

The Scenic Pathway

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Master Thesis explanatory document
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The Scenic Pathway

An Architectural research project exploring an atmosphere around those facing their imminent demise.

We shall not cease from exploration

And the end of all our exploring

Will be to arrive where we started

And know the place for the first time

T.S.Eliot

A Research Project submitted in partial fulfilment of the requirements for the degree of Master of Architecture Professional.
Unitec Institute of Technology, 2016

Abstract

This research project endeavours to develop a design for a room and its supportive context that seeks to nurture a dying individual - dying that is supported by the architecture.

“Architecture creates the places where human time takes place”¹

While the concepts around death and dying are very taboo the design process here sensitively confronts and explores the journey of palliative care through its connection to nature at human scale, notions of protection and sanctuary away from the institution, scenes of intimacy and sensory qualities as well as social aspects of inwardness and outwardness.

¹ Ken Warpole, *Modern hospice design The Architecture of Palliative care*, (Abingdon, Routledge, 2009), 96.

² Verderber, Stephen & Refuerzo, Ben J., *Innovations in Hospice Architecture*, (Oxon, Taylor & Francis, 2006), 3.

Acknowledgements

First and foremost thank you to my wonderful family for your unwavering support and encouragement throughout this whole process.

I would also like to thank my supervisor David Chaplin for your constant belief in me and my project and guidance along the way. To Carla Goebel who has gone above and beyond to help me see this through.

To Janine Ewan at Dove House thank you for your enthusiasm in my work, taking the time to answer my questions, and for sharing with me your insight and knowledge.

Finally to my incredible friends who have continuously supported, encouraged and inspired me throughout this project and my years at Uni.

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1.0 INTRODUCTION

1.1 Research Question

How can the design of the interior (connection with one's self) and exterior (social community) of the "Room" in a hospice focus on the autonomy of those dying people who wish to die with honour and grace? How can the architecture of a hospice provide the right atmosphere so as to allow its users "the right to a good death"?

1.2 Aims and Objectives

*"When confronted with designing for death and dying, the architect is called upon to envision for those who will soon vanish"*²

To carefully study the way death and dying is dealt with in contemporary society particularly in western views. Different situations and circumstances can evoke diverse atmospheres around this stage in our lives. This project rests on the premise that dying exists within the natural processes of life and as such the brief seeks to acknowledge this. I will explore with this project how the design of a hospice can celebrate and sanctify the act of 'dying' in its design. This project aims to create an atmosphere and environment that can be an uplifting and honourable/positive/empowering experience around the terminally ill and their support; a space (outside of the home) that will help them deal with what is happening in all forms of comfort (physical, emotional and spiritual).

² Verderber, Stephen & Refuerzo, Ben J., *Innovations in Hospice Architecture*, (Oxon, Taylor & Francis, 2006), 3.

My primary aim is to focus on the people the building will accommodate (dying that is supported by the architecture), secondary to the services the building will provide. “A hospice needs not wrap itself around its own tectonic armamentarium,”³ instead the emphasis will be on human contact and social interaction rather than spaces devoted to high-tech diagnostic and testing machinery, hospices can be planned and designed nearly entirely for human inhabitation and social interaction. The hospice is the background that the final days of a person’s life are played out in front of; the scenes that surround the act of dying can happen and be honoured by the spaces, lighting, material and colour all adding up to an atmosphere that honours the end of a person’s life.

In this project I intend to investigate how cultures deal with the inevitability of the approaching death of a person, concentrating on the physical environment around this person. The focus will be on designing a style of hospice/palliative care centre that would encompass the needs of cultures within a New Zealand urban environment.

“Where death is involved, matters of human reassurance and comfort surely come to the fore”⁴

Mortality due to heart disease and cancer are rapidly increasing, leading to many more deaths occurring outside the home. Palliative care is a developing area within New Zealand, and statistics show there is a real need to facilitate this in communities around the country, particularly within the city. The majority of occupants entering into palliative care are terminally ill with cancer. Statistics show that:

- In 2000, approximately 90% of people known to be accessing hospice palliative care services had cancer.⁵ (source palliative care strategy 2001)

³ Verderber, Stephen & Refuerzo, Ben J., *Innovations in Hospice Architecture*, (Oxon, Taylor & Francis, 2006), 32

⁴ Ken Warpole, *Modern hospice design The Architecture of Palliative care*, (Abingdon, Routledge, 2009), 10

⁵ “Palliative care strategy 2001,” <http://www.slideshare.net/chrispaton/jan-nichols-strategic-directions-in-palliative-care-a-nz-perspective>, (Accessed October 26, 2010).

