospital in London as part of her academic education. Eager to have as much face-to-face contact with patients as she could, she was given the opportunity to personally interact with terminally ill patients, many of
whom she befriended simply by listening to their concerns and allowing them to relate their life experiences. Through this ‘unusual’ approach of listening to life stories and personal worries instead of requesting specific medical feedback, Saunders recognized the need for patients to be informed and in control of their own medical care.\footnote{Cicely Saunders, \textit{St. Christopher’s In Celebration: Twenty-one years as Britain’s first modern hospice} (London, UK: Hodder and Stoughton, 1988) 16} She made it her life’s mission to observe, comfort, and empower the terminally ill and her work raised attention to end of life issues across England and Europe.

In 1963, her experience with terminal care and development of the hospice philosophy caught the attention of Florence Wald, the dean of the Yale University School of Nursing. Saunders was invited by Wald to give regular lectures and workshops on the hospice philosophy of care through continuing to 1966, sparking an interest in hospice care in the United States. During this time Saunders had also overseen the creation of St. Christopher’s in London, the first ever facility devoted solely to the hospice philosophy and the care of the terminally ill, which opened its doors in July of 1967.\footnote{Baird & Rosenbam, \textit{Caring for the dying} 35}

Saunders’s work found a resonance in the US, not only through interest from the nursing community via
Florence Wald, but with a growing public sentiment of comfort with end of life issues. Elizabeth Kübler-Ross, M.D. Had been conducting similar and simultaneous research into the lives of dying patients, resulting in the publication of the book *On Death and Dying* in 1969. Based on detailed personal interviews with dying patients and their families, Kübler-Ross exposed the hidden lives of the dying, drawing on their needs and inner fears to outline 5 stages of grief: Denial, Anger, Bargaining, Depression, Acceptance. Though sometimes contested, her seminal work introduced US culture to a more comprehensive look at the dying process and paved the way for the widespread acceptance of hospice care. Thanks to both Saunders and Kübler-Ross’ leadership on the issues and the impact their work had on the medical community, the first hospice facility in the United States opened in New Haven Connecticut in 1974, known now as ‘Hospice of Connecticut.’
Since Saunders’ St. Christopher’s opened 40 years ago, the hospice philosophy has spread across the globe with programs established in most western nations, a robust support in Japan and growing interest throughout Asia. Though it has had its share of troubles and setbacks - for example the euthanasia debate as mentioned earlier and the reluctance of doctors to accept death as anything but a failure of their responsibilities - hospice care has been remarkably successful in engaging the public desire for individual authority and for a more humanistic focus on terminal healthcare programs.

Hospice as place

Since one of hospice’s primary goals is ensuring the comfort of the dying patient, the environment in which the individual finds themselves at the end of life is considered a high priority. Many hospice programs even state that they aim to get patients out of hospitals and back into their homes, noting that busy hospital environments are inappropriate for people already under stress and that they can be a significant source of discomfort to patients. To their credit, hospice care has been able to effectively accomplish this goal and in the US around 80% of hospice patients are able to live out their lives in their own homes. However as we continue to age or as our illnesses progress, the medical care and attention we require may not always be feasible or even available within the home setting. Patients may have to turn to other environments to receive the program of care that they and their caregivers have planned for. It is here, however, that we find an internal debate brewing in the global hospice community.
Hospice in the United Kingdom is based on the system put in place by Cicely Saunders which has grown up around the independent hospice facility. Through the early 90’s the majority of hospice care was coordinated through or took place in freestanding palliative care units. Since that time, a trend towards home-based care has been on the rise, and has now become more prevalent in the UK with 45% of hospice patients dying at home.\textsuperscript{19} While this is an encouraging trend that should be supported, the inpatient unit still is and will remain a strong cornerstone of the European hospice movement.

Hospice in the US has its direct origins in the UK model, but has nevertheless departed from the independent hospice facility and is primarily practiced out of the home or other established medical facilities. Reasons for this change are diverse, ranging from the financial to the political, but the most important justification is a universal access to hospice services. US hospice care prides itself on being solely a philosophy of care and as such, not tied to a particular location or architectural stereotype. This approach makes a program highly mobile, able to carry out the hospice mission in any given environment.\textsuperscript{20}

The debate then is whether or not hospice should employ architecture as tool to be utilized, or treat it as a circumstance to be adapted to: Hospice as a place or hospice as a system. It must of course be noted that regardless of the architectural outcome, a hospice’s philosophy of care

\textsuperscript{19} Baird & Rosenbam, \textit{Caring for the dying} 42
\textsuperscript{20} Baird & Rosenbam, \textit{Caring for the dying} 43
and the general governing rules remain the core foundation of any hospice program.

**Against a place**

One argument against hospice as a place is the potential for reduced emphasis of the home care setting. Since the intent of any hospice program is to allow individuals to remain in the familiar surroundings of home, opponents fear that a focus on hospice facilities would redirect program resources, negatively impact, and effectively limit the practice of home care. This concern has been with the hospice movement from the beginning. In 1972, the newly formed National Hospice Organization in the United States desired to follow the UK model and put it’s work and funding into freestanding inpatient units. A majority of medical practitioners felt that home-care was too important and that a dedicated building typology would discourage new workers from participating in home care, drastically hindering the hands-on education of new practitioners.21

Another argument raises the fear of institutionalizing the dying process. The proliferation of a particular architectural form as the most appropriate environment for the end of life could risk the inadvertent institutionalization of hospice care and create the perception that hospice will mandate the only appropriate and proper way to die. Rather than being viewed as a flexible, personalized, philosophy of care, it could be

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framed as a philosophy for living and action.\textsuperscript{22} This would be the antithesis of the hospice movement, as envisioned by Saunders.

The primary argument against hospice as a place is the concern of sequestering the dying. A dedicated architectural environment for hospice could create a ‘sacred space’ for dying; a place that is the best and only place to go if one wishes to experience death with dignity. On the one hand, such an outcome would introduce exclusionary practices, putting undue pressure on those who cannot, for whatever reason, attend the hospice facility. On the other hand, it could encourage the public to tie hospice programs and end of life care to a specific built form and not a philosophy of care.\textsuperscript{23} Turning hospice into an ‘sacred space’ would only serve to further remove the dying process from public view, detaching it from the mainstream, supporting the re-mystification of death and providing misinformation about the goals of hospice care. In short, critics fear that an independent hospice facilities could become the next nursing homes, and come to be viewed as places where we send people to die in an environment that is separate from the realm of social life.

<table>
<thead>
<tr>
<th>Demographics in the United States</th>
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<tr>
<td>Provision of services</td>
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<tr>
<td>90% at home</td>
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<td>48% female</td>
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<td>74% of females</td>
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<tr>
<td>&gt; 65 years old</td>
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<td>2% renal failure</td>
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\textsuperscript{22} Teresa Chickako Maruyama, \textit{Hospice Care and Culture} (Vermont: Ashgate Publishing Co., 1999) 69

\textsuperscript{23} Maruyama, \textit{Hospice Care and Culture} 16
Promoting Place

The reality is that the literal demand for inpatient hospice facilities may already be on the rise. Many studies on the use of home care services have been conducted and though the numbers can vary, there does seem to be an emergent decline in the use of in-home care. A survey by the NHO (National Hospice and Palliative Care Organization) found that from 1994-1995, roughly 90% of hospice patients received in-home care. The period from 1997 to 1999 saw a drastic upswing in the number of patients and families utilizing hospice care, (see figure) but the average percentage of people receiving more than half of their care at home dipped to 80%. Some more recent studies have suggested that the percentage may have dropped to as low as 60% from 2003 to 2005.
Some reasons for this trend may be found in the changing demographics of the US and the dynamic nature of the modern family unit. According to US census bureau information, the fastest growing population in the nation are those over the age of 64.\footnote{US. Census Bureau, \textit{Global Population at a Glance: 2002 and Beyond} March 2004, \texttt{<www.census.gov/} \\ \texttt{ipc/www/wp02/html>}} The ‘Babyboomers,’ the current largest US generation, has recently begun to cross over the 60-year age bracket, but even as this age group begins to require end of life care, they will have fewer family resources to draw upon for support. Modern families have become smaller and more dispersed. Parents, siblings, children and grandchildren can stay in near constant contact over significant distances through technology, and it is not...
uncommon to find families spread out across the country. Consequentially, the decentralized family is hard pressed to form the core unit of care or provide a home environment for the dying patient. More and more individuals will have to seek support outside of the family unit and outside of their own homes, putting hospices as stand-alone facilities in high demand.

A benefit to enabling hospice to have an architectural space of its own will be the continued education of patients and the public about the hospice mission and the process of dying. “The patient in a palliative care unit has not died before, but is surrounded by others who are dying and will watch them with considerable interest.”26 It is fair to say that patients and families will observe the actions and attitudes of those around them and will learn from each other both about the process and the moment of death. Having a dedicated environment that is populated by people receiving hospice care can literally be an educational tool for showing what may happen, what palliative interventions can be taken, and how death ultimately occurs. It will demonstrate to people what the dying process isn’t, showing someone pass away in quiet and comfort as opposed to the frenzied ‘assault’ on the body in the attempt to keep death at bay in the acute-care environment. People learn by seeing and by doing, and facilities catering to the needs of patients can show them how to achieve death on their own terms.

