

# HONOURED GUESTS, HONOURED PLACES

An Essay by Ken Worpole

to

Promote Discussion on the issues of Design & Dignity

for the



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# 1 Preface

The Irish Hospice Foundation is a not-for-profit organisation whose vision is that no one should have to face death without appropriate care and support. The Foundation concerns itself with all issues related to dying, death and bereavement and its activities span home, hospice and hospitals – where the majority of people die.

The Foundation is initiating a national Hospice Friendly Hospitals Programme, in partnership with the Health Service Executive, to implement culture change by putting hospice principles into hospital practice. The programme will focus on four key themes: Integrated Care; Communications; Patient Autonomy; Design & Dignity and will address the needs of the patient and family, the staff and the hospital as a system.

This essay was commissioned in the Autumn of 2005 by the Hospice Friendly Hospitals Programme. It deals specifically with the architectural and design aspects of the care of people dying in hospitals, and the quality of the spaces and places in which the dying and those close to them may find themselves in at the end of life. The growth of the modern hospice movement seems to offer lessons which general hospitals, providing care at the end of life, might seek to emulate or adopt.

The general argument here is informed by evidence suggesting that patient-friendly architecture and design can provide support and comfort at such a significant time. Some prefer to use the term, human-friendly architecture, which responds to all those human needs which are under stress at such times – those of patients, certainly but also of staff, visitors, and others. In the same way that people design and furnish their homes and gardens around their own sense of well-being and identity, so too should health and hospital service planners and managers acknowledge that the environment in which patients and their families have to spend their most critical times, can either support or undermine feelings of dignity and self-worth, feelings which may form enduring life experiences for those who are left bereaved.

The opening sections focus on the long history of hospitals, their buildings, locations, landscape settings and changing ethos. Most people still have an ambivalent attitude towards hospitals: as places of hope and healing certainly, but also places of institutionalisation, loss of bodily and emotional autonomy, and even fear. Sweeping changes are now occurring in hospital services throughout the world, though one of their functions – as places in which increasing numbers of people are going to die – remains too little discussed. The ‘Hospice Friendly Hospital Programme’ seems especially timely in the scope of its concerns and sense of urgency, and it was gratifying to be asked to contribute in this way.

I would like to express my thanks to the Irish Hospice Foundation for commissioning this essay, and providing invaluable help in many ways. With the support of the Foundation and Atlantic Philanthropies I visited hospitals and hospices in Ireland, the UK and Scandinavia, where many people gave up time to answer questions, and engage in full and serious discussions about issues raised by the Hospice Friendly Hospitals Programme. There is no doubt that the question as how best to make the end of life for people in hospital as dignified as possible now exercises care professionals in the developed world.

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It should also be a priority concern for architects, designers, hospital managers and building administrators too.

Thanks are also due to the people who gave up their time to attend the 'Design and Dignity' workshop organised by the Irish Hospice Foundation at their headquarters in Dublin on 16 May 2006, and who contributed so many insights to the issues under discussion. Gratitude is further expressed to the following people whose ideas have been woven into the final report: Dr Mary Baines, Jens-Petter Bakjord; Jennet Berg; Rodd Bond; Ian Clarke; Louise Gray; Edwin Heathcote; Anne Hirsch; Anne Ingeborg; Charles Jencks; Orla Keegan; Valerie Mulvin; Nick Pahl; Denise Robinson; Thomas Schneider; Mervyn Taylor; Kate Trant; Erling Tronvik; and Inger Williams.

## HONOURED GUESTS, HONOURED PLACES

*'Over half of all people who die in Ireland each year die in hospitals. It is time to recognise the significance of this simple fact and to face up to its many implications.'*

'Dying and Death in an Acute Hospital', Care for People Dying in Hospitals Project, 2005

*'Overall standards of care in relation to the dying have declined. It was something we did better years ago, when we had proper regard for the value of the person and respect for human experience – dying being a wholly human experience. Privacy and dignity were accorded because it was the right thing to do.'*

Attendee, 'Design and Dignity' Seminar, Dublin, May 2006

## 2 Dying Well

Patrick Cockburn's recent memoir, *The Broken Boy* (2005), describes the unhappy experience of contracting polio in Cork in the 1950s. It is full of disturbing memories of hospitals. One of the most shocking is his account of talking to the physiotherapist who treated him, and who told him of her daily walk through a room filled with 'long bundles wrapped in white Hessian cloth'. She assumed this was dirty laundry, but subsequently discovered that these were the bodies of the poor, unclaimed by relatives, and awaiting burial in a mass grave.

Where people die, and how they die, is a subject that is still broached with some difficulty. In an ideal world everybody should die at home – preferably surrounded by a close and loving family. But of the almost 30,000 people who die in Ireland each year, most will die in hospitals and institutions. Some will have outlived their families, or become geographically distant or even estranged from them, and will die alone. In the UK up to 60 people die on their own at home each week, leading Liberal Democrat MP Paul Burstow to depict 'a stark picture of isolation, loneliness and, in many cases, impoverishment.' In such cases, spending one's last days in residential care may be preferable. An All Party Parliamentary Group on Dying Well has now been established in the UK.

These issues are of concern to the Irish Hospice Foundation. Working with them has involved visiting a number of hospitals and hospices in Ireland. In one former 18<sup>th</sup> century military academy, now acting principally as a hospital for elderly people, we were told that up to a third of the patients have no surviving family. A number of those will die on an open ward, shocking perhaps to some, but not to others who believe that the staff and other patients now represent a surrogate family.

Most hospitals, old and new, attempt to provide single rooms for those for whom death is imminent, though some patients refuse this option. Nevertheless, no matter how good the care and the attentiveness of the staff, many of Ireland's older hospitals are simply not good places from which to leave this world. One's last days ought to be spent in conditions of tranquillity and beauty – not facing a windowless wall, with a television blaring in the

background. Such truly awful conditions are rare, but it can and does still happen from time to time. In the words of one senior manager we spoke to, the elderly and the dying are 'the canaries in the coal-mine'. Their treatment alerts us to what may be going wrong in the priorities of society at a deeper level.

Dying in hospital usually, but not always, involves older people. It also affects all those of whatever age who have been diagnosed with a terminal illness, irreparably damaged in an accident, or who suffer some other fatal condition. The indignities of having to wait upon death in distressing circumstances affects the living equally. Some years ago I and close family members found ourselves in a waiting room outside the Intensive Care Unit of one of London's most prestigious hospitals. It was a narrow ante-chamber, filled with people in a state of anxiety and despair. We were amongst the lucky ones, finally brought good news. Yet in the 48 hours in which we were imprisoned by circumstances in this desperate room, two families had to endure the worst news there is – that their children had died - and they had to suffer this personal catastrophe in these cramped conditions, wholly without privacy.

The quality of the places and spaces at the end of life are crucial to the notion of dying well – which is not the same thing as learning to live with death, as some cancer patients and others suffering from a terminal condition need to do. Hospital planners, architects and hospital managers have a duty when they refurbish old buildings or plan new ones, to think long and hard about creating places of final sanctuary and farewell. Yet in one new Irish hospital visited, a room designed to hold the bodies of accident victims awaiting the arrival of the grief-stricken families had the grim nullity of a police-station holding room. Poor design and lack of control over lighting and heating combined to make a bad situation even worse.

Great changes are occurring in hospitals across the world. There are widespread moves towards providing single room accommodation for everybody in the hospitals of the future, and strategies are being developed to treat more people at home. The changing and more fluid set of relationships between the hospital, the hospice and the home is a key theme of this essay. In the last stages of their lives, many terminally ill people move between the hospice and home as medical needs require, though often with the intention that death finally occurs at home, as so many desire. Hospitals are beginning to seek the same flexibility, learning both from modern hotels, as well as the long tradition in which the hospital was by definition also a guest-house, a sanctuary, and a residential retreat.