While the New Zealand hospice movement continues to expand, and influences palliative care treatment in mainstream hospitals as well; this progress highlights ethical issues around the time and conditions in which people die. The role of design in overcoming the limitations of what are often highly sterile and functional spaces arises from this development. My aim is to explore how design can embrace a sense of “privileged ritual and ethos” before the functional needs of the building.

1.3 Project Outline

This project will firstly outline contemporary views around death and dying and consider a historical analysis of the history of the hospice, and the modern hospice movement. Studies on palliative care in New Zealand address the fact that it lacks the needed cultural knowledge and sensitivity, and I will uncover the lack of empathy around certain cultures, in particular, the Māori culture. I will then investigate some of the unique needs of various cultures in NZ briefly and then look at how the design of a space might address these.

I will examine Elizabeth Kubler-Ross stages of dying to gain some insight into the dying process. I will then explore the Buddhist and Māori relationship to the body (for example the Māori stay with it) and perhaps this is something that might be accommodated later in my design process. I hope that that a variety of cultural rituals might be observed thus connecting various building users.

Precedent studies are then carried out along with a site analysis, which considers the aptness of the site and proposed location, and draws on the sense of place before I utilise the knowledge gained by my research in a design process. The design process begins with the design of the 'room' (the interior) by establishing atmospheric qualities essential for a space in which one will spend their last days. Adaptability of the room to meet individual 'death plan' or various cultural needs of the person dying. I will be exploring spatial sequencing – journey through the building – the scenic pathway as a metaphor of the journey preparing for death. I will be aiming to design a building that will allow for beautiful rituals to take place that is:

- open to the essence of Māori & Pakeha culture.
- with the focus on the "Room."
- a built environment that is sensitive to cultural rituals and values around a dying person and their support.
- addresses loss.

1.4 Scope and Limitations

The biggest limitation I have encountered thus far is around the broadness of this subject concerning how it can be perceived and interpreted around patient centred care. I have also found these limitations:

- The huge variation in the perception we have of each of the many different cultures and how to apply these to a “special design space.”
- The time to adequately research the entirety of this subject
- The topic of death and dying and how sensitive it is and how each individual’s perceptions of this subject are continuously evolving
- The belief in spirituality varies greatly

2.0 CURRENT STATE OF KNOWLEDGE

2.1 Death and Dying in Contemporary Society/ Attitudes towards Death and Dying

“We fear what we don’t know” Deepak Chopra

“We would think that our great emancipation, our knowledge of science and of man, had given us better ways and means to prepare ourselves and our families for this inevitable happening. Instead the days are gone when man was allowed to die in peace and dignity in his own home.”⁶

Prior to the 20th century, dying was accepted as part of life’s journey; the meaning and ceremony surrounding it was accepted and nurtured as part of life. Our ancestors took it as ‘nature’s rhythm’, an accepted and inevitable occurrence, and as such each individual’s death was celebrated and experienced by the whole community. Death would usually occur at home, and the mourning process would arise in the context of the dead person’s life. Behaviours, customs and rituals were openly expressed and involved keeping the dying patient as a member of the family and community until they die. The culture and understanding of those relationships facilitated the grieving and healing of those left behind. The rituals practised with the passing of a loved one were an integral part of cultural values.

Thanks to science we can expect to live longer, but death is, of course, inevitable. There are far fewer deaths as a result of infection, but death due to heart disease and cancer is rapidly on the rise leading to many more protracted deaths occurring outside of the dying person’s life context.

The emphasis has become more focused on the medical environment and less on the needs of the patient. The development of medical technologies has prolonged life and transformed the process of dying outside the home because the medical profession has accepted a role that refuses to give up on the effort to save somebody’s life. They risk professional legal responsibilities as they balance letting people die with dignity, with the need for intervention to sustain (even without dignity) life. The ethical balance between humanistic orientation to their dying patients and technical intervention is something each physician must face.

⁶ Elisabeth Kubler-Ross, *On Death and Dying*, (Great Britain, Tavistock Publications Limited, 1970), 17.

Death has become a medicalised and controlled process for many that is frequently hidden away from view and “*often comes without tenderness, comfort, or serenity*”⁷

It is evident that medicalization has had a significant effect on how we perceive and deal with death in contemporary society. “*In this culture to not get better - decline, to die – is to fail... popular culture inevitably isolates the sick, the dying, and the grieving*”⁸. With the removal of death and dying from the community and its relocation to the hospital, a shift from the social body to the individual body concerning death and dying led to the contemporary desire to hide deaths experience and organisation away from public domain.