Like it or not, the reality of aging and illness may render us unable to remain in our own homes even with the absolute best care and attention.

26 Walter, The Revival of Death 124
Navigating the halls and rooms and furniture layouts of our homes can become difficult if we have restricted mobility or require the constant aid of machines or other healthcare apparatus. Caregivers themselves cannot operate to the best of their abilities if hindered by the environmental limitations of residential architecture. If we cannot stay in the home, then where can we go to receive comprehensive hospice and palliative care? Hospitals in general have proven inappropriate. They are governed by the authority of doctors and are intended for the necessary efficiency of practitioners as they attempt to cure the body of its illnesses. A hospital is not a place for dying and was never designed for the mediation of palliative care. Nursing homes are similarly inappropriately environments for dying, even though they have become repositories of the old and ailing in the mind of the public. “Federal policy emphasizes that rehabilitation and restoration of function are the goals of nursing home care.”27 They are intended to be active care facilities, meant for recovery and recuperation, and so have not been designed to accommodate the long-term and end of life care that is being requested of them. If patients find themselves no longer capable of remaining in their homes and alternative environments cannot adequately support their needs, it falls upon the hospice community to provide comfortable, appropriate functioning environments for those at the end of life.

The final argument to consider making a place for hospice is that hospice care is not only for patients who are dying. A program of care

incorporates the comfort and support of loved ones, bereaved friends and caretakers themselves. At some point, the patient’s experiential world begins to shrink from the wide perspective of their communities to the built environment they are housed, to the room in which they sit and then to the five to ten feet around their beds.\textsuperscript{28} The sheer effort of seeing with one’s own eyes, let alone attempting to comprehend objects and space can become too difficult for some, and so their world diminishes to the confines of their own body and mind. If a patient’s experience of their environment diminishes and becomes less important over time, possibly even burdensome, then critics might reasonably justify that architecture need not intervene. But hospice programs serve to educate and counsel the living as well as the dying and dedicated hospice facilities can offer peace of mind and contribute to the emotional well-being of survivors and caretakers.

Any of the arguments against the design of environments specific to the hospice mission seem to be based on the notion that independent facilities would become the \emph{only} accepted and effective operating model for hospice care programs. While these fears are valid and may indeed become reality if hospice chose to limit itself to operating solely within its own environments, no one is suggesting that an inpatient unit would be anything more than one option among many. Proven effectiveness of at-home care, the overwhelming request of patients to remain or return to their own homes, and a growing popularity of home-care services in the UK and

abroad are evidence enough that hospice should not and would not abandon its core principles by binding end of life care to a particular, mandated form. Alternatively, some patients will also need to remain in acute care situations due to the severity of their condition or because of their requested plan of care, proving that hospice programs will always need to be able to operate in a variety of locations.

If hospice care facilities are designed with sensitivity to the fears of limiting, institutionalizing or sequestering the dying process, there is no reason that they couldn't be a significant benefit to the hospice community or serve as a more appropriate alternative to some of the current environments that dying patients find themselves in. It is clear that demand for hospice services will certainly rise in the coming years due to the growth of aging populations and increased interest from the public. Trends are showing that a freestanding, independent facility is becoming a more popular and more necessary concept as the mission and practice of hospice continues to spread, indicating that hospice programs and architectural design are now prepared to work together to symbiotically address all stages of the dying process.
Chapter 2: The Hospice Precedent

A partnership between architecture and hospice care is sure to prove beneficial to both practices. As hospice helps inform architects about the needs of dying patients, architecture will help inform hospice workers how to use the built environment to enhance the comfort of those in their care. Much can be learned by way of design intent from simply listening to patients and caregivers discussing the realities of life at the end of life, but as effective as this approach may be in revealing specific environmental responses to lifestyles and activity patterns, a hospice facility must be able to provide effective environments for the simultaneous care of multiple patients with different personal and medical concerns. Designing a facility with too narrow a view results in individually scaled spaces that provide a great deal of comfort but may be difficult for hospice staff to navigate while providing medical care. Too wide a view and a facility may end up trying to accommodate too many variables and find itself sacrificing comfort for efficiency of design.

Hospice architecture then must walk a fine line, balancing between the desire to create home-like environments and the need to provide top-notch medical care at a moments notice. What the architect is being asked to do is to draw upon two major precedents, one defining the life of the patient, the other defining the requirements of healthcare, both of which have valuable benefits to offer but on their own are not the most appropriate models to use. Hospice architecture must offer the best of both worlds; the hospital and the home.
2.1 The Panopticon

Hospitals and nursing homes, as mentioned earlier, can come into conflict with the philosophy of hospice and the physical, emotional, and spiritual care it provides. If not appropriately defined and clearly followed, a patient’s plan of expected care can be a source of confusion and conflict within an active-care institution. However, it cannot be ignored that the underlying design imperatives of such buildings has been crucial to the development of healthcare architecture and have been highly effective at meeting the needs of medical practitioners.

What hospitals and other active-care facilities do, architecturally, is accomplish the visual and physical outlining of a clear role of power and hierarchy between the doctor and the patient. They make possible the effective observation of medical conditions and the efficient delivery of treatment, and allow the medical staff to function with unquestioned authority in all manners pertaining to the human body. To understand how this hierarchy is constructed, architects must refer to the Panopticon, one of the most prolific architectural precedents in the healthcare industry.

The Panopticon was the combination of a theory of moral philosophy and a practical exercise in architecture put forth by Jeremy Bentham, the so-called ‘father of utilitarianism.’ Throughout his life, Bentham championed the notion of achieving the greatest possible good for
the least amount of effort, clarifying his positions in series of collected ‘letters’ written in 1787 in which he applied his rational, utilitarian approach to the task of organizing and controlling dynamic social systems.  

29 Termed the Panopticon (all seeing place) the focus of the concept was to create the most efficient and effective program possible for a community which required detailed surveillance and constant supervision. Bentham chose to place his emphasis on the prison, or as he termed it, the Inspection House.

Putting aside the distasteful correlation between jail cells and hospital beds, (though many would argue that they bear a great deal of resemblance in our modern day, in part thanks to the Panopticon) Bentham’s conceptualization of the panopticon has proved quite useful in healthcare architecture from the point of view of the medical practitioner. Bentham himself describes his Inspection House as a multi-use platform applicable to prisons, manufacturing centers, poor houses, mental asylums, schools and even medical hospitals. One letter in the collected Panopticon Writings goes into specific detail about how the architectural components of the Inspection House are ideal to the practice of medicine and that it “might render such a situation preferable even to the home, in the eyes of many. ... [The Panopticon] would be perhaps a better hospital than any building known hitherto by that name.”

29 Jeremy Bentham, The Panopticon Writings, M. Božovič, Ed. (New York: Verso, 1995) 1

30 Bentham, The Panopticon Writings 85
The Architectural Panopticon

“Morals reformed - health preserved - industry invigorated - instruction diffused - public burthens lightened - Economy seated, as it were, upon a rock - the gordian knot of the Poor Laws are not cut, but untied - all by a simple idea in Architecture!”31

Figure 2.2 Section drawing of Bentham’s proposed ‘Inspection House’

The Panopticon Writings reveal the zeal with which Jeremy Bentham wished to apply his practical, utilitarian concepts to real world situations and environments. Ever concerned with the ‘greatest good’ at the ‘least cost,’ he envisioned a simple approach with a simple cast of players as a very real solution to complex and morally turbulent problems. His collected letters distill his philosophy into an outline for the basic construction and habitation of a physical environment, using the

31 Bentham, The Panopticon Writings 31
contemporary prison house as an example to showcase the buildings proposed effectiveness. For Bentham, the panopticon was very much a physically feasible structure and one which he fully intended to build but never realized. He had even gone as far as buying property in London for it’s construction, though he was eventually forced to give it up after failing to construct anything for several years, prompting the government to revoke his funding.\(^\text{32}\)

In his letters, Bentham freely admits to not being an architect nor of possessing the knowledge and experience of a builder. Nevertheless, he devotes the full contents of two of his twenty one letters to making detailed descriptions of room dimensions and square footage, early programatic studies of required functions and their layouts, and numerous hypotheses regarding aesthetic choices in the architectural design.\(^\text{33}\) By any modern standards and even by some of the standards of his time, his proposed architectural experiment would have

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\caption{Plan, section, elevation drawing composite of the physical panopticon.}
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\textsuperscript{33} Bentham, \textit{The Panopticon Writings} 38-43
been a cramped and uncomfortable space that ironically contradicted and undercut the very theory he placed at the core of his Panopticon.

Bentham’s “simple idea in architecture” though can be boiled down to several important design requirements. First, the Panopticon was to be, ideally, a circular building with three or more stories. Arranged along the outer walls of the circle would be rooms dividing the circumference into equal segments and providing uniformly sized ‘cells’ that would overlook an open central court. Configurations of the walls dividing each room were meant to ensure that the occupant of one could not observe his neighbors to either side and had minimal visual access to the rooms opposite their own. At the center of the open court, Bentham placed the ‘Inspectors Lodge’ which had unimpeded visual access to each and every room around the building’s circumference and allowed for the 24/7 observation of the Panopticon’s inhabitants. A key point of this building’s layout was to create an exclusive relationship between the centralized authority of Inspectors Lodge and the individual occupant’s rooms. Bentham even claimed to have conducted acoustical experiments with “small sound transmission tubes” that would permit sounds within a room to be heard only by the lodge, ensuring that the various occupants

Figure 2.4 Illustration drawn from the perspective of the panopticon prisoner.
would be visually and auditoraly separated, a useful feature for prisons and, he proposed, a blessed relief for already overtaxed medical patients.  