Most people leave hospitals returned to health, but for others the hospital or hospice is the final stopping place on their journey in this world (even though many medical professionals have difficulty in recognising that hospitals are places in which people actually die). When death comes it should be to a place better than the freezing waiting room at Astapovo railway station, where we are told Tolstoy spent his last hours.

### 3 The Places of Death

Death is place-specific, though it occurs within a wider geography of human mortality. In fact the very place where death occurs is likely to be imprinted for ever in the minds of the witnesses and survivors. It is a common procedure in many hospitals that whenever possible the bereaved family and loved ones should be able to view the deceased in the bed and room (or public ward) where death occurred, before the body is removed to the mortuary or post-mortem room. This places a tremendous symbolic importance on the quality of this setting, which attains something of the notion of a sacred place. Sometimes the whole meaning of a person's life, and the memory of it, can turn on the experience of these last few days or hours.

So too can the experience of being told that one is terminally ill. This is the pronouncement of a death sentence, which, given the circumstances in which it is given, can either cause the person to lose hope immediately, or, instead, to choose to embrace what is left of life and to live differently. As one of the two principal instigators of the Maggie's Centres initiative - along with his wife Maggie Keswick Jencks who died of cancer in July 1995 - the designer Charles Jencks has said that when such pronouncements are made, 'The hardest decision is the decision to live.' Clinical, diagnostic and care buildings can either provide an environment for hope, or an environment for resignation and despair.



Mortuary Chapel, Our Lady of Lourdes Hospital Drogheda – before renovation



Death in a Norwegian hospital bedroom is marked by a special bedcover and with flowers and a candle outside the room.

As Maggie Keswick Jencks herself wrote, shortly before she died, ‘At the moment most hospital environments say to the patient, in effect: ‘How you feel is unimportant. You are not of value. Fit in with us, not us with you.’ And just as their experience of this ordeal inspired Charles and Maggie Jencks to set in train the development of the Maggie’s Centres, so too did the entirely and unnecessarily miserable death of his father, cause architect and academic, Stephen Verderber, to undertake with colleague, Ben J.Refuerzo, their inspiring study, ‘Innovations in Hospice Architecture’ (2006).

Yet despite these new initiatives, for many older people the experience of hospitals comes with a pre-history of popular memories and mythologies: the high-walled, blackened brick building (in England, often the former workhouse) on the hill, adjacent to the cemetery, now with a new notice-board; the labyrinthine hospital complex with buildings of all periods and designs randomly scattered between service roads and car parks impossible to navigate; the ominous - because windowless - mortuary building set in its own forbidding asphalt hinterland, and distinguished by the double doors and porte-cochère at the rear; the rubber and plastic door entrances; the corridors partially obstructed by broken medical equipment or old mattresses; the long corridors smelling of disinfectant; harsh neon lighting; wards and individuals rooms which are over-heated and under-ventilated; rooms in which candles and flowers are prohibited for health and safety reasons; box rooms filled with computer equipment to which people are called to be told confidentially that little further can be done through any kind of medical treatment; the views from the dirty windows across to a roofline of ventilation shafts and extractor fans; and so on.





A view of a cemetery from the entrance to an Irish hospital

If it is thought that such conditions belong to another place and time, here is the architectural correspondent on *The Financial Times*, Edwin Heathcote, describing his experience in 2005:

*'I spent more of last year than I would have liked in hospitals. Once you become ill and enter the system for treatment, a general assumption seems to descend that your time doesn't really matter any more...'*

*'It is an extremely peculiar situation in which you feel suddenly physically vulnerable at the exact time you are most traumatised. Days seem to go by in plastic stacking seats and sticky easy chairs, waiting in claustrophobic booths, perched on the edge of benches and beds, always waiting for blood tests, for nurses, for doctors, for results.'*

*'The bad news was given to me in a room the size of a Photo-me booth, with my wife and myself leaning precariously against a day-bed and a bunch of doctors lined up against the wall a foot away looking morose.'*

Here is another contemporary account, by the writer Alan Bennett:

*'He died on the Saturday morning when I was already on the train north, so when I saw his body on the Monday at Airedale Hospital he had been dead two days. The mortuary was somewhere at the back of the hospital; not a facility I suppose they wanted to make a show of, it was near the boiler room and the back doors of the kitchens. I was put into a curtained room (called the viewing room) where Dad lay under a terrible purple pall. There were two attendants, one of whom pulled back the shroud. It was a shocking sight. His face had shrunk and his teeth no longer fitted so that his mouth was set in a snarl, a look about as uncharacteristic of him as I could ever have imagined. It was the first time in his life (except it wasn't in his life) that he can have looked fierce. I noticed that the attendants were looking at me, more interested in my reactions than in the corpse which to them must have seemed commonplace.'*

Of course there will always be problems of over-crowding, lack of staff, inadequate funding for new wards and buildings, and the never-ending 're-structuring' of hospital administration. All these issues have to be tackled. But design also matters – and matters very much. Design cannot simply be reduced to issues of beautification, of heritage colour schemes or contemporary furnishing styles and aesthetics. Good design not only makes places and organisations look better, it also enables them to function more efficiently and achieve their goals more effectively – not necessarily at extra cost, sometimes even at less cost. How have we ended up with so many hospital interiors becoming, in architect Ian Clarke's words, 'exercises in sensory deprivation'?

For much hospital time is spent waiting, by patients and their visitors. Edwin Heathcote specifically noted that the assumption given by much hospital life is that 'your time doesn't really matter any more.' Yet waiting can be an exercise in cruel punishment, or offer opportunities for a state of calm self-reflection and a gathering of inner resources. The design of the places and spaces in which waiting occurs can tip the balance one way or the other.

Design, therefore, is an organising principle of the highest order of institutional and clinical success. Appropriate design enables individuals and organisations to see more clearly what is really happening and to exercise greater control. The improved design of hospitals should enable people to establish and sustain better relationships to each other and to the living world outside, and to find themselves in a calm and restful place, especially as they approach their last hours.

This is why there is some truth in the proposition put forward by the American writer, Robert Pogue Harrison, in his book, *The Dominion of the Dead* (2003) that 'only an architect can save us.' That book is about the redemptive power of architecture to house our human mortality, as it has so often in the past. For our own book on this subject, *Last Landscapes: the architecture of the cemetery in the West* (2003), the photographer Lorraine Worpole and I travelled throughout Europe, visiting and photographing burial sites from the pre-historic to the contemporary, seeking to understand just how crucial is the connection between the tomb, the monument, the burial ground and the wider landscape, as a means of establishing the connection between architecture and the meaningful inhabitation of the world, both for the living and the dead. The house at the end of life, for both the living and the dead, should be the culmination of what is best in architecture.

Some may think that architects are the last people to come to the aid of the sick or the dying, and in recent decades many of the best architects appear to have abandoned an interest in hospital design for more ambitious, iconic – usually corporate – building projects. It may be that the Maggie's Centres programme inaugurated in the UK, along with some of the best new hospital designs and practices now seen in Ireland, may reverse this trend, bringing the best architectural and design minds back to these quotidian places.



Maggie's Centre, Edinburgh, Scotland

It has happened before. In the mid 20<sup>th</sup> century hospital planners, administrators and architects in Ireland responded boldly to the widespread scourge of TB, creating buildings and landscape settings of great clarity and clinical optimism. If anything the functionalist, pared down minimalism of the early modern movement was ideally suited to the design of sanatorium buildings, and many of these buildings are now recognised among the best architectural achievements of the twentieth-century.