Perhaps there is some reassurance to be had in handing over our dying loved ones to professionals; we can alleviate some of the basic human apprehension of the unknown. The paradox is of course that we perpetuate our ineffectualness when dying is removed from the community as we are robbed of the opportunity to confront death. There is a certain dignity to be had that comes with acceptance and ritual of these important life passages. We divorce ourselves from this experience by leaving it all to the specialists.

2.2 A Brief History of the Hospice

“*Historically 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 and respite.*”⁹ Such buildings could be found in Ancient Greece (around 100BC) known as healing temples dedicated to the Greek god of healing Asclepius. Patients who were considered chronically or terminally ill would visit these sanctuaries built far from the heat and noise of cities and towns, and they always had fresh water sources and a magnificent view of the sea and surroundings.¹⁰ It is clear that they had addressed right from the beginning.

⁷ Kubler Ross, Elisabeth, *On Death and Dying*, (Great Britain, Tavistock Publications Limited, 1970), 17.

⁸ Verderber, Stephen & Refuerzo, Ben J., *Innovations in Hospice Architecture*, Oxon, (Taylor & Francis, 2006), 14.

⁹ Ken Warpole, *Modern hospice design The Architecture of Palliative care*, (Abingdon, Routledge, 2009), 14.

¹⁰ Esther M. Sternberg, M.D, *Healing Spaces – The science of place and Well-Being*, (United States of America, 2009), 220.

Linguistically the word *hospice* stems from the Latin word 'hospitum' meaning "guesthouse". These 'guesthouses' were a place of shelter for sick and weary travellers and pilgrims returning from lengthily and arduous journeys throughout Europe and lands beyond. During the Middle Ages many of the religiously operated hospitals provided "Hospice" quarters which consisted of private rooms for travellers who were unable to travel any further due to illness and exhaustion and needed some respite and shelter to rejuvenate.¹¹ Its adoption as a term exclusively denoting a place of care for the dying did not happen until the end of the nineteenth century.

Almshouses were "poorhouses" created predating the industrial age for the elderly and those who were without family or support. Both Almshouses & monasteries alike offered sequestered sanctuaries with internal courtyards and gardens. Early European hospitals would have similarities to the principal elements of these early monasteries being concealed off from the outside world but having within their walls ambulatory space and beautiful courtyard gardens.¹²

¹¹ Verderber, Stephen & Refuerzo, Ben J., *Innovations in Hospice Architecture*, (Oxon, Taylor & Francis, 2006), 10.

¹² Ibid, 15.



Figure 2.1.1: Internal courtyard overlooking nature in Geffrye Almshouse, London.

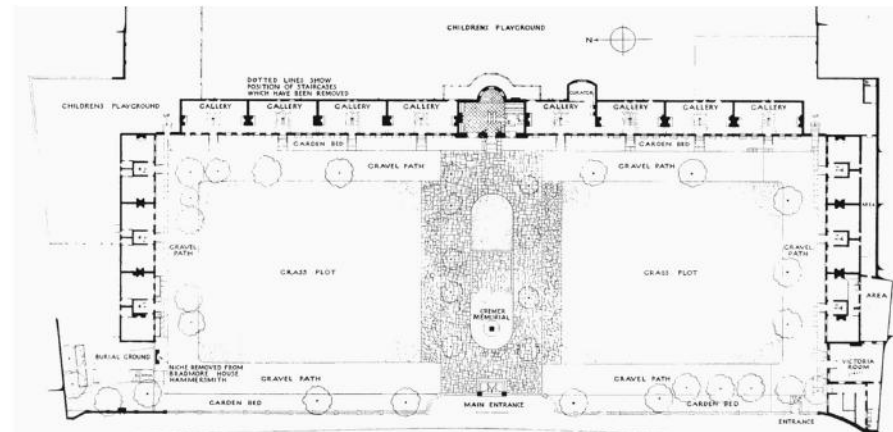


Figure 2.1.2: Plan of Geffrye Almshouse, London.

During the 18th century when society was changing rapidly and becoming more urbanised with the industrial revolution there became more apparent need for patient treatment institutions on a larger scale. The now burgeoning population made up of people leaving their communities where they were once cared for by their families now required a place for rehabilitation and care or in some cases a final resting place before dying.