Very few Panopticons have been built or attempted since the idea was first proposed. Those that were constructed in the context of the prison system were mildly successful, but none were every truly faithful to the plan laid out by Bentham. However, the architectural concept of a centralized base of power responsible for the observation and welfare of separate and individual entities remained an interesting and effective design strategy, particularly when compared to the needs of the medical institution. Just as Bentham had suggested, the Panopticon as a physical environment was found to be an extremely accurate reflection of the functions required of the modern hospital, though less because of Bentham’s particular composition of space than for the architectural concept it embodied. The efficiency offered by the architectural concept would greatly improve the ability of a

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34 Bentham, The Panopticon Writings 83
limited doctoral and nursing staff to administer ‘round-the-clock’ care and
treatment to as many patients as possible.

The Philosophical Panopticon

More interesting than the physical properties of the Panopticon, and perhaps more important from an experiential viewpoint, is the ideology behind Bentham’s grand concept. “The main thrust of the panopticon writings is that a certain reality...is sustained in existence by something that is utterly unreal, that is, by an imaginary non-entity.”35 The philosophy that drives the panopticon is that the non-real - the fictional - can be used and manipulated to influence what is real and vice versa, which can be used for both the individual good and the greater good.

Key to the successful operation of the Panopticon is the situation that the people under surveillance are not able to see their inspectors while the Inspector’s Lodge is afforded total access to those very people. It is impossible for one man to keep constant and uninterrupted observation of many, but if the presence of the inspector was made clear even while his form and actions were hidden, then the inhabitants of the inspection house could never really be sure that they weren’t being watched at any given point and would behave as though watched over by a supreme authority. “Bentham creates the fiction of ‘God’ in the panopticon through a gaze an a voice ... We are

35 Bentham, The Panopticon Writings 2
seen without seeing the one who sees us; we hear a voice without seeing the one who speaks."  

In the minds of the inmates, the concealed inspector of the panopticon, by virtue of being able to see and hear anything at any time, therefore must be seeing and hearing everything at all times. A central, undefined authority figure, who in truth may not even be present, becomes an omniscient, omnipresent, and omnipotent force.

We can interpret the Panopticon as an exercise in perception and experiential perspective that is effective at achieving a balance between reality and perceived reality by use of a “simple architectural concept.” The express goal of this exercise is to redistribute authority from one party to another through the creation of a “new mode of obtaining power of mind over mind, in a quantity hitherto without example.”  

It is this relationship, the power and influence of one person over many, that resonates with the general state of the healthcare institution which has, as outlined previously, held the knowledge, expertise and authority over that of the patient’s in matters pertaining to bodily health.

The Evolving Panopticon

Again, putting aside Bentham’s preoccupation with applying the Panopticon to the incarceration of criminals and the mental images of heavily stereotyped, spartan, dismal cells that go hand in hand with the idea of prisons, the architectural and ideological aspects of the Panopticon can viewed as useful tools in the design of healthcare facilities.

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36 Bentham, The Panopticon Writings 11
37 Bentham, The Panopticon Writings 31
Unarguably, doctors have access to the knowledge of how best to treat the human body and consequently carry the responsibility of observing patients and exerting their power and authority in order to do their job of keeping our bodies from failing. At any given time, they are responsible for a great number of individuals with vastly different conditions and the Panopticon provides an efficiency of access and support of authority that is unparalleled by other design strategies.

It is no mistake that most hospitals up through the 21st century are organized in a circular or radial plan whose perimeter is occupied by patient rooms and who’s centralized focal point is occupied by a nursing or doctor’s station responsible for monitoring each patient and coordinating their treatment plans. Even nursing homes, an extension of active-care hospitals, have adopted this form of a centralized base of authority through

Figure 2.7 Plan drawing proposal for Lucile Packered Children’s Hospital, displaying the panoptic ideal of many occupants, constantly observed by a central authority.
which service is coordinated to the rest of the facility. Assisted living facilities have broken out of this mold to some degree, often encouraging less circular forms, but they too incorporate a ‘centralized authority’ with immediate access and radial plan layouts.

This is not to say, however, that the modern healthcare panopticon has stood unchanged from the utilitarian practicality and ideological exercise proposed by Bentham. For one, the unseen ‘God’ of the Panopticon has been replaced by the very real and tangible presence of doctors and nursing staff. The mystery of the inspectors lodge is replaced with the visible nurses station, providing a helpful interaction of contact rather than an imagined gaze and disembodied voice. Conversely, surveillance methods aimed at monitoring health status and the condition of patients has made the the impossible task of constant and absolute observation of the panoptic ‘God’ a possibility. The fiction of the omnipresent ‘God’ is completely removed by the physical reality of an authority figure, while the fiction of the omniscient ‘God’ upheld by the reality of technology, in essence turning the centralized power of the modern medical Panopticon into ‘demigod;’ a Perseus of medical Practice. The fiction of an absolute authority no longer needs to be artificially created, existing as fact in the presence of a real authority figure who exhibits the capabilities reserved for deities.

However, as established, hospice care returns the power and authority of medical care at the end of life over to the hands of the individual patient. From the very beginning of the dying process, hospice completely changes the roles of medical professionals. Aggressively
treating an illness or curing a disease is not always compatible with a
planned quality of life, and under palliative care, doctors must mitigate
pain, manage comfort, and let death come. Responsibilities to the patient
remain much the same and constant monitoring and efficient access must
still be carried out, but the doctor or the nurse cannot unilaterally act on those
observations and operate as the sole authority. Likewise, the form of the
Panopticon must change to suit this new relationship. The Panopticon of the hospice
facility is not about obtaining power of mind over mind, but of entrusting power
from one mind to another or of achieving power through the cooperation of
many minds. Disproportionately hierarchical environments that enhance
the perceived power of one space over another is not an appropriate
architectural design strategy for the process of dying. The inspector’s lodge
of the hospice facility must continue a constant and conscientious
observation of its patients and retain the efficient and effective access to
individual patients, but there must be a reciprocal gesture of access
allowing the individual to observe the functions of the caregiver and to avail
themselves of the knowledge and expertise of staff as needed. Stations of power must
actively refute a hierarchical ordering of space and present themselves as a support
structure for the authority of the individual.
2.2 Prospect & Refuge

Active-care facilities are only one end of the architectural spectrum that hospice care and the architecture of dying must reference. The residential home embodies many of the environmental qualities that hospice care strives to provide for patients. Home is in many ways a sacred space, having a value to its occupants that is separate from the physical entity. Our homes are extensions of our own experiential worlds, venerated personal sanctuaries that help us combat feelings of loneliness, hopelessness, and boredom.\(^{38}\)

Removing someone from their home, no matter how necessary it might be, is to remove the sense of place and protective sanctuary that they have spent their whole lives constructing. Doctors often describe grown adults breaking down and sobbing at the prospect of having to move their mother or father to a nursing home,\(^ {39}\) fearing to place their loved ones into environments which had no value to the patients at all. Hospice facilities will need recognize that people seek solitude, not loneliness, that they seek to be active participants in their environments, not helpless, that they seek comfortable stability, not stagnation and boredom, and that value is found in environments that patients have created or can create for themselves. “This means that we do not design interiors of buildings. We make worlds.”\(^ {40}\)

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\(^{38}\) Thomas, *Journal of Healthcare Design* 59

\(^{39}\) Thomas, *Journal of Healthcare Design* 57

\(^{40}\) Thomas, *Journal of Healthcare Design* 58
What is it about the physical properties of a home that serve as a scaffold for world building? In researching the homes of Frank Lloyd Wright, author Grant Hildebrand concluded that his successful residential designs are analogous to a theory of aesthetics proffered by geographer and landscape designer Jay Appleton. “Appleton’s argument is that there is a deeply seated, genetically driven, human predilection for conditions of prospect and refuge.” Referring primarily to landscape features, the basics of his concept, a place to see without being seen, nevertheless appear to be definitive qualities found in Wrights’ homes and appealing residential environments in general.

**Prospect**

Appleton’s theory begins with the notion of ‘prospect,’ or an unimpeded place to see and observe. It can be demonstrated most emblematically in the “vast sweet visage of space” found in broad meadows, open plains or great sweeps of water. In any of these examples, it is possible to view one’s surroundings unhindered and to clearly identify points of interest and places of importance, and to determine potential

\[\text{Figure 2.10 Open meadow land, acting as a zone of prospect from which to determine points of interest, importance, or threat.}\]
threats. Prospect can also be found by changes in vertical orientation. Elevated vantage points such as a hill or tower greatly expand the visible horizon and provide a completely different point of view with more opportunities to observe and making it possible to gain information that would otherwise be impossible to obtain. Hildebrand brings to light that this concept works on differing hierarchical levels in residential architecture, with Wright’s homes in particular exhibiting strong and varied examples. Prospect offered by landscape vistas lead us to discover potential zones of prospect offered by the residential structure. These new prospects encourage us to explore interiors and in turn, to discover yet more zones of prospect within the building. With a deft hand, Wright utilizes the macro and micro scales to draw the individual from one prospect to another with the promise of new and different perspectives. Appleton’s theory terms this linking of one location to another via the offer of prospect “reduplication,” accomplished visually through the use of design elements such as balconies and terraces which naturally imply an

Figure 2.11 Views from Chatham Beach on Cape Cod. The image at right offers prospect through the open view of the beach. The image at left takes the same view taken atop a nearby bluff, offering more expansive prospect options through elevation change.
alternate view without specifically revealing it, or deep eaves and overhangs that can suggest an extension of visual access into the landscape, throwing the eye out towards the horizon line.  