This was evident in our programme of visits, where in a number of Irish hospitals there were still single-storey sanatorium pavilions in use in the grounds (at Connolly Memorial Hospital, Blanchardstown and St Mary's in Phoenix Park, both in Dublin). These continued to function extremely well, though adapted to new uses. They offered much more stimulating environments to the patients within them – providing large amounts of natural light, access to sheltered terraces and even gardens - than the more forbidding barrack blocks seen elsewhere. While it is true that single-storey buildings are land-hungry, in the end society has to

choose its priorities: either to warehouse older people in barracks-like buildings, or provide them with something that seems like home, close to the earth, and with views on to landscapes and gardens which evoke another world. That is a political choice. What is also true is that architecture and interior design can fundamentally enrich the experience of both curative and palliative care.

## 4 A history of hospitality

The most obvious ways in which architecture has attended to the needs of the mortal human body, is through the design of buildings such as hospitals and other places of sanctuary or respite. Such institutions were found in ancient Greece; in Rome (*valetudinaria* for the care of sick slaves, gladiators and soldiers were said to have existed around 100 BC); and in ancient India. The earliest dedicated hospital building of which we still have floor plans is the hospital in Mihintale, Sri Lanka, dating from the 6<sup>th</sup> century. A visitor to Persia in 1160 found 60 hospitals in one city. Hospitals were established elsewhere in the Muslim world between the 8<sup>th</sup> and 12<sup>th</sup> centuries, particularly in Baghdad.

In medieval Europe, care for the sick fell to religious organisations, to the monasteries, as did the provision of alms-houses for the elderly. In the fifteenth century, Florence was known for its hospitals; in the 18<sup>th</sup> century, France had the largest hospital population in Europe, with over 2000 hospitals. The Royal Hospital at Kilmainham near Dublin (now the Irish Museum of Modern Art), was opened in 1684 for 300 invalid army veterans, and had many rooms in series (four men to a room), opening on to a gallery at ground level, and on to corridors on the floors above. In general terms, though, hospital building was still a rarity until the end of the 19<sup>th</sup> century. In the USA, for example, there were only two hospitals to be found in 1800; by 1873 this number had grown to 178, and by 1923, 4,978.

The historian Theodore Zeldin claims that ‘there have been periods when hospitals flourished, treating their patients with more or less respect, and others when they could not care less.’ Florence Nightingale once wrote that she ‘looked forward to the abolition of all hospitals.’ Different societies alternate between regarding the treatment of the sick and the care of the dying as something to be done in an institution or something to be done at home.

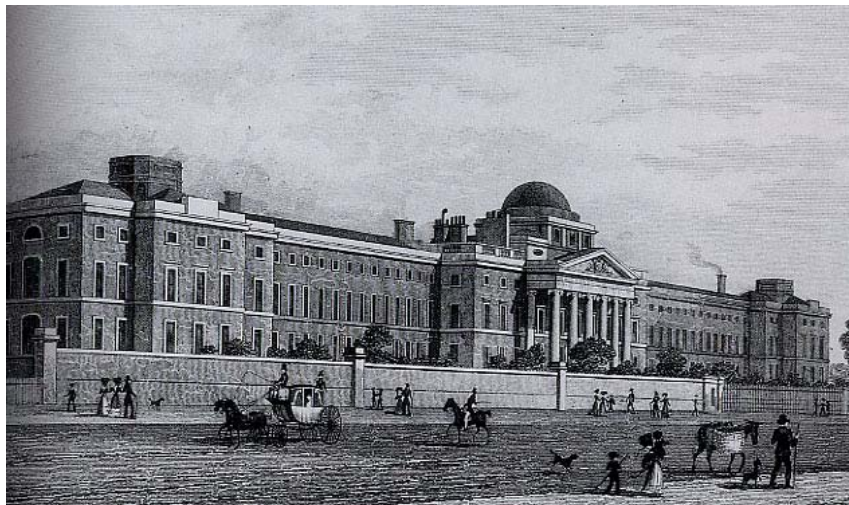
While most early European almshouses and hospitals were provided by religious orders, today they are more likely to be provided by the state, or occasionally by independent not-for-profit or profit-making trusts or corporations. Some of the more experimental therapeutic or care settings, such as Vidarkliniken in Sweden, are provided by quasi-religious or ethical movements such as the Rudolf Steiner community. In the UK, the architectural historian and landscape designer Charles Jencks, has pioneered a programme of ‘Maggie’s Centres’ in memory of his wife, Maggie Keswick Jencks, who died of cancer in 1995, as has already been observed. These are therapy centres designed by some of the world’s leading architects, intended to demonstrate that design can have an important therapeutic effect upon those suffering from serious or terminal illness. The ‘mixed economy’ of hospital and hospice provision is likely to expand. Innovation usually comes easier to the voluntary or private sector, or to those organisations that work at a smaller scale.

Early European hospitals often shared the cellular structure of monasteries, closed off from the world but with ambulatory space and courtyard gardens. This model was also found in alms-houses, and the tradition of the *begijnhof*, still strong in The Netherlands, which were sanctuaries for single women, where they could live independently and go out into the world, returning at night to a secure, gated retreat. Such hospitals would also function as hostels for pilgrims, and indeed the word hospital, derives from the Latin, *hospes* (hosts/guests), which is also the etymological root of hostel, hotel, hospice and hospitium. The oldest almshouse in Britain still in existence is the Hospital of St Oswald in Worcester,

said to date from 990; the almshouse at Kinsale, County Cork, built by Sir Robert Southwell to provide a home for eight people, was built in 1682. There is a Hospitium at York which acts as a lodging house for visitors to St Mary's Abbey close by, and another Hospitium at Reading for pilgrims to Reading Abbey. It is worth noting the retention of the word hospital with its origins in hospitality in Ireland, America and the UK and elsewhere, compared with the root etymology of the sjukhus, ziekenhuis or krankenhus (sick-house) in other countries and cultures such as Scandinavia, The Netherlands and Germany.

Almshouses and hospitals were inter-changeable names for similar institutions, sometimes also known as Spital Houses. The almshouses combined the root architectural form of the private dwelling (terraced house or cottage), replicated in series, to produce a larger collective institution, and often anchored by a chapel or refectory building, with a cupola, clock or sundial over the central door.

There is also a darker side to this history, or at least another perspective, which the French historian, Michel Foucault, once referred to as 'the great confinement'. In his view, the 1656 decree setting up the Hôpital Général in Paris was the start of a European-wide movement to establish institutions for those who were not properly settled within conventional family life for various reasons – old age, infirmity, ill-health, madness, poverty, vagrancy, loss of family, and so on. Although this appeared to be an act of charity, it was also an early form of social control (if not correction). 'For the next two centuries,' in the words of architectural historian, Thomas A. Markus, 'this programme consumed by far the largest slice of public building resources in the construction of poorhouses, workhouses, orphanages, almshouses, prisons, hospitals and asylums.' That architectural tradition is still with us today, in physical form but still also lingering in institutional mindsets and practices.



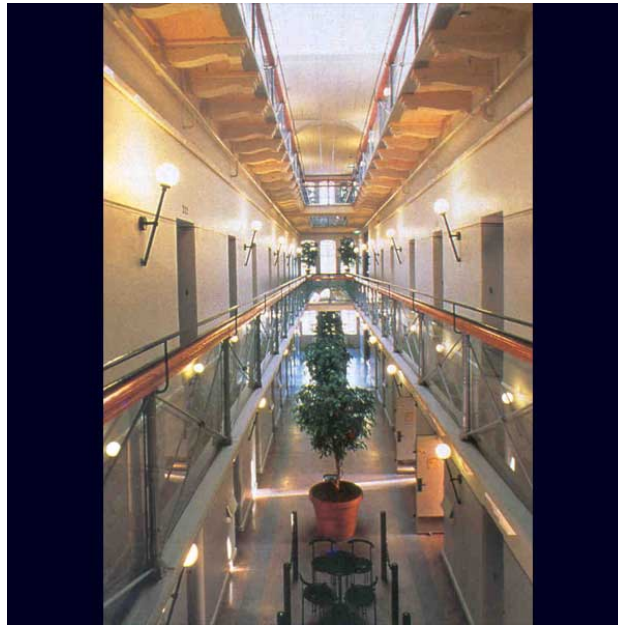
Bethlem Hospital opened in 1815 in south London, for the mentally ill. Originally the windows were unglazed to promote good health for the 200 patients. It is now the Imperial War Museum.