In 1842 a hospice for the dying was opened in Lyon France by Mm Jeanne Garnier and later Our Lady's Hospice at Harolds Cross Dublin was opened in 1879 by the Irish Sisters of Charity. It was here that the term 'hospice' was first used in the modern sense that it is now used today associated with the English language.

*"No one comes here expecting to be cured, nor is it a home for incurables, as the patients do not look forward to spending years in the place. It is simply a 'hospice' where those received who have very soon to die, and who know not where to lay their weary heads"*¹³

In 1891 Trinity Hospice was founded in London. It is one the oldest and largest Hospices still in operation in London that operates three wards for inpatient care St Michael's is the largest of the wards, situated on the ground floor accommodating 13 beds. An important feature of St Michael's is that all of the bedrooms have direct access and look out onto beautiful restorative gardens. By the time of the early 1900's Hospices in London were now starting to become recognised as a specialised building type.¹⁴

¹³ Used by Verderber, Stephen & Refuerzo, Ben J., *Innovations in Hospice Architecture*, Oxon, Taylor & Francis, 2006 from Miller, A.B and Stjern, J (eds.) (1992) National Cancer Control Programmes

¹⁴ Verderber, Stephen & Refuerzo, Ben J., *Innovations in Hospice Architecture*, (Oxon, Taylor & Francis, 2006), 12.

2.3 Machine for healing – A disconnection with nature

By the 5th century BC, the Ancient Greeks had established the healing benefits and therapeutic functions of nature in healthcare milieu. As previously mentioned, care of the sick took place in healing temples where patients were encouraged to associate with nature as a part of a holistic healing regime.

This tangible relationship between the indoor and outdoor realm was somewhat lost much later during the design of hospitals during Renaissance era. They were designed with a focus on the outward appearance, the idea that the sun was a symbolism of spiritual salvation, void of hygienic value. In a shift towards the hygienic ward –there may well have also been a fear that they needed to keep the sick and dying isolated and out of the community.

The post-1945 era saw the establishment of numerous modernist community hospitals. By the 1960's High-tech 'Mega-hospitals' had evolved into inwardly focused cities. These Machines for healing were designed purely for their external appearance and were not created as an expression of internal planning. The courtyard gardens were done away with in order to fully utilise the medical centres site to justify rising land costs. Patient rooms often had no outlook or visual connection with nature and instead looked out onto barren light wells. One was no longer able to have access to fresh air with the belief that natural ventilation was a contaminating influence on patient health.

The focus and design of the building became more about optimising the space. The needs of the patients became secondary to accommodate the latest diagnostic equipment. As Verderber states “*Physical space became sparse giving way to the latest in an era of unprecedented expansionism and accelerating construction costs, had to be spent meeting more and more building code and regulatory agency requirements.*”¹⁵ There was no longer room for the courtyard garden or expansive lawn, and so a connection to nature was lost because there was no longer the room to expand anywhere else.

¹⁵ Verderber, Stephen & Refuerzo, Ben J., *Innovations in Hospice Architecture*, (Oxon, Taylor & Francis, 2006), 14

The advancements in medical technology lead to a culture to heal at any cost. The notion of declining or dying meant failure so patients with terminal illness were often housed in back wards away from social realms where the higher status wards whose patients and carers were accorded significantly more attention within the institutions hierarchy. Little amenity for the dying was provided, and the culture of denial (of death) continued. In the early 1980's at St Lukes Hospital, Bayswater there was an unspoken policy where the patients that were terminally ill were moved out of the central ward and put into a private room in isolation. As Verderber states, this policy was a natural by-product of the ward configuration's architectural openness. And hence there was little consideration for the holistic needs (physical, emotional and spiritual) of these patients.

Hospital Architecture reflected the style and design ideas of its time. These buildings usually owed their external appearance to the designer's preconception of what a building type should look like from the outside. They were not created as an expression of the internal planning and room functions, which has been the conventional generator of the architecture of modern hospitals. Finding the balance between outward form and internal function had become one of the great architectural dilemmas for hospitals in the contemporary age.

In his book on modern hospice movement, Warpole states *"Since the 18th century there has been considerable overlap in architectural form and ethos between places of care, custody and even correction as society became more institutionalised."*¹⁶

In later years due to strict health regulations hospitals became more and more sterile and in turn more stressful an environment to patients who use them. One of the biggest stresses in a modern hospital is the acoustics as non-acoustic materials are generally more sterile than sound absorbing alternatives. *"By and large, the architectural principles informing the design of modern hospitals and hospices remain largely functional, with the efficient delivery of medical and technical services being given priority over the wellbeing of the patient."*¹⁷

¹⁶ Warpole, Ken, *Modern hospice design The Architecture of Palliative care*, (Abingdon, Routledge, 2009), 14.