Refuge

Appleton’s concept of refuge is similarly straightforward, defined literally as a place to hide and be safe. A most basic representation would be the simple cave or grove of trees in the landscape, exhibiting the opportunity for concealment, and embodying the primitive functions of habitat and architecture as shelter from heat, cold, sun, wind, rain, from light and dark, and from other individuals. Hildebrand notes that refuge,
like prospect, also serves a dual purpose as both a source of and a symbolic representation of its intent. “A building, by its very existence conveys a signal of its refuge potential, thus is more or less automatically not only refuge-provisions but also refuge-symbol.” Like prospect, the refuge concept works on the micro and the macro scale, playing itself out through the interaction of landscape and built environment, the interplay of public and private interior zones, or even the arrangement of furniture layouts within a room. Other more specific architectural details that can act as visual hints at refuge potential might include sheltered landings, recesses in the building envelope, deep or large windows, and any other design element that might suggest penetration into a closed space that reveals the potential for a zone of refuge.

Figure 2.13 The building that exists in a zone of prospect is immediately defined as a symbol of refuge, regardless of its architectural elements or even its habitability.

43 Hildebrand, The Wright Space 32
44 Hildebrand, The Wright Space 35
Prospect AND Refuge

The true strength of the concepts of prospect and refuge really only becomes evident in the interplay between the two. Through zones of prospect, we are able to locate and identify points of potential refuge, while through zones of refuge, we can have the opportunity to observe areas of potential prospect. Hildebrand even suggests that we derive satisfaction and aesthetic pleasure from simply witnessing the two conditions working together, instilling the desire to explore each one and stimulating memories of similar environments. Working together, prospect and refuge create the possibility observing one condition from within another, of being able to “see without being seen,” an highly desirable circumstance that accommodates solitude and privacy without secluding or limiting the observation of the environment. It is up to the architect then, to manipulate the degree and intensity with which prospect and refuge interact in order to

Figure 2.12 Diagram of prospect refuge characteristics in Frank Lloyd Wright’s Cheney House, offering a place to see without being seen.
generate positive experiences through the built form of various ‘gradients’ and hierarchies of either condition.

Hildebrand references the intricate and iconic stained glass windows found in some of Frank Lloyd Wright’s residential design as prime examples of the manipulating prospect and refuge. Large expanses of glass that Wright employed tended to offer prospect from both interior and exterior viewpoints. During daytime, the glazing would reflect most light and effectively render the surface as opaque, appearing at once as having the potential for refuge while promising a vast potential for prospect to the outside observer. From within, however, the occupant cannot be sure of what can or cannot be seen through the glass, and the fear of perceived exposure breaks down the concept of refuge from within, particularly during nighttime hours when visual properties of the glazing would be
reversed. To sidestep the problem and preserve the specific prospect-refuge hierarchy, Wright divided up panes of glass with leaded lines and filtered the access of both sight and light with variations of stained glass colors and transparencies. “One senses that one is hidden in the dark recesses behind the foliage and the branches of a grove.”

Contemporary architects have gone one step further and encouraged an active and ongoing manipulation of prospect and refuge zones. Through moveable walls, fields of operating windows, mechanized shading devices, and other devices, the occupant of an environment is invited to participate altering the physical form of the structure and thereby the potential for prospect conditions and refuge characteristics. (figure) Whether active or passive, the juxtaposition or cooperation of the two concepts layered upon themselves and organized into hierarchical orders can create rich, complex

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45 Hildebrand, *The Wright Space* 43
and dynamic environments. Yet in spite of such a density of order, Hildebrand illustrates that there seems to be a clarity of experience that is immediately discernible to the human mind, something which Appleton himself argued was an almost genetic imperative born of survival instincts and integral to our rationalization and pleasure when selecting habitats.⁴⁶

We can now understand that this innate desire for interrelating and intertwining zones of prospect and refuge is something we all look for in our home environments. Refuge offers the potential for solitude, prospect offers the potential for discovery and participation, and the combination of the two creates the stability of readily understandable and familiar environments. The simultaneous sanctuary with a view or view with a sanctuary is then the framework upon which a home might grow and accumulate personal value.

**Lessons for Hospice**

The environments we find ourselves occupying during the dying process will become the entirety of our experiential world in our final days.

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⁴⁶ Hildebrand, *The Wright Space* 16
Hospice care will work to ensure that we spend those days in comfortable surroundings of our choosing, but given that our first choice may not be achievable, hospice will be asked to provide appropriate alternatives; one of which will be the stand alone facility. Hospice care cannot rely on medical facilities to operate in accordance to the patients plan of care, nor can it continue to operate exclusively in the home environment.

The former draws on decades of precedent that spring from concepts hierarchical power structures, utilitarian efforts at containment or confinement, and an efficiency of access organized around needs of a pre-appointed authority figure. Medical facilities primarily based on the model of the Panopticon do not take into account the value we place on the home environment or the conditions we prefer to seek out in our personal habitats. There is no refuge in the hospital hallway. The nursing home has no place where an individual might find solitude for often bedrooms are shared with other patients The nursing station offers no vistas of prospect and unlike the inspectors’ lodge of the Benthamite prison, offers little concealment. In the modern medical panopticon there is no place where one can see without being seen.

The latter precedent, that of the home, employs a complexity of visual cues and deliberate organization of physical circulation to create areas intended for specific use patterns. Promoting experiential comfort, encouraging occupant participation and demonstrating stability through prospect-refuge relationships is a high priority for the residential environment, but unfortunately a solitary refuge does not permit easy and immediate access. Dynamic environments can easily become a burden to
both the patient and their caretakers, hindering the actions required for the practice of palliative medicine. A wheelchair cannot easily navigate narrow halls, thresholds or stairways, the boundaries between zones of prospect and zones of refuge, nor do visually comforting environments necessarily address the very practical requirements of the body.

A modern hospice facility will have to fully recognize the shortcomings of its two main precedents, but it can be strengthened by attempting to supplement the deficiencies of one with the benefits of the other. The Panopticon provides and efficiency of organization and an ease of accessibility which the environment of home requires. The home provides a richness of experience and support that the panopticon utterly lacks. A careful balance between these two models can provide a positive experience for all participants in the dying process and result in an environment that is inherently easy to understand and comfortable to use, with the flexibility to offering efficient and accessible care.
Chapter 3: Buildings at the End of Life

The middle of the 20th century saw a so-called ‘golden age’ for the generic urban hospital. Active care facilities had swollen with the desire to provide the newest and best tools for diagnosis and curative treatments, and their size and spatial organization grew to reflect the objects of their attention. Focusing so much of their effort on the curative process, these huge facilities completely lost touch with the patients they were there to assist, particularly those that could not be cured who therefore did not seemingly merit the hospital’s attention. “Their failure to respond humanely to death and dying fueled the legitimization of the autonomous hospice.”

We therefore see the development of hospice facilities, at least from the perspective of architecture, as occurring at the rise of the postmodern expression of the late 1900’s. “Its prevailing zeitgeist remained ingrained in humanist and historicist sensibilities...and was intended as a rejection of the hospital and all it stood for.” With an emphasis on residential scale as opposed to the large institution and a directive for comfortable, personalized spaces in lieu of clinical sterility, hospice facilities began to tailor their environments around the individual and their inherent authority in the face of death

48 Borderer and Refuerzo, Innovations in Hospice Architecture, 26
3.1 Elements of Hospice

Rejecting the modernist approach to medical facilities meant rejecting any rigid conventions that would dictate the extent and scale of palliative care. As a result, there is a widely diverse array of architectural accommodation of the hospice philosophy. The design of an independent facility varies based on the specific hospice program’s intent, context and planned services. Defining a building type is therefore more easily accomplished by looking a range of potential and required programmatic elements.

Building Intent

First to be considered is the intent of the hospice’s program; what kind of medical care is to be provided? The development of hospice as a recognized branch of medical practice has led to the refinement of ‘categories of care’ that an inpatient program would be able to provide.49

*Residential-Care:* Offering comfortable, home-like environments in dedicated inpatient units for full time patient residence.

*Respite-Care:* Offering short duration stays of five to seven days for hospice patients in order to allow family members and non-staff caretakers a period of relief.

*Day-Care:* Offering staff supervised visits to hospice facilities, intended provide engaging activities for patients and assist family caretakers.

Any or all of these categories can be included in the function of a hospice facility, depending on its context. Independent Hospice’s can exist

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in a variety of forms and are not necessarily autonomous structures. The ‘stand-alone’ hospice is one that functions completely on its own, requiring that the facility house not only patients but administration services, program offices, medical storage, and housekeeping services. This nearly self-sufficient arrangement may be the first to spring to mind, but hospices can also be found as satellites of larger, more institutionalized medical centers. Such facilities are able to forgo much of the spatial requirements for administration services, able to house them and storage capacities in nearby areas of the medical center. Still other hospice facilities are fully incorporated into existing healthcare structures, carving out their own interior space and adapting it to the comfort and care of dying patients. Common to all these design approaches are context issues pertaining to site characteristics and entry sequences.