In this period the hospital was transformed as an architectural type, along with the prison and the school, becoming what has been described as a total institution, designed to make surveillance and the imposition of order as standardised as possible. Many hospitals also functioned as workhouses, which were publicly feared as places where the elderly - with husbands and wives sometimes separated on admission – eked out their last years in



authoritarian and forbidding surroundings. The boundaries between care, custody and correction often became blurred in such institutions, and ambiguities as to the prevailing ethos of these hospital types persists among many people – especially the elderly - even today.

The related purposes of hospitality, shelter and sanctuary created great similarities in the design of almshouses, hostels, hotels and hospitals (and indeed prisons), so much so that each could easily be adapted to serve the needs of another. This has become more evident in recent years, as a number of redundant hospitals have been successfully converted into apartments - the German Hospital in Hackney is just one of many examples. More astonishingly, perhaps, we have also witnessed former prisons being converted into hostels or hotels. Langholmen Youth Hostel in Stockholm is a former prison, as is the Malmaison Hotel in Oxford, opened in 2005.



Langholmen Youth Hostel, Stockholm – once a prison, now a hostel



Malmaison Hotel, Oxford – formerly Oxford Prison

## 5 The architectural family

A number of common design elements can be seen in the following building types or ensembles of buildings relating to the institutional custody or care of people away from home. This historical pattern book of types exemplifies the blurring of architectural and institutional ethics mentioned above.

Monastery	Sanatorium
Almshouse	Isolation hospital
Asylum	Spa village
Hospital	Retirement village
Workhouse	Convalescent home
Prison	Health Farm
Old people's home	Hotel
Nursing home	Hospice

If these building types exist on a continuum, then at one end you have the prison, a walled monolith, wholly impermeable to the society around it, whose only landscaping takes the form of a bare exercise yard. At the other end there is the health farm or retirement village, an elective campus or settlement, open to the world beyond, but distinguished perhaps by its architecture and setting, as well as by the ethos of the life lived voluntarily within. Here the provision of gardens or communal landscaping, exquisitely so in some places, is common. Sometimes the crossovers between building types and internal regimes are surprising. Some hospitals for the mentally ill (formerly known as asylums) have been run as prisons in all but name, whilst others have been designed and run as almost self-managing therapeutic communities, occupying village type settlements.

These institutions can be described schematically:

<b>Function</b>	<b>Building Type</b>
A self-enclosed community devoted to an over-arching ethos of religious observance, duty or care, with strict rules of entry	Convent Monastery
A settlement set apart from society for reasons of contagion or security	Leper colony Isolation hospital Asylum Prison
A residential community providing care, but whose residents belong to, and may be active, in the wider society	Almshouse Foyer Begijnhof
A residential community which sets itself physically apart from the wider society according to self-chosen criteria	Gated community Retirement village
A building or set of buildings providing hospitality and shelter to pilgrims, travellers or tourists, on a relatively casual or open-access basis	Youth hostel Inn Hotel
A building or set of buildings providing respite or health facilities on a paid,	Health Farm Rehabilitation clinic

voluntary basis	
A building or set of buildings providing diagnosis, treatment or palliative care for illness on a publicly accountable referral basis	Hospital Hospice

One thing the above share is that they either are established with a pre-ordained ethos (of care, custody or correction), or quickly develop one of their own, informally. This ethos may be for good or bad, and has been subject to much interesting sociological investigation, notably through the work of Erving Goffman. Sometimes the ethos of an institution and its staff can overcome the restrictions of the building. This was observed in our programme of visits, where we saw dedicated staff achieving home-like, caring conditions even in the most inappropriate buildings and settings. For other institutions, the design and regime are consciously intended to produce conditions which are unhomey: those of isolation, self-reflection and a sense of withdrawal from the world, whether chosen or imposed. But as we continue to observe, the boundaries of institutions are too frequently blurred, especially when the building form has been designed for one purpose but now finds itself used for another.

The blurring of boundaries often creates ambiguities within the public mind, as well as producing organisational problems. Private medical care has often promoted itself as offering hotel-quality accommodation and levels of comfort and service. Yet we were told by one administrator in a private hospital that leaning too far towards the hotel model had created problems with hygiene standards, owing to the design of interiors and the use of materials which were not really suitable for strict cleaning regimes. By definition acute hospitals have to place a priority on efficiency and rapid response clinical regimes, even though many patients are there for rest and recuperation.

Edwin Heathcote has suggested that the tendency towards blurring the boundaries between the hospital and the hotel only makes sense – if at all – if it is clear precisely what kind of hotel the service has in mind. There is a world of difference between a budget hotel which is little more than a cell with a bed and toilet facilities, and a luxury hotel suite designed to make visitors want to stay for as long as possible. The former might offer a model for a hygienic, private space for treatment and rapid recuperation – the latter certainly would not.

The more social benefits of higher grade hotel accommodation might be offered outside the place and regime of hospital care. This is now happening at University College Hospital, London, where patients receiving treatment for leukaemia and other malignant blood disorders, are accommodated, often along with family members, in the nearby Radisson Edwardian Grafton Hotel. This has proved to be cheaper than keeping them as patients on a ward. The system only applies of course to those patients able to function normally in between bouts of treatment. One of the London UCH consultants, Tony Goldstone, is quoted as saying that in future up to 20% of patients being seen regularly during the day may be sent to stay in nearby hostels or hotels, noting that many large cancer centres in the US have hotels provided by one of the larger chains on site. (Meikle 2005)



In St Olav's Hospital, Trondheim, in Norway, a patient hotel was opened in September 2004, with 110 rooms. The majority of the rooms are used by patients who need treatment on a daily basis but not full time medical supervision, including those who have come from more remote parts of the country. The top floor is given over entirely to the mothers and fathers of new-born babies who are given their own room six hours after birth, where they can stay for free for several days. Some cancer patients may stay for up to three months at the hotel while receiving treatment. There are emergency alarms in all rooms and all hotel staff have received basic medical training. Yet it looks and feels very much like a good quality modern hotel (in fact at least 20% of the rooms are let commercially), where people come and go as they wish. We were assured that it is cheaper to provide some patients with this kind of hotel accommodation than it would be to look after them as in-patients occupying a bed on a conventional ward. Such economic insights, counter-intuitive though they might be, are now at the forefront of what is called 'evidence-based design': how can better treatment be provided in much more amenable surroundings, and yet still not cost more?



A room in St Olav's Hospital Hotel, Trondheim



Lunch time at St Olav's Hospital Hotel, Trondheim

## 6 The rise of the hospice

The last hundred years has seen the development of a new kind of institution, the hospice. It has been claimed that, 'Our Lady's Hospice at Harold's Cross, Dublin, opened in 1879 by the Irish Sisters of Charity, in all likelihood represents...the first use of the term in the modern sense in the English language.' In the UK, the first dedicated hospice, St Joseph's in Hackney, London, was opened in 1905. These were religious institutions committed to the care of dying people, though not necessarily with a full knowledge of the use of drugs in pain control.