¹⁷ Watts, Jacqueline H, *Deathscapes: Spaces for Death, Dying, Mourning and Remembrance: Chapter 2: 'Its Not really Like a Hospice' Spaces of Self-help and Community Care for Cancer*, (United kingdom, Ashgate Publishing 2010), 21.

2.4 The Hospice Movement – Palliative care

By the 1960's an alternative philosophy was emerging where the dying patients would no longer have only two choices, either to be sent home to fend for themselves or left in the isolation of the hospital oncology unit for their remaining days. This emerging alternative was palliative care, the contemporary hospice movement. By employing teams of professionals such as physicians, nurses, social workers, therapists and clergy and in turn encouraging family and friends to share the caregiving process the hospice offers terminally ill patients a third alternative location in which to endure their final moments.

First established with the opening of St Christopher's Hospice in Sydenham, London 1967 founded by Cicely Saunders (later Dame Cicely Saunders) a nurse who was inspired by one of her dying patients a Polish refugee by the name of David Tasma. After meeting and developing a relationship with him, the two discussed the idea of creating a more homely place where people could die with greater dignity and tranquillity than what was the current state. *“As the first “modern” hospice, it sought to combine three key principles: excellent clinical care, education, and research.”*¹⁸

What is of strong symbolic significance is that the various meanings and history of the hospice from the past to the contemporary are deeply linked to ancient traditions of compassionate care that can be traced to the earliest records of civilisations.

¹⁸ Sheila Payne, Jane Seymour and Christine Ingleton, *Palliative Care Nursing: Principles and evidence for practice Second edition*, (Berkshire, Open university press, 2008) 44.

2.5 Modern Hospice Design – Palliative care

“As it stands the hospice has done well in managing the place and care of its occupants but the architecture itself has been described as being ‘bland’ and ‘ducking the issue of death.’”¹⁹

As it seems architectural principles currently employed in the design of modern hospices, primarily prioritise function, medical and technical services while the spiritual well-being of the dying person appears to be secondary.

“It may no longer be enough simply to add a chapel or sanctuary space to a conventional residential setting; somehow the hospice in its entirety has to be imbued with a sense of place and occasion. However, modernism itself has had a problem with accommodating ritual, especially rituals associated with death.”²⁰

Typically the design and programme of the building is left deliberately neutral to allow those managing and working in it to personalise, colour and shape it over time. In most instances, it has become too neutral. A bland non-design; “studied neutrality is not an architectural aspiration”. With a one-size-fits-all approach to design, we run the risk of producing a one-size-fits-no-one. Tailoring requires a specific, thoughtful response that can be appreciated for its advantage. By giving precedence to the comfort, needs and rituals of patients as well as minimising the intrusiveness of the medical equipment we can begin to create an atmosphere of both space and time in which the buildings occupants can process the rite of passage which is death.

“In much the same way that we can say that architecture allows us to shelter in space, it can also allow us to shelter in time, if the spaces it creates are calm and beautiful; places in which being can become an act of meditation or inhabitation of a sensuous richness, not of endurance and anxious distress.”²¹

¹⁹ Warpole, Ken, *Modern hospice design, The Architecture of Palliative care*, (Abingdon, Routledge, 2009), 10.

²⁰ Ibid, 90.

²¹ Ibid, 10.

There seems to be a shift in this direction as many hospices and related initiatives such as the Maggie's Centres and Dove House are now creating buildings and interiors, which aim to foster hope and human communion and bring assurance to people as well as a sense of meaningful time and appropriate ending.

The modern hospice movement can go further by approaching the design problem from an even more holistic standpoint. We can consider places for meditation, for intimate communication, for sanctuary and repose and we start to discover a sensual space. The building itself can become a sanctuary, of balance, of calm energy. The design as a whole can imbue a sense of place and serene atmosphere.

My research has uncovered the hospices role to simply care for the dying; I want to stretch this further by exploring the design problems associated with preparing people mentally, physically and emotionally for death.

2.6 Palliative Care In New Zealand

As part of my research, it was important for me to gain insight from those who have worked in these spaces for me best to understand the needs of the both the dying person and career. I was privileged to have the opportunity to interview the director at Dove Hospice, Janine Ewan, a nurse who has worked with terminally ill patients in palliative care for the past 20 years. Janine was able to give me guidance for the design and brief of my project.