Figure 3.1 Aerial view of the medical campus at Aichi Prefecture, Japan. The AHI Hospice is located in the upper right corner of the image, a satellite hospice facility to the main hospital (center).
Site Concerns

“By and large, a hospice is a quiet place.”\textsuperscript{50} Containing spaces for solitude, reflection and meditation, it is incredibly important to determine to what degree unwanted sounds may be filtering into the hospice environment. As general noise can be a distinct distraction and therefore an unwelcome burden on the dying patient, the buffering of unwanted sounds will have to play a key role in building orientation, landscaping strategies, and design details.

Also critical to the success of any hospice facility is the availability, design, and proper location of parking services. “Too few spaces on a site in too close proximity to the building can be a source of stress in patients and families.”\textsuperscript{51} Similarly, too much parking located too far from the building will put strains on landscaping initiatives and view corridors and a long distance from a vehicle to the building’s entry will be a strain. Any access drives should lead directly to the facility’s main entrance, while service drives to retrieve waste and biohazards medical supplies should be separated or buffered from the public arrival sequence.

Arrival sequences for any hospice are important opportunities. As a gesture of making the ‘first impression,’ approaching and entering the front door must be a welcoming gesture, scaled to the human figure and operating as an extension of the building’s design into the landscape. Many facilities have adopted a covered canopy at the main entrance that “allows

\textsuperscript{50} Borderer and Refuerzo, \textit{Innovations in Hospice Architecture}, 62

\textsuperscript{51} Borderer and Refuerzo, \textit{Innovations in Hospice Architecture}, 62
the patient [or visitor] to be dropped off without being subjected to inclement weather, or having to walk from a remote parking area.”\textsuperscript{52} A serialized progression of entry is then often adopted, moving from the exterior arrival point to an interior entry foyer. This foyer is the suggested location for a reception desk and welcoming station, and while the inclusion of such an element might run contrary to the concept of a private residential experience, it can operate as a symbolic gateway to the hospice in general and serve as a prime screening and control point, embodying a sense of safety, security and refuge.\textsuperscript{53}

Program Services

Hospice care is by nature a multidisciplinary approach. It pools together the resources and insights offered by physicians, nurses, social workers, counselors, therapists, clergy, trained volunteers and other professionals whose services are required by the patients plan of care. Even relatively small hospice programs may need to incorporate a great many different programatic

\textsuperscript{52} Borderer and Refuerzo, \textit{Innovations in Hospice Architecture}, 63

\textsuperscript{53} Borderer and Refuerzo, \textit{Innovations in Hospice Architecture}, 64
elements in the design of a dedicated facility. For the purposes of narrowing down the list of possibilities, the research has been directed at outlining the crucial components necessary for the success of a small or moderately sized ‘stand alone’ hospice facility providing residential care services.

The first area of focus, often termed the “residential milieu,” consists of all the spaces we have come to associate with the home or home-like environments. This begins with the private palliative care bedroom, perhaps the most important room in a hospice. It is the first place a patient is familiarized with and it is the stage from which care will be administered throughout the patients experience. Early hospices often housed patients in semi-private rooms with typically two to three patients in

![Figure 3.3 Light-filled, independent hospice bedroom of George Mark Children’s Hospice.](image)

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*Borderer and Refuerzo, Innovations in Hospice Architecture, 69*
a single bedroom. While this practice is still ongoing in other cultures, most notably in Japanese hospices, the US and Europe are seeing a definite trend towards maintaining individual private rooms. Most hospices have also increased the size of individual bedrooms by 20-25 percent larger than the typical hospital room, based on the observation that the bedroom has come to serve as a space for personal solace as well as social gathering and later as a space for grieving. Some key aspects of the private hospice bedroom include the exposure to natural daylight, access to exterior spaces, access to private (or less desirable, semi-private) bathroom facilities, and articulated entrances that act as zones of transition between more public areas and the bedroom itself. Another very important aspect of the patient bedroom is the potential for personalization. Some hospices achieve this through the inclusion of built-in cabinetry for the display of personal belongings and allowing space for residential furniture to be arranged, while others allow for the complete reorganization of interior space layouts. Regardless, it is important to let patients and families make their mark on a space.

Next up in the residential milieu are the social activity spaces, including living rooms, dayrooms, kitchen

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Figure 3.4 Articulated entry to patient bedrooms allows for personal identification of space. Some hospice facilities go one step further, offering deeper articulated entries with sitting areas.

Figure 3.5 Patient bedroom employing natural materials and expansive views to exterior garden space.

55 Borderer and Refuerzo, Innovations in Hospice Architecture, 69
and dining facilities, and other housekeeping spaces. Some of these, such as living and dining rooms, seem rather self explanatory and can operate as formal or informal places for families to gather and for people to mingle with other patients and staff. The dayroom in most hospices is actually a multipurpose room. It may be used as a dining room, a place to celebrate an occasion or holiday, and provides a place to experience contact with others.\textsuperscript{56} Dayrooms should be flexible and adaptable, able to accommodate a wide range of uses. In the hospice facility, kitchens and other housekeeping spaces are seen as important opportunities for social interaction and exchange, and for support of self-care and independence seeking.

\textsuperscript{56} Borderer and Refuerzo, \textit{Innovations in Hospice Architecture}, 65

\textit{Figure 3.6} Individual patient bedrooms at AHI Hospice allow the patient and their families to completely rearrange furniture layouts, even room functions via movable partitions.

\textit{Figure 3.7} Community kitchen with multiple zones for cooking and eating, at Evergreen Hospice Center in Kirkland,
activities. “The design and layout of a kitchen will be most supportive if it gives the patient and the patient’s family options to prepare food independently.”

Similarly, laundry facilities are a key necessity of life in hospice care. “Clean linens are required on a daily basis, and family member should have a room where they can wash their own clothes.”

Making these spaces accessible to all occupants can foster healthy relationships and feelings of purpose by allowing patients to become authors of care.

Necessary to the proper function of a hospice is the effective coordination and layout of administrative spaces. Physician and nursing office, storage of medial equipment and supplies, records filing, private staff restrooms, break rooms, and overnight accommodations are all essential to

57 Borderer and Refuerzo, Innovations in Hospice Architecture, 67
58 Borderer and Refuerzo, Innovations in Hospice Architecture, 74
running any inpatient healthcare facility, let alone one dedicated to end of life care. A common design strategy when addressing these spaces in the hospice setting is to gather them into one location that can be distinctly separated from the residential milieu, so as not to expose patients to unnecessary disruptions. The exception to this approach is the inclusion of comprehensive nursing stations close to patient rooms and social areas. These stations are used by doctors, nurses, assistants and volunteers as central points of observation and control. As highlighted earlier in the research, these spaces require direct access to patients, but they need not be implemented in the authoritarian hierarchy of the hospital institution. Rather, it is suggested that the hospice explore design solutions that blur the lines between patient space and caregiver space and reduce the traditional, pronounced line of demarcation between the two.59

Quality Alternatives

Some programatic elements, while not strictly necessary to the success of a hospice facility, are able to provide complimentary environments to administration and residential milieu spaces. Sometimes overlooked, they can add to the richness of the hospice environment and the help to improve quality of life for its occupants. Resource libraries are one such space, functioning as reading room and media center with computers, internet access, and private libraries of books and magazines. Occasionally, the library may be tasked with social functions from time to time, but it is primarily a “semi-private places where one can spend time

59 Borderer and Refuerzo, Innovations in Hospice Architecture, 72
reading, studying, and relaxing.\textsuperscript{60} Another quiet space
that can fulfill the need for a relaxed space for meditative
contemplation and reflection is the hospice chapel.
These spaces are not necessarily for worship, but are
meant to be primarily non-denominational refuges for
rest, solace, reflection and grieving.\textsuperscript{61}

With an eye towards more lively environments, a
hospice might consider the inclusion of activity rooms for
visiting youth. Hospice patients are more likely to be in
elderly age groups and environments tailored to their
needs do not reflect the needs of younger family members
who may be visiting for periods of time. To help young individuals cope
with the concepts behind hospice care, some facilities have sought to
include areas where adolescents could “release stress, and be able to spend
time alone with friends away from the influence of adults.”\textsuperscript{62} Another
activity element to consider is the accommodation of pets within the
hospice environment. Pets have proven time and again to be meaningful
companions to the terminally ill. “They are a source of joy, a reminder of
the sounds and rhythms of life. ... Undemanding, unwavering attention
goes a long way to breaking the spell of being isolated in a room.” \textsuperscript{63}
Hospices that promote sustained contact with a pet cat or dog or offer the

\textsuperscript{60} Borderer and Refuerzo, \textit{Innovations in Hospice Architecture}, 68
\textsuperscript{61} Borderer and Refuerzo, \textit{Innovations in Hospice Architecture}, 75
\textsuperscript{62} Borderer and Refuerzo, \textit{Innovations in Hospice Architecture}, 65
\textsuperscript{63} Borderer and Refuerzo, \textit{Innovations in Hospice Architecture}, 68
soothing effects of an aquarium or bird sanctuary can help ease the strain of the loss of control and dignity associated with the process of dying. And finally, a direct connection with nature through physical access and contact with outdoor spaces can suggest “a symbiosis between building and landscape [that] empowers patients and families and promotes privacy and autonomy.”