A roof statue on a Drogheda hospital serves as a reminder of the role once played by religious orders and the development of health services in Ireland.

It is commonly agreed that the pioneering example of the modern hospice movement was established by Cicely Saunders at St Christopher's Hospice in London in 1967, set in train with a bequest from a grateful hospital patient she had tended during his dying days. First and foremost in what it offered was 'total pain control': physical, emotional and spiritual. It remains a beacon institution and is today dedicated to education and research as well as direct palliative care. The first hospice in North America, Connecticut Hospice, New Haven, opened in 1974. Today there are now 8,500 hospice projects in 123 countries throughout the world, whose work is monitored and promulgated by organisations such as the International Observatory on End of Life Care at Lancaster University in the UK.

Hospices have attracted much favourable attention, and are regarded as sanctuaries of intense care and single-minded devotion. In one Swedish hospice visited, it was said that 'to die in a hospice is to be very modern'. Sometimes they appear to achieve their reputation at the expense of the general hospital, where palliative care if it exists is only one small part of the hospital's function. This is causing some people to ask for more hospices as one solution to the problem of how elderly people with complex and chronic conditions can spend their last days in dignified, personalised care.

But there are real problems here. The most obvious one is that of scale. Hospices are by their very nature small-scale, almost domestic in the buildings they inhabit and in the design of their interiors. However, while St Christopher's Hospice in London only has 48 bed spaces, it may be treating as many as 540 people in their homes. The building itself is only one small part of the hospice programme.

Many operate as trusts, funded by donations, bequests and endowments, and run by staff who feel a particular calling to look after the terminally ill. They also tend to specialise in the care of those with cancer, or some other aggressive or rapidly progressing terminal condition. Many will prioritise providing places for children or younger patients. The care of the vast majority of elderly people for some of whom dying may be a long, drawn-out process, has never been a principal concern of the hospice movement – nor is it likely to become so.

Hospices are singular institutions with a singular purpose. Removing people who are dying into separate buildings - especially older people – seems to go against the grain, with the potential to isolate and marginalise patients even further. So while all older people are bound to die sooner or later, conventional forms of residential care for the elderly, or the hospitalisation of older people for treatment ranging from minor to acute conditions, still offer a window of hope for a return to domestic life and care in the home. Nevertheless, there is much that hospitals providing care at the end of life can learn from the hospice experience, which is precisely the point of the Hospice Friendly Hospitals Programme.

General hospitals are a microcosm of the wider society, treating and accommodating the young and the old, the rich and the poor, the seriously ill and the short-term clinical patient. Large urban hospitals are almost like city-states themselves, the architectural critic Edwin Heathcote has argued, and they offer the vibrancy and cultural mix of a city, as well as the division of labour between service staff and doctors, residential accommodation for nurses, cafes, shops, and so on. Heathcote, like others, finds something still vital and attractive about the general hospital with its more varied social flows and connections to the wider world.

It is of course possible to create this open-house culture in a hospice. The new restaurant wing at Our Lady's Hospice, Harold's Cross in Dublin, serves patients, visitors, staff and other casual users, including members of An Garda Síochána (police service in the Republic of Ireland). The light, airy design of the building, the quality of the food and reasonable prices, have all helped create an unexpected bridgehead or connection back into the wider community, as the restaurant is also used and enjoyed by working taxi-drivers, and people living on the local housing estate. The advantage of city centre hospitals and hospices is this ability to overcome the problems of social and physical isolation from the rest of the world. Too often, it has been said, the elderly suffer a social death years before their physical death, as the places in which they find themselves are cut off from others.

Another good example of an institution for the elderly retaining this direct connection to the wider society is to be found in a new 120 bed old people's home in Soest near Utrecht in The Netherlands. Described as a 'nursing home without walls' it is located in the middle of the town, so that patients and visitors if they are able can use the shops and services of the local high street, and the nursing home canteen is in fact a café-bar open to everybody

in the town, providing a meeting place where the elderly no longer feel isolated. (Manthorp 2005)

Architecturally, much imagination has been exercised in the design of hospices for children. Robin House is the second CHAS (Children's Hospice Association Scotland) children's hospice in Scotland, designed by Gareth Hoskins and opened in 2005. It is set on an isolated site on farmland. The hospice caters for eight children at any one time, staying with their parents and siblings for between three and ten days, staying in their own suites of rooms. It is more about respite breaks for children and their families, rather than long term care, hence its distance from the nearest town, and its country hotel approach road and entrance lobby. The curved roof 'exudes a sense of quirkiness and playfulness'. The building mixes activity areas, spa pools and play areas, with a bereavement suite and quiet rooms.

In Norway a degree of scepticism about the hospice movement was apparent amongst some hospital professionals. This was not because there weren't wonderful examples to be found there, but because some felt that once a particularly charismatic hospice founder or leader had themselves died, or moved on, there were dangers that the hospice could become isolated from developments in palliative care being pioneered in the mainstream health service. 'A hospice should not be a place, but a set of contexts which can be reproduced anywhere,' was the opinion of one senior pastoral care worker interviewed. 'In our hospital we try to spread the lessons learned from palliative care throughout the whole hospital – and you would not get that if the hospice and the hospital were separate institutions.'

In the Vidarkliniken, near Stockholm in Sweden, patients with terminal illnesses were originally looked after in general wards, though this recently changed due to the development of a single-room policy and the decision to locate palliative care patients in one building. Nevertheless the idea that dying patients are regarded by other patients as 'honoured guests' still obtains.



A lakeside hut at Vidarkliniken, Stockholm

One particular strength of many hospices is that staff tend to stay working there for a very long time and become very committed to its ethos. Rather than being depleted emotionally by the constant presence of death amongst their patients, nursing staff seem to be strengthened by the relationships they create and foster. As so often it was noticeable that by far the majority of nursing staff in hospitals and hospices visited in Ireland, Norway and Sweden are women, particularly in hospices. At St Christopher's Hospice all of the home visiting teams are women.

Hospices have also learnt to handle the emotional needs of the nursing staff better, given that it is their principal role to care for the dying. In a general hospital dealing with sudden, traumatic or any other kind of death (especially that of children) can be distressing for younger or less experienced nursing and ancillary staff. They too need places where they can gather, sit quietly or talk afterwards, ideally with skilled help.

The staff are the principal assets and resources in the care of the terminally ill or dying, yet too often their needs for time and space to come to terms with the stresses of their work remain overlooked. A broom cupboard or changing room is the last place suitable for a good cry after a favourite patient has just died, nor is an overly religious chapel, particularly when it belongs to another faith.

## 7 Hospitals, hospices and homes

A hospital is not simply a building. In a recent essay on the transformation of the traditional 19<sup>th</sup> century hospital, Professor Nick Black has argued that there were three principal elements to the development of a wholly new approach to hospital provision towards the end of the 19<sup>th</sup> century: advances in medical knowledge, nursing reform, and improvements in buildings. Of these three, he highlights the latter two – a combination of new ideas in nursing allied to architectural advances - as constituting the principal cause of progress. ‘The sanitarians, of which Nightingale was a leading member, advocated fresh air, sunlight, ample space and cleanliness...In this way, Nightingale established a role for nurses, alongside architects, doctors and sanitary engineers, in the design of hospitals.’ Professor Black argues that medical advances were only forthcoming because hospitals had become well-organised, clean places managed by trained and experienced nurses ‘hugely committed to their duties’. In short, well-designed buildings allied to high standards of nursing were a pre-condition of medical advance.

Yet is this understanding of the importance of building space and quality appreciated in Ireland today in decision-making circles? One Irish architect commented in the course of this study that today ‘Departmental briefs are very mean on space, and areas which do not have defined clinical uses are minute – foyers, waiting rooms, interview rooms are all too small. There are also very defined ratios of wall to floor and wall to window, none of which contribute to good architectural quality...Good design needs space and daylight first and good materials second. If you haven’t got the first, the second cannot really solve the problems caused.’