Therapeutic gardens, balconies, and patios can provide opportunities for interaction or offer chances at solitude and tranquility for the dying patient. Semi-private courtyards can become outdoor rooms, extending the realm of interior space out into nature, encouraging patients and caregivers to consider their environments as part of the surrounding landscape.

Figure 3.10 Each patient room and social space has direct access to exterior gardens and walking paths at Evergreen Hospice Center.

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64 Borderer and Refuerzo, Innovations in Hospice Architecture, 76
3.2 Examples of Hospice

By their very nature, hospice facilities symbolize the antithesis of the impersonality and immense scale of the modernist acute care hospital and medical center. The very first contemporary hospice was constructed in London, UK in the 1960’s, at the end of the era of modernism in architecture. Indeed, the growth of architectural postmodernism paralleled developments in the institution of healthcare that led to the ‘rebellious’ formation of the hospice philosophy. Hospice was in many respects a rejection of the modernist view of buildings as a machine for living, and a testament against the institutionality of the oversized modern hospital. So called ‘megahospitals’ had become a phenomenon in the United Kingdom and “critics blasted the federal bureaucracy for the overbuilding of these

![Image](image.png)

Figure 3.11 St. Thomas Hospital, 1975 addition earned the nickname of ‘megahospital’ after negative reactions to its disproportionate scale from both public and governmental officials (whose view of the river was blocked by the new building).

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65 Borderer and Refuerzo, Innovations in Hospice Architecture, 43

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Their only guiding concept seemed to be ‘the more beds the better.’ Dame Cicely Saundar’s interaction with dying patients within these environments inspired her pioneering work on palliative medicine and directed, individual care for the terminally ill, focusing on patient awareness, education, and self empowerment. Subsequent developments in her philosophy of hospice prompted her to direct the construction of St. Christopher’s.

However, this first contemporary hospice was very modernist in it’s outward appearance. “This, for better or worse, was nearly entirely due to the need to comply with National Health Service (NHS) standards for medical facilities” in the U.K., in other words, the megahospital. But on the interior, Saundar’s hospice allowed residents to wear their own clothes, and bring their own possessions, even furniture. “Without the formidable presence of the megahospitals life-extending apparatus, such as respirators and dialysis machines, there was now space for these important comforts of home.” St. Christopher’s still remains an active center in the

66 Borderer and Refuerzo, Innovations in Hospice Architecture, 14
67 Borderer and Refuerzo, Innovations in Hospice Architecture, 16
68 Borderer and Refuerzo, Innovations in Hospice Architecture, 16
hospice community of the U.K., and is currently being renovated as a 40th anniversary initiative to update systems and facilities and enhance the lives of its charges. Saunders building and philosophy have been an inspiration for further development of environments at the end of life.

The following pages will look at successful examples of environments that embody the hospice ideal. These facilities are a study in smaller scale units, showcasing that hospices need not utilize the form of active care centers. They illustrate how far from the modernist hospital, and even the first hospice, that we have come. Hospice facilities do not have to recreate an individual’s home, but they can create home-ness in an appropriate environment of personal and medical support.

St. Christopher’s Hospice, “Latest Developments” St. Christopher’s Hospice, 21 June 2008 <http://www.stchristophers.org.uk/page.cfm/Link=852/t=m/goSection=10>
MAGGIE’S CENTER, DUNDEE - 2003

Location: Dundee, Scotland
Architect: Frank Ghery

The Maggie’s Center initiative was established in 1995 to provide an alternative to mainstream, conservative approaches to cancer care and education. It was spearheaded by architectural critic and historian Charles Jencks after his wife, Maggie Keswick Jencks’ death from breast cancer as a reaction to her mostly negative experience with hospital environments. Though not a true hospice facility, the Maggie’s Centers have helped raise the awareness that even twenty years after the formation of hospice and the popular acceptance of palliative care, current healthcare

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70 Borderer and Refuerzo, Innovations in Hospice Architecture, 44
environments simply are not appropriate for those facing terminal illnesses and dying.

Designed as a freestanding building on an existing medical campus, the center supplements the medical care received in the active care hospital by providing an environment of gathering, retreat, and refuge. Evolving from the inside out, it seeks to establish a personal bond with its occupants and, in turn between them and the rolling, open landscape. “The scale is residentialist, not unlike that of a rural farm cottage, and serves as both a visual and functional antidote to the nearby hospital,” achieving an iconic representation of its purpose.

Architect Frank Ghery designed four interwoven spaces; the arrival and main lounge areas, kitchen services, informal sitting area, and media library. The result is a versatile and expandable space with an open arrangement, few ‘closed cells,’ and no corridors, signs, or clinical overtones. Prospect-refuge characteristics are strong and

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Figure 3.16 First and second floor plans of the Dundee Maggie’s Center.

71 Borderer and Refuerzo, Innovations in Hospice Architecture, 44
immediately apparent. The building itself is an object in the landscape, implying refuge by its sheer presence and orientation. Sitting atop a hill, it offers enormous prospect opportunities through orchestrated views of the Tay Estuary and the valley below. (figure)

Interior thresholds and material changes in flooring and wall treatments divide the open plan into readily determinable spaces without walling them off, allowing occupants to see while taking advantage of a particular room’s refuge characteristics. The exterior building envelope employs Ghery’s characteristic, undulating forms, creating a collage of spaces that hint at interest and activity in within the intersecting volumes. Overhanging roofs and large penetrations of doors and windows encourage shelter seeking behavior and imply refuge potential, while an elevated terrace extends into the horizon and the two story tower offer increased potential for prospect and seeing without being seen.

As stated, this is not a hospice facility and there is no inclusion of nursing stations
or medical service administration functions, demonstrating that a building of this scale simply cannot provide the requested services of a fully fledged hospice program. The open plan, while appropriate to a building of this size, tends to eliminate possibilities for seeking solitude, either for grieving, quiet reflection or religious meditation. Lastly, the entirety of the building is not universally accessible, eliminating the chance for patients and visitors to experience the full range of prospect refuge characteristics. Despite these drawbacks, Ghery’s Maggie’s Center does serve as an appropriate model for hospice facilities, offering indications as to how smaller scale approaches might meet the needs of the hospice community.

Figure 3.19 Maggie’s Center, Dundee from entry, offering refuge potential as a shelter in an open field and depicting the expansive views to be had from within the building.
THE ARK CENTER FOR PALLIATIVE CARE - 1999

Location: Roermond, the Netherlands
Architect: Architectenbureau Humblé Neuhof

The Ark Center is another example of a satellite facility, located on the grounds of the S. Camillus convalescent care facility. Though connected to its parent structure though an umbilical corridor, the hospice functions autonomously. Situated in a rural, wooded area, its design centered on a low profile single level pavilion style concept that would keep the building's scale at a more residentialist scale. Employing unbroken, curvilinear planar geometries, the facility clearly defines the differing realms of private patients spaces, social activity spaces, and administration spaces, without being exclusionary or hierarchical in its allocation of space. Fourteen,

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72 Borderer and Refuerzo, Innovations in Hospice Architecture, 97
residential-care patient bedrooms are located along the curve of the southern oriented building envelope, offering articulated room entries with individual access to exterior spaces. From an exterior point of view, the large, recessed panels of glazing offer a cue for the refuge potential of the patient rooms beyond while within, the views through these expansive windows and doors establish a strong connection between the building and its dramatic natural landscape, offering prospect potential of the exterior patio, garden and water feature below.

Though the curved form allows for a clear delineation of function and an uncluttered diagram of the space, as the patient bedrooms rotate around the plan’s radius, their visibility to attending nursing staff is reduced. Panoptic concepts of observation may be upheld by technological advancements, but direct access along the curve begins to degrade as...
patient rooms seem to move further from targeted care spaces. Furthermore, as mentioned, the hospice is an autonomous facility but not a self-sufficient entity. The umbilical visible in the plan (figure) allows the hospice to house the majority of its medical storage requirements and nursing administration functions in the convalescent home parent structure and does not illustrate how those spaces might be incorporated such a clean and clearly defined spatial form. Lastly, while this spatial clarity of use patterns is applaudable, the lack of interaction between them creates a hollow, no-mans-land circulation corridor whose scale seems too large at times and which divides the zones with a potentially uncomfortable transition space.

Figure 3.22 The south facing patient bedrooms offer recessed, sheltered views and access to exterior spaces.
HOSPICE LaGRANGE - 1996

Location: LaGrange, Georgia
Architect: Nix Mann and Perkins and Will

This hospice is also located on an existing medical campus, that of the West Georgia Medical Center, but is a self contained, stand-alone facility offering residential-care, and respite-care services. Eschewing the institutionalized forms of its neighboring active care facilities, Hospice LaGrange takes a different approach to the spatial organization of administrative areas and the residential milieu through a parti diagram of clustered patient room pods. (figure) Dividing private patient spaces not

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73 Borderer and Refuerzo, *Innovations in Hospice Architecture*, 131
only serves to break up the monumentality of a more linear approach, but also promotes the perception of individual residential structures, creating a “rural village” community of autonomous ‘farmhouses.’

To connect these ‘farmhouse’ units together, the architect envisioned an active corridor full of alcoves and opportunities for visual and physical connections to exterior and social activity spaces, noting that double loaded corridors of more institutional facilities offered no refuge characteristics and long hallways discouraged the use of spaces at their terminus.

Patient housing consists of four clusters of four beds each, adjoining a living room-dayroom, offering interior prospect-refuge transitions from private bedrooms to active social spaces, much like a private residence. The bedrooms themselves are large enough to accommodate extra temporary beds for family use, along with full residential furniture settings and individual private bathrooms. With the dispersed plan layout, multiple opportunities for connections to the landscape are made available which the building’s design takes advantage of through access points in each individual space and the arrangement of the ‘rural village’ to enclose an interior courtyard.

This parti does have its drawbacks, however, the first of which is the need for an increased building footprint. Even when divided into individual clusters, care must be taken to sufficiently

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74 Borderer and Refuerzo, *Innovations in Hospice Architecture*, 131

75 Borderer and Refuerzo, *Innovations in Hospice Architecture*, 132
differentiate primary spaces from circulation methods. The materiality of
the exterior aesthetic for this hospice facility does not make the distinction
between patient zones and circulation apparent, causing the perception of a
much larger, linear organization of space instead of individually defined
houses. (figure) The separation of administration spaces and the residential
milieu is quite well articulated, but gain due to the spread out nature of the
building design, there is a long distance between conference and
consultation rooms and physician offices. This separation also negatively
affects entry sequences, with long travel distances between arrival and
residential spaces that can be a source of burden and stress on visitors.

Figure 3.25 Plan view of Hospice LaGrange.
15 CANUCK PLACE CHILDREN’S HOSPICE - 1995

Location: Vancouver, British Columbia
Architect: Downs/Archambault & Partners

Canuck Place was the first freestanding children’s hospice in North America, housed in an adapted early twentieth-century historic mansion, and offering residential-care and day-care services. It is most notable for showcasing that existing buildings can be successfully adapted for reuse by the hospice community. Located in a residential neighborhood in a historic section of the city, the hospice is a freestanding facility able to bring service to the community, further the education of the hospice ideal, and is

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76 Borderer and Refuerzo, Innovations in Hospice Architecture, 163
openly supported by the community with local volunteers. Accommodating eight patient beds and space for use by four families, the facility utilizes its four story building to separate functions of privacy, social activity, administration and meditation to retain as much as the residential quality of the existing structure as possible. “In retaining the amenities of the manor residence, a feeling of home was maintained.”

Dining and kitchen spaces are strongly reminiscent of the home environment, while

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Figure 3.27 Canuck Place, floor plans.

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77 Borderer and Refuerzo, Innovations in Hospice Architecture, 164
living rooms and multiple dayrooms are located throughout the building to complete the appearance of an anti-hospitalist environment in virtually every respect. 

Prospect zones in the closely divided interior are achieved by offering glimpses of other rooms through visual thresholds between adjoining social spaces. The entire building is elevated from the ground plane, requiring the ascension of stairs before reaching entry porches that promise differing vantage points. Refuge characteristics are also implied by these elevated entry porches, relying on the physical barriers of the elevational changes and deep covered overhangs.

As with any renovation, compromises must be made to program requirements. The drawbacks of reusing a residential manor meant the sacrifice of preferred circulation patterns and accessibility. Multiple levels

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78 Borderer and Refuerzo, *Innovations in Hospice Architecture*, 164
requires the use of an elevator, but the structure and layout of the manor
house could not permit implementing one in a centralized role. Instead,
this primary means of traffic for patients requiring wheelchairs or other
medical apparatus must be located far from social and private patient areas.
The circular rooms also present a problem as the curved walls made it too
difficult to achieve pockets of refuge.\textsuperscript{79} (figure) This condition also presents
a problem to the use of the rooms since they were intended to
accommodated two patient beds each. The lack of refuge potential in this
space requires the patient and their families to seek alternate means of
achieving privacy and solitude.

\textbf{Figure 3.29} Patient bedroom in renovated, circular rooms offer few opportunities to seek solitude.

\textsuperscript{79} Borderer and Refuerzo, \textit{Innovations in Hospice Architecture}, 166
Chapter 4: Quissett Harbor House

The research presented in this thesis makes the case for a more comprehensive architectural response to the processes of death, dying and bereavement. It has shown that the authority over dying, the power to mandate how and where one is treated in their final days, has now been put back into the hands of the individual. It has highlighted hospice care as an invaluable service and effective support system for the dying patient, but has also demonstrated hospice’s need for appropriate architectural environments in which to practice its philosophy of care. Through hospice, architects have found the opportunity to truly serve those at the end of life.

Delving into the spatial and conceptual precedents behind the requirements of hospice, it was revealed that the institutional panopticon would continue to play a key role in the contemporary hospice. It was also found that the elements of a residential environment that provide a density and richness of experience are tied to a layering of prospect and refuge situations. The benefits of each concept balance the deficiencies of the other, and both can work together for the creation of appropriate and effective hospice care facilities.

Results of this research are to be used in the design of an independent inpatient hospice facility in southern Massachusetts on Cape Cod. The purpose in this effort is not to mandate a particular form for hospice, nor to establish a ‘best-practices’ method for hospice design. To do so would violate the principle of individual authority at the core of the hospice philosophy, and would be the literal realization of fears about
limiting, institutionalizing, and sequestering the dying process. The intent, rather, is to demonstrate how architecture can effectively meet the needs of the hospice community as a tool for hospice care programs to enhance the quality of life at the end of life.

The following pages detail the selection of a site on Quissett Harbor, its history, its contemporary context, and an analysis of its characteristics. This analysis will serve as a basis for explorations into design methodology, developing a common language used throughout the process. A final, fully realized design for a hospice facility will be conducted separate from, but relying heavily on, this document, serving as a complimentary architectural project to the research herein.

Figure 4.1 Rendered plan view of Cape Cod, Massachusetts and the islands of Martha's Vineyard and Nantucket.
4.1 Site Analysis

Location

Cape Cod, Massachusetts plays host to an interesting and varied demographic population. Known as a seasonal destination spot, its towns and villages swell in size during the summer months as people seek out its varied beaches and travel to the islands of Martha’s Vineyard and Nantucket. Coastal tourism and recreation are a prominent way of life, but there is an equally strong and dedicated community of year-round residents, one of the largest of which is the Town of Falmouth. Falmouth incorporates several older village communities including Woods Hole, the transit hub for

Figure 4.2 Context plan of the Quissett Harbor area, depicting the jetty formation, ‘The Knob’ (far left), public park-land (center), the immediately adjacent existing buildings on the chosen site (center) and the surrounding residential neighborhood.
vehicle and pedestrian traffic to Martha’s Vineyard, and Quissett, which boasts public access beaches and wildlife preserves and is the location for the proposed design project. The site itself is located on the promontory that forms Quissett Harbor, a naturally protected public anchorage surrounded by an active, year-round residential community. Only four miles away from the Steamship Ferry Port and three miles from Cape Cod’s premier hospital institution, the site seems ideal for potential location of a hospice facility; a quiet place in an active community.

History

![Quissett Harbor, Falmouth, Mass.](image)

**Figure 4.3** Quissett Harbor as a vacation spot, depicted on a postcard, circa 1909.

By the early 19th century, Quissett had developed from a collection of residences into a thriving village community. Its harbor at one point contained two separate salt-works facilities, one of which served as the foundation for the existing buildings on the site, and a shipbuilder company. The addition of railroad access to nearby Woods Hole brought an increase in public tourism to Quissett Harbor, which fast became a
favored vacation spot. In 1874, the two prominent houses on the promontory now known as ‘The Knob’ were joined together to become the Quissett Harbor House, which grew in popularity until the mid 1900’s, finally closing its doors in 197580. Of the expanded hotel, only the original two buildings and a salvaged dining hall remain. The majority of the hotel’s property was donated by the last owner to Salt Pond Area Bird Sanctuaries, Inc., who have let it return to its natural vegetated state and have made it into a publicly accessible beach and bird sanctuary.

Site Analysis: Environmental Conditions

By virtue of its location, bordered by a wildlife preserve, a residential neighborhood, a busy inner harbor and the open water of Buzzard’s Bay, the site is subject to vastly different, constantly changing influences. The following images are representations of environmental factors that produce dramatic changes on the characteristics of the site. Each rendering began with a single printed image of a vantage point that looks past the existing building, over a hollow of coastal wetlands and to the open water beyond. Through the application of various media, this image was changed, as in nature, to reflect different conditions of season,

weather, and time of day. These renderings make the implication that any structure built must be able to accommodate the extremes and the subtleties of these environmental changes.

Figure 4.5 Quissett Harbor House grounds and view, photographic panorama.

Figure 4.6 Quissett Harbor House grounds and view, rendered during storm conditions.

Figure 4.7 Quissett Harbor House grounds and view, rendered during typical fog conditions.
Figure 4.8 Quissett Harbor House grounds and view, rendered during late summer.

Figure 4.9 Quissett Harbor House grounds and view, rendered during nighttime conditions.

Figure 4.10 Quissett Harbor House grounds and view, rendered during overcast conditions.
Figure 4.11 Quissett Harbor House grounds and view, rendered during winter.