The same architect singled out services engineers in particular for giving too little thought (or being too poorly briefed) to understand the importance which staff, patients and their families attach to the quality of, and personal control over, heating, lighting and ventilation, especially in wards or rooms in which some people may spend years of their life, or their last days. It is not surprising that in a consumer society, personal control of circumstances and private choices should now be ascendant – yet many hospitals have yet to come to terms with this enormous cultural shift. Choice is now inextricably linked up with ideas of self-worth and the armature of individual identity.

Nursing staff and patients (and their families), should be amongst the first to be consulted in the drawing up of design briefs for refurbishments or new build proposals, especially with regard to the care of the terminally ill or dying. This does not seem to be the case at present. However, it is not enough to consult on the details; patients, families and staff need to be consulted on the larger vision, raising expectations beyond matters of curtains or blinds, to real design issues of circulation, privacy, access to natural light and uplifting views, communal meeting places and other substantive design matters.

In the Hospice Suite in the Ersta Sjukhus in Stockholm which we visited, the Director of Nursing described how in the wholesale conversion of a set of traditional Nightingale wards into a hospice environment, the nursing staff insisted on having the final say regarding the design and furnishing of the new suite of rooms and communal spaces. What was achieved was an exquisite atmosphere and sense of hospitality like the very best

country hotel. In this sense the hospice offered something more than a home, domestic in feel perhaps, but with a more powerful sense of honour, dignity and occasion.

For at the end of life, the hospital also needs to transform itself into a home, offering a wider range of spaces than the functional ward, patient room, or medical consulting room. There will need to be rooms where patients and family can be taken to hear the clinical diagnosis, and be given time and space (in calm surroundings) in which to absorb the implications of bad news when it comes. There will need to be informal gathering places and spaces where families can meet and confer, and talk with care staff. Whether these places are called 'quiet rooms' or 'comfort rooms', the status and dignity of such rooms need to be respected at all times.



A family room at Accident and Emergency in Karolinska Hospital, Stockholm

There will also need to be guest rooms where close family or friends can stay overnight if need be; some may be able to stay in the patient's room if it is big enough and can still guarantee the privacy of the patient. Basic catering facilities and telephone services need to be provided for those keeping vigil. After death, there need to be respectful procedures and places provided during which the deceased can be washed, dressed and laid out for viewing by family and close friends and relatives.

The provision of these places and facilities is not expensive in capital terms, and can make an enormous difference, but unless such family rooms, ceremony rooms, or quiet rooms, are respected in their own right, they will quickly be colonised for administrative, medical or storage purposes, and lose their rationale. They do not always need to be rooms. The design of entrance halls, corridors, congregating areas, can offer opportunities for providing niches, setbacks, alcoves, smaller, more intimate places, where a table, chairs and tea-making facilities can be situated, not only providing meeting places for families and friends, but also enlivening the appearance of otherwise featureless corridors and halls.



One person at the Dublin seminar said that, 'I would add that facilities for the dying must be inherently valued by staff in order for them to prevail. To have rooms for the dying included at the design stage is not in itself enough – you must embed the behaviour that will support the use of the room for its intended purpose very early on when the building is occupied. This is our greatest challenge.'

Architects and designers can make an enormous difference. However, it was sobering to be told by one senior hospital administrator in Norway that, 'The problem is most architects are secular and they simply don't understand how deeply religious hospital buildings can be.' This wasn't a claim for overtly religious places and spaces, but it was a claim for a strong sense of ritual, of processional, of sanctuary and quietude in buildings and rooms that the newly born, the sick, the mentally distressed and the dying, inhabit in ways which we may never fully understand – until it happens to us.

There is also the issue of time and time pressures on staff and resources, especially in an era of targets and bed management. 'Aren't they dead yet?', has been heard in mock-ironic tones from a bed manager desperate to find beds for new patients. This was a common complaint in a number of hospitals. As general hospitals are managed to provide an even faster turnover of patients than ever before, the culture of the institution is in danger of becoming pre-occupied with bed management rather than looking after people. As was noted by one participant in Focus Groups conducted at Our Lady of Lourdes Hospital, Drogheda, 'time for dying patients and their families is a real issue.'

One workshop member drew attention to the difference between the ethos of the general hospital and that of the psychiatric hospital. In the case of the latter, the patient is ideally given as long as they need to stay and be cared for, whereas in hospitals the pressure for beds often means that time and space for the patient is kept to an absolute minimum. The psychiatric hospital is a sanctuary, the general hospital a high turnover clinical machine. As general hospitals become more like short-stay hotels, psychiatric units become more like residential communities.



## **8 The Evening Land: ambiances and interiors**

Architecture, it is often said, is a problem-solving discipline. Not only do buildings have to provide shelter, warmth, security and house a series of discrete functions, their design also has to anticipate and solve conflicts of use, different time patterns of use, and be adaptable to the introduction of new services, functions or technologies. For the care of the dying, anticipating and responding to this complex gathering point of physical and existential dynamics which dying incurs is of the greatest importance.

The issue of intrusive noise alone – the close or distant sounds of a vacuum cleaner, drilling, ambulance sirens, the broadcasting of Mass, the distress of other patients, the background soundtrack of nearby television or radio sets, as well as chatter from the nurses' station - is of extreme concern. This issue is picked up in the report, 'Dying and Death in An Acute Hospital' (2005). Careful design should be able to obviate or screen out some of these problems, while obviously management practices should attempt to solve others.

There is also a problem with both the compression and expansion of time during the hospital day, required to fit every eventuality in, particularly during times of high intake of new patients. While the patient's day often starts early, there is still too little time available for staff to spend too much non-clinical time with individual patients. The familiar time patterns and routines of home life are institutionalised into a feat of endurance. Ian Clarke has noted that, 'Conventional 'distractions' such as reading, TV/radio, are only of limited assistance – they may be difficult to sustain for more than a few minutes for patients who are very sick, and they take mental and physical effort. What is needed in addition is a truly multi-sensory environment which provides sensory interest on a moment to moment basis...the natural world provides this in abundance – changing light, the breeze, garden plants and trees swaying in the wind.' (Clarke 2006) The importance of views out onto gardens and landscapes cannot be over-emphasised.

Then there is the ubiquitous problem concerning the control of heating and lighting - in the building as a whole but even more importantly in individual rooms. What the sick and the dying (and their families) most often feel, as we have already seen, is a complete loss of control over their own situation and circumstances. Yet hospitals are still being built in which heating, lighting and access to fresh air, is controlled centrally – and often badly. Many hospital rooms are over-heated, sometimes creating difficulties when it is necessary to keep a dead body in a room for several hours, awaiting family members to attend. Garish strip lighting reduces human relations to those of the factory or interrogation centre.

A pre-occupation with health and safety continues to prevent, as we witnessed on a number of occasions, the opening of windows manually, the lighting of candles, the use of Venetian blinds to block out miserable views of the local cemetery, or the taking of a number of other little initiatives with which people would like to temporarily personalise these spaces, especially at such critical times. The opportunity to quickly create a different mise-en-scène through the use of lighting, personal belongings (such as family photographs), the addition of flowers – so common to the drama of religious ritual – is frequently disallowed.

There is also the issue of corridor clutter, rooms filled with unused or broken medical equipment, creating a general feeling of entropy or technological breakdown. At Sloan-Kettering Cancer Centre in New York, patients never get to see the fearsome technology of examination, scanning, surgery, or even minor elements of hospital procedures such as syringes and clinical equipment, in the normal course of a visit or stay. The technology of life and death is hidden off-stage. Anybody visiting a dentist's surgery for even the smallest matter appreciates how frightening and disturbing medical equipment can appear, particularly when you are already feeling vulnerable. The clear separation of caring and treatment functions is an important aspect of design.

## 9 A time and a place to die

This leads to a wider problem when dealing with the terminally ill or dying: the fraught battle which goes on, in acute hospitals particularly, between the competing values of human resignation and solace in the face of imminent death – though many still do rage against the dying of the light until the very end - and technological can-do wizardry. As one eminent American doctor has noted,

*'Few can turn quietly to the wall to go peacefully. For one thing, hospitals are too expensive a place to await a quiet death. For another, we doctors and nurses are not good at waiting. Our house staff are young and confident, eager to prove their mettle. In intensive care units the dying find no rest, but are kept in motion by machines blowing up their lungs and beating their hearts; electrical connections sometimes seem more important than the bodies they serve. There are few last words from dying patients because most have tubes in their throats; the staff are too busy shouting orders to hear them anyway.'* (Spiro 1996)

The design of the places where people are treated, cared for, and helped come to terms with approaching death, needs to be clear as to how the palliative and clinical functions are demarcated, or made to fit in congruence with each other. From my own experience attending the final moments of one parent and one parent-in-law - where both occurred in the frenetic conditions of an emergency ward - medical staff appeared to be in competition with nursing staff over the desirability of resuscitation. This left us family members as merely on-lookers, uncertain as to how and when the ultimate decision was going to be made – and by whom. This is not what anybody wanted.

There is a genuine dilemma for hospitals here, and is dealt with as a key issue in the report, 'Death and Dying in an Acute Hospital', where it was noted that 'The focus in acute medicine was on treating people rather than dealing with the reality of dying. The inherent tension between letting people die and 'doing everything we can' was an ongoing challenge.' By common agreement the principal function of hospitals is to save lives, to repair broken bodies, or to treat clinical conditions with drugs and therapy, returning people to the outside world as well as possible. It is not yet considered part of their core activity to help people die well.

In one Stockholm hospital, a senior nurse admitted to this dilemma, saying that it 'simply was not possible to die with dignity if the patient is wired up to machines'. On the other hand, it was also thought too alarming to family members keeping vigil to start switching

off machines or disconnecting patients who were clearly in their last hours or minutes, as this might look uncaring or precipitate, even though it might allow death to come more naturally. At St Christopher's Hospice in London, and no doubt in many others, there is a clear understanding that their core aim is to help people die without pain, and in circumstances that are as benign and supportive as possible. Medical intervention is simply not part of the programme, and X-Rays, blood tests, and even the taking of blood pressure, are all regarded as intrusive forms of treatment that can harm the palliative and dying process.



Accident and Emergency facilities in Karolinska Hospital, Stockholm

In a world of constant evaluation and target-setting, it would seem appropriate to propose that one new 'performance indicator' for hospitals would be that they provide full and proper conditions for the terminally ill patient and his or her family to be together in an environment of peace, tranquillity and attentive medical care. This is most easily achieved through the provision of single rooms for everybody.

There is now a large body of evidence supporting not only the medical advantages of single rooms – avoiding cross-infection particularly – but also demonstrating that the running costs of providing single rooms for all patients is no more costly in revenue terms than in continuing with public wards. (Single and Multiple Occupancy Patient Room Study, 2003) For those in palliative care, single rooms can bring privacy to the patient and family, particularly when medical staff are discussing confidential matters with them, but they also offer the increased dignity of having one's own toilet and washing facilities – and even an armchair or couch where a family member or visitor might stay overnight. In all of the new palliative care wards at St Olav's in Trondheim, the rooms are arranged in clusters ('Sengetun' – bed courtyards) around the nursing station, and it is said that not only do nurses save a lot of time not having to walk up and down long wards any more, but feel closer and more involved with their patients because of this spatial arrangement.

While the advantages of single room accommodation are now evident, there are still some benefits to be had from multi-occupancy rooms, where these are well designed. People are sociable beings, and for many older people there may be few visitors, and the ability to

form relationships with other patients can be of real value. Design can create multi-occupancy rooms which offer patients the choice of feeling they are in a private space, but which also offer the choice of engaging with others as and when desired. Designs by the architectural practice Jane Darbyshire and David Kendall for the CABE Healthy Hospitals programme provide good examples.

It is also the case that in the foreseeable future most elderly patients in hospital will continue to be accommodated in rooms or wards shared with other patients. The worst of all possible worlds is to move people from shared wards into a single room at the very end, as it symbolises to both the patient and all others, that death is a shameful thing to be hidden away. At St Christopher's Hospice, where there are single rooms and four-bed rooms, any patient admitted to a four-bed room will remain there until they die. Many visitors have been greatly impressed with the work carried out to personalise bed areas at The Royal Hospital Donnybrook in Dublin, even though the greater space accorded to each patient has meant a small loss of bed numbers. This surely is a price worth paying to achieve this increased sense of personal autonomy and homeliness.

The continuation of the use of public wards in the foreseeable future puts an additional onus on hospital administrators to ensure that privacy and respect can still be afforded to each patient and their family, for as the Irish Ombudsman has recently stated, 'Patients admitted to health care establishments have the right to expect physical facilities which ensure privacy, particularly when health care providers are offering them personal care or carrying out examinations or treatment.' Furthermore, the Ombudsman asserted 'the right of people who are dying in hospitals to a dignified death, pain free as is possible, and in conditions which enhance their dignity and privacy.'

Places are more than just buildings. There was once a strong tradition of setting hospitals in well-maintained grounds, where patients could walk or sit amongst trees and flowers, if health or mobility allowed this. Other patients might be taken out in beds or wheelchairs on to balconies or terraces overlooking such gardens, both for the fresh air and the uplifting views. Hospices such as Trinity Hospice, Clapham Common, St Joseph's in Hackney, and St Christopher's, all in London, make a central feature of their gardens, and indeed are famous for them. The same is true of the growing number of Maggie's Centres, where complementary landscaping is every much part of the design brief as the building itself.



Gardens at St Christopher's Hospice, Sydenham, London

All these bodies would claim that a close relationship - and even engagement with - the natural world of trees, shrubs, plants, flowers and water, can be immensely therapeutic and morale-raising. One commentator on the design of the new St Oswald's Children's Hospice in Newcastle by JDDK claimed that even a view of nature through a window could be as rewarding as being in the garden itself: 'Offering glimpses of greenery can be as important as providing access to gardens.' (CABE 2006) Indeed there is a whole movement devoted to the therapeutic value of providing natural settings to hospitals and other places of respite and physical sanctuary, even claiming that an investment in well-kept grounds and gardens was a cost-effective way of aiding an improvement in morale without the use of drugs (and even faster recovery times for those hospitalised for treatable conditions).



Hospital de la Sante Creu, Barcelona

In any case, who could doubt that a view of a garden is to be preferred over a view of an industrial estate or adjacent boiler-houses, incinerators and service yards. The monastic tradition, as well as the almshouse tradition, located buildings, rooms and corridors around a central courtyard or garden. In the design of sanatoria as well as hospitals for the mentally ill, the landscaping of grounds and gardens was part of the basic design brief. Yet in a number of hospitals visited, the grounds were often poorly maintained, and in some cases prohibited to patients - decisions not fully transparent or reasonable to outsiders.