Figure 4.12 Quissett Harbor House grounds and view, rendered during typical

Figure 4.13 Quissett Harbor House grounds and view, rendered during sunset.

Figure 4.14 Quissett Harbor House grounds and view, rendered during morning hours.
Site Analysis: Existing Construction

Exhibited here is a section through the existing building and through the topographic elevations it sits atop. This piece seeks to demonstrate the relationship of the building to the landscape, and the landscape to the water, revealing that inclement conditions may render much of the site under the threat of ocean flooding.

Site Analysis: Emblematic Modeling

The site model presented here began as an exercise in representing the unique characteristics of the landscape. Construction of the model began by assembling chunks of hardened and discarded red clay on a found plywood base into a representation of the perceived elevations and prominent landforms of the site. Existing buildings were positioned atop.

Figure 4.15 Building section through existing structures on site, located on a portion of a long site section. White lines in the background indicate water levels at various tide conditions, the highest of which depicts storm surge effects during extreme weather events.
the clay, and the forms were then lashed down to the base by a single, continuous strand of hemp twine. Repeatedly looping and wrapping the twine over the forms and around the buildings created a woven topographical matt that, if interventions were not taken, would unravel the entire model when cut. This representation made plain the prominent yet delicate nature of the landscape and the potential for any additional built forms to drastically alter the nature of the site and its surrounding community. On other levels, this emblematic model represents the physical geography of the Quissett Harbor area. The woven matt derives its form from the objects below it, which in turn are stabilized by the presence of the string, just as the site’s land forms are determined by the area’s rocky deposits, which are held together with soil and vegetation.

Figure 4.16 Emblematic Site Model.
Figure 4.17  Emblematic site model depicting existing building on the approach to the site.

Figure 4.18  Emblematic site model depicting the existing buildings' relationship with the immediate landscape.
4.2 Design and Methodology

The following are exercises that attempt to define a common language for tackling issues pertaining to dying patients, the end of life, and terminal healthcare.

In-Dependance

The physical diagram presented here began as an investigation into the desire for independence even under the requirement of dependence. The hospice patient wishes to live out their lives in a manner that they choose, but they remain wholly reliant on some manner of structured support. Each horizontal or vertical string has been laid out over the orthogonal lines of the existing structure’s footprint. As indication of the reliance on a built form for, at the very least, shelter, these lines have been extended to create a girded framework. Points of interest on the site were

![Independence diagram shown in context with building section and site section drawings.](image-url)
selected and translated onto the diagram, each spawning a unique and growing web of experience that nevertheless remains dependent on the established lines to give it form.

**Figure 4.20** Points of asserted independence stretch the established grid of dependency, but are never truly separate from support it provides.
Wrappings

Each of the objects presented below had their origin as a common device or unwanted object with no relationship from one piece to another. This exercise was firstly an effort in unification, of finding a way to bring utterly different items together and making them to relate to one another. Completely wrapped in a single piece of hemp twine, one distinctive object now speaks to the experience of all the others, prompting an analogy to the truly universal process of dying.

As the nature of the objects moved from the mundane to the odd and then to the filthy, the actual process of wrapping them took on a role of its own. Not only did it unify each item, but it began to obscure certain characteristics that had made some items undesirable and unapproachable. As in palliative care medicine, the twine was treating unwanted symptoms and signs of deterioration, allowing others to see past an outward condition and interact with the form of the thing.
Lastly, like the emblematic model and the independence diagram before them, each of these objects possesses new, distinctive form and line patterns reliant on the original object for their existence. A single strand of twine is wrapped around an object, never relying on knots, glue or other fastening systems so that, when cut, lines and forms will unravel. It is the object that informs the end result and so too will the existing structures and landscape inform the design of a new hospice facility on the site.
Figure 4.26 Cross section of tree branch, wrapped in hemp twine.

Figure 4.27 Sea shell from Quissett Harbor beaches, wrapped in hemp twine.

Figure 4.28 Rusted, circular barbecue grill, wrapped in hemp twine.
Stepping Stone For Design.

Piecing together the information learned from these site analysis and design concept exercises has helped form a general scope and scale for the eventual building design. To lessen any impact on the site and to honor the rich fabric of the existing buildings, every effort will be made to adaptively reuse the main structures of the Quissett Harbor House. In keeping with this notion and the realization of the limits of the site, the facility will be kept fairly small in size, devoted to residential-care and respite-care services for 12 patient beds. Fewer beds reduces the amount of new construction required, but the nature of the site and existing buildings would overwhelm a smaller program. Housing more beds would invite stricter requirements at the behest of medical staff, and runs the risk of institutionalizing the created hospice.

The final design for ‘Quissett Harbor House,’ a hospice and palliative care center serving southwestern Cape Cod, will be carried out supplemental to the research and concepts presented in this document. It will seek to incorporate a panoptic model based on cooperative methods and not authoritative power struggles. Through a plan for adaptive reuse and a scale set by an easily manageable number of patients, prospect and refuge conditions can be accommodated at all levels of design. Issues of dependence and independence at the end of life will be brought to bear in the consideration of patient spaces and the creation of an environment for hospice that embodies, overall, death with dignity.
We will all have to deal with the issues and tough personal decisions that are inherent to caring for the dying. Whether we have had to face the decline and death of our grandparents, our parents or even a close friend, or whether we will have to consider our own needs and desires at the end of our own lives, we will all be witness and participant to the process of dying. When the time does come and we begin to lose command of our failing bodies, any chance to exert control over our experience will be welcome. Determining the environments in which we live out our last days is a powerful tool to achieve such control, ensuring that we remain in comfortable, familiar environments that house our memories and embody our life experiences.

Unfortunately, this method of personal control has been difficult to effect. The choice of environments for the dying patient are often inappropriate to their needs, either obstructing the physical requirements of medical care, or alternately denying emotional and spiritual experiences. It is the responsibility then, of architects and designers to provide appropriate environments for the dying process.

To understand how architecture can accomplish this, it is first important to look at why architecture hasn't comprehensively addressed death and dying until now. Delving into the issues and research has revealed that the mandate for such appropriate environments comes from those with the knowledge, power, and influence over the dying process. Until recently, that authority had long rested in the hands of the medical
institution and architects, therefore, worked to create built environments that focused on the technological advancements and intensive measures taken by doctors for the purpose of keeping the patient alive for as long as possible. However, these architectural responses and the medical procedures that inspired them did not seem to tally with the human experience at the end of life. Patients and their families desired a new focus on quality of life rather than quantity of life, and began a shift in authority away from the medical institution. We have seen the authority of the self emerge over the dying process.

Hospice care arose out of the desire to support the individual in their quest for autonomy in terminal care. Focused on palliative measures of alleviating pain and treating symptoms of terminal illnesses, hospice seeks to get patients back into comfortable environments to ensure a desired quality of life at the end of life. It can accomplish this goal in many ways, one of which, as argued by the research presented here, is to provide facilities designed specifically for administering the hospice philosophy. Hospice needs architecture to enable and enhance their program of care, and if architecture hopes to address the dying process, hospice is the ideal partner work with in support of the individual’s newfound authority.

This thesis has presented three approaches in the design of inpatient hospice facilities. The first is an understanding of the basic function of a hospice, delivering efficient and effective medical care at a moment’s notice, and offering comfortable, home-like environments. Precedents for these are found in the idea of the panopticon, a spatial exercise in observation, access and authority, and the concepts of prospect and refuge,
creating spaces for solitude, opportunities to observe one’s surroundings, and the chance to engage and interact with others. The second approach is to look at the programatic requirements of a self contained hospice. Successful facilities have determined the importance and hierarchy of spaces such as patient bedrooms, social gathering rooms, dining options, administrative offices, and nursing stations, among many others. Architectural gestures involving entry sequences, patterns of use, and interaction between indoor spaces and landscapes have been shown to warrant added attention in the hospice layout as well. The third approach addresses the representation of issues or concerns of the dying patient in built form as a way to enhance the experience of the individual. Design concepts explored by the author exemplify this, illustrating through emblematic spaces and physical exercises the desire for independence and individual control even while requiring the dependence on outside assistance. All three of these approaches must be used in concert by the architect in order to create appropriate environments for hospice care.

Architecture can indeed address the process of dying if partnered with the hospice community. Understanding the needs and requirements of hospice and respecting the authority of the individual patient will lead not only to improved environments, but improved awareness of end of life care. Death attitudes will not change overnight though. Dying is still a painful process to witness or go through, and the willful adoption of that pain is not something that will happen quickly or easily. Understanding this, the point of this thesis is not to provide an instant, universal ‘cure’ to the problem of
terminal care environments. Attempting to do so would be asserting the authority of the architect over that of the individual, mirroring the medical institution’s approach to dying, death and bereavement. If architecture were to do so, the form of the hospice facility would become rigid and proscribed, a direct conflict to the core of the hospice philosophy. Instead, this thesis highlights the importance of place in the lives of the dying and states that, like hospice, architecture must offer options and support, not limitations and direction. In an era in which personal authority leads people to seek a desired quality of life at the end of life, the research presented here acts as a starting point, a base of knowledge for the future design of terminal care environments. This thesis, and the design endeavors that follow will create an architectural language that will speak with clarity of the architecture of dying.
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