## 10 Past, present & future: the importance of evidence-based design

There is now a considerable body of evidence to show that well-designed and well-maintained buildings and gardens can improve the well-being, morale (and even efficiency) of those who live, work or visit them. The new report by The Institute of Public Health in Ireland, 'Health Impacts of the Built Environment: A Review', a review of international research is summarised as follows:

*'Well-designed hospitals which take into consideration patient and staff requirements can have a positive impact on patient outcomes, staff performance and staff and patient safety.'*

Another survey of research into patient-friendly hospital environments concluded that:

*'The design of the built environment of the hospital can have a major effect on the degree of 'social interaction' that takes place. Some interviewees describe this in relation to the importance of the positioning of beds or furniture within a ward that makes it easier for patients to interact with each other. For others, it meant having places to go either alone or where they could mix socially with others. For many, this idea of homeliness was defined by the presence or provision of places that they could offer visitors a cup of tea, or for long stay patients, somewhere they could go for a meal with friends or family. Their suggestions for how this could be addressed in future design models included the provision of café bars, restaurants, gardens and leisure facilities that they could use with families and friends.'* (CH Douglas & MR Douglas 2004)

In the clinical sphere, there is a body of specialist research demonstrating how aspects of design can alleviate distress, comfort, and even inspire staff and patients. With regard to those specifically concerned with the care and well-being of people dying in hospital, this is especially important.

Evidence-based design is both an old and a new science. Those who designed the early monasteries and almshouses were often attentive to the detail of how individual rooms and wards related to issues of light, access to sheltered ambulatories, as well as to gardens. Modern evidence-based design is rather more focused, in that it often breaks down design into multiple elements such as air quality, light, noise reduction and sound-proofing, ergonomics, distances between staff and patients, views of nature, use of sympathetic materials, use of colour in interior design, and flexibility of layout to allow for single and multiple uses of individual rooms and work-spaces, and so on. While it is hard to agglomerate all these factors into a single assertion that good design is proven to produce greater peace of mind and improved staff and patient outcomes, few will now gainsay that this is clearly the case. On every indices now studied, environmental factors can now be shown to be instrumental to human well-being and sense of value and dignity.

For the purposes of definition in this essay, design includes the basic structure and architectural type of the building or settlement – its external appearance, its immediate setting, its basic floor plans – as well as matters of interior design, light, ventilation, heating, colour, ease and legibility of circulation, hierarchies of spaces (professional,

technical, public, private and intimate), physical accessibility, flexibility and adaptability, ease of cleaning and maintaining, links to internal courtyards and gardens. These elements are outlined as follows:

## **SOME KEY ELEMENTS IN THE DESIGN OF PATIENT-FRIENDLY BUILDINGS AND SPACES**

**The design brief.** It is vital that the needs and interests of patients and staff are at the centre of any refurbishment or new-build programme. Yet there is still too little experience in developing design briefs at a local level, which invariably means that standardised hospital or care plans are rolled out as the quickest and easiest way forward. Time spent on consulting staff and patients, and customising the design and furnishings of new care places, may be recouped through improved patient and staff morale.

**The dilemma of location.** Many care units are housed in or adjacent to older hospitals, some in busy urban settings which can be quite noisy and offer few attractive vistas or spaces for patient open-air recreation. Yet this allows for 'close functional and operational links between the unit and the acute hospital.' (Marymount Hospice 2005) They are also much more easily accessible to visitors using a variety of transport means. On the other hand rural settings can provide greater tranquillity (and more space and low rise accommodation which lower land prices allow) for residential homes for the elderly, hospices or palliative care in-patient units, but at the price of social and medical isolation and difficulties of transport and visitor access.

**Transport issues.** These play a vital part in the early stages of location choice and decision-making around ease of visiting and access. Given the reality that many if not most visitors will travel by car – especially in periods of medical crisis – then access and ease of car parking are vital to close family and friends of hospital patients. In whatever form car parking facilities are provided, they should not visually dominate the hospital landscape, or provide an obstacle course to pedestrians and other hospital visitors.

**Exterior form and appearance.** This should seek to express the ideals and values of the care regime within; where an older and more monumental building is still being used, its forbidding appearance can be tempered by new exterior detailing, landscaping and coherent signage.

**Imaginative landscaping.** Well-designed landscapes can easily (and at relatively low cost) soften the appearance of a difficult building or set of buildings, as well as providing attractive vistas for patients within. The deterioration in quality of hospital landscapes and gardens in recent years is sadly evident in many places.

**Reception and internal signage.** These should offer welcoming and coherent messages to visitors, particularly since many may be in distress or may not know the building from previous experience;

**The move to single rooms.** This is occurring in hospitals across the world, and is especially important to the care, privacy and dignity of those in end of life care. The spatial arrangement of these single rooms – in clusters around the nursing station for example –



can allow closer distances between staff and patients, saving time on walking distances which can be spent on direct care.

**The nursing station.** This may need to be rethought, especially in regard to some of the disadvantages they offer in terms of confidentiality of records and diagnostic conversations, distance from beds, and a reinforcement of a 'them and us' spatial configuration.

**Lighting, heating and access to fresh air.** These should be controllable on a room by room basis – not centrally.

**Private spaces and multi-functional rooms.** A variety of private spaces, rooms and seating areas for friends and family, with refreshment facilities, and easy telephone access, should be available to patients, staff and visitors. Easily accessible private spaces are crucial to the process of breaking bad news, confidential consultations, family and staff discussions and emotional release and recovery. The management and care of these spaces should be made explicit in day to day hospital activity. Multi-functional use of rooms, in hospitals where private spaces can be difficult to find or develop, needs to be actively promoted.

**Learning from hospices.** It is recommended that the interior design of palliative care accommodation and places for those in a critical or terminal medical condition, should move towards a more domestic aesthetic in decoration, furnishings and fittings;

**Medical technology.** At the end of life, technology becomes less important, and personal relationships, companionship and spiritual matters take priority. In such conditions medical equipment should be hidden or back grounded as much as possible.

**Overnight rooms.** These and the provision of bed-settees in patients' rooms, for family members who wish to stay, should become much more readily available.

**The transfer to mortuary.** This should be a dignified ritual, given appropriate time for family to come to terms with the death where it occurred on the ward or in the single room, preferably using a hospital bed – rather than man-handling bodies from one trolley or gurney to another – and following pre-designated routes which avoid passing through inappropriate spaces and places.



**Mortuary chapels.** There should be thoughtfully designed mortuary chapels or viewing rooms where loved ones can spend time with the body of the recently deceased, without interruption, and with dedicated entrances and exits away from the hustle and bustle of routine hospital life.

Good design should not only allow patients and staff to interact more easily, and to feel part of a community rather than an institution, but, as importantly, it should embody the best ideas about the greater use of natural lighting, natural ventilation, and efficiency of cleaning and maintenance regimes. The MRSA crisis which has hit many hospitals has re-focused attention back to elementary issues such as the daily hygiene regime, which hi-tech surgical innovations often displaced in the public attention, but are as important to health and well-being as surgery itself, possibly more so.

However, very few initiatives to improve the conditions of those dying in hospitals will be based on the commissioning of new buildings. Many of them will have to be based on adaptations, extensions, or the 'retro-fitting' of existing buildings and campuses to meet such higher expectations and standards. In either case, a clear brief for the work to be done and the outcomes to be achieved will be necessary. Yet most hospital organisations understandably have little experience of preparing such briefs. The US health design academic, Professor Roger Ulrich, when asked to advise the UK NHS Estates, found that 79% of UK health trusts had little or no in-house experience in preparing briefs for future hospital improvements or development.

It is hoped that this essay can promote discussion, so that past, present and future hospital provision in Ireland becomes more patient-centred, especially for those who are terminally ill or dying. There is much to learn from the hospice movement, but both hospitals and hospices ought to be complementary places, aiding each other's work and good practice. In turn both are likely to develop a stronger relationship with the patient's home, so that wherever the patient finally dies, the hospital, the hospice and the home, are seen to have been part of a continuous circle of care, sanctuary and respect.

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