Specialized Hospice's such as Mercy Hospice.

- Offer a small window of care .
Will not see people until the last few months of life.
- The most common place of death is the Home and acute Hospitals
- Remain more functional



Dove House offers day care and specialised holistic treatments for terminal People. The building is informal, and the people are very friendly, they work around the idea that it is a family culture. They run regular support groups for the bereaved and also for the staff who are encouraged to instil a sense of wellbeing in their lives. There is support offered for people who have come through Cancer and need help to reconnect with normal life again.

Therapists

- Aromatherapy
- Meditation & Breathing
- Oncology Massage – 5 specialists
- Nursing expertise
- skin and nail therapy

See Appendix 9.2 for further information

2.4 On The processes of Death and Dying

2.4.2 Death/Dying in a Hospice – the process of crossing over

Dying is a hugely sensitive subject about one of the most profoundly impacting moments in a person's life. In order for the design of the building to be attuned to the dying person's needs, it is of significant value that I as the designer have an understanding of the whole process of the last stages of dying. It is of equal importance for me to have some knowledge of the unique supportive nature of the care provided by the hospice and its staff/nurses. I believe in order to create a space that will be adequately meaningful both in terms of providing for the patients and their loved ones a more comfortable, peaceful and uplifting atmosphere as well as taking into account their spiritual wellbeing so they can afford the autonomy and respect during this time, I need to gain an overview of all aspects of the dying process.

It is possible that becoming aware of enduring beyond death in this particular form provides comfort and confidence for the patient that he will endure or continue in some personal way beyond death.... Recognition of some continuance beyond death is recorded as far back as 60,000 years ago as ancient peoples in the now Iraq buried their dead with preparation for afterlife, indication that this belief is long-held and tenacious.”²²

Is there more to life after death and is this journey part of a bigger picture? Basic science does not say much about human transcendence. Knowing about the imminence of one's own death brings about a tremendous sense of loss and although we know about how people respond on an emotional level to loss, moving on from some of these emotions of anxiety, fear and isolation can bring both healing and personal “spiritual” growth.

“With a patient who is in the process of separation, it is mandatory that we allow him to wean off in order to find his own inner resources and peace.”²³ When a person dies their world becomes smaller and smaller, and their values change.

²² Elizabeth Niven, *Living Toward Death: The enduring work of terminally ill people*, (Doctoral Thesis, Massey University, 2001), 205.

²³ Elisabeth Kubler-Ross, *Questions and Answers on Death and Dying*, (New York, Touchstone, 1997), 32.

*“The living, embodied passage toward disembodiment is also in a sense a transcending. The focus on the body as the centre of self identity begins to shift with the unreliability of the body, and as it grows increasingly weaker, Exley (1999) notes a move away from physical issues to the spirit as more important than the body.”*²⁴

Some Physical Observations of Dying

Patients tend to experience a process of detachment from the physical world a loss of interest in the things that may have formally brought them pleasure. There is a tendency to require more sleep and often the appetite is diminished, and there is less desire to talk. The dying person becomes less responsive to voice and touch and may not awaken at all in the days or hours preceding their death. This sleep can often be accompanied by auditory or visual hallucinations, restlessness and agitation as the patient relinquishes their life. *“Terminal delirium” is a condition that may be seen when the person is very close to death, marked by extreme restlessness and agitation.*²⁵

*“According to Dr Katherine Clark who is a staff specialist in palliative care at Royal Prince Alfred Hospital, Sydney a person in the last stages of life will typically sleep more. Even so, loved ones are encouraged to keep talking to them. “There’s research based on electroencephalograms (EEGs) of people’s brain waves that indicates hearing is the last sense to go.”*²⁶

What role can architecture play that caters to each patient’s journey of crossing over? It is essential to consider the knowledge of what materials to use for the walls pertaining to the resonating and sound deflection and the sensitivity of the lighting as well as its location. The indoor-outdoor flow of the access out to courtyards and healing attributes of the gardens and nature. Likewise, it is crucial to have respect for one’s own space requirements of his or her cultural needs. How will each space relate to the emotional and spiritual needs of the individual (both dying and the family/carers/support)?

*“The reality is that apart from diagnosis and death, everything in between is individual to the patient and his life”*²⁷

²⁴ Elizabeth Niven, *Living Toward Death: the enduring work of terminally ill people*, (Doctoral Thesis of, Massey University, 2001), 203.

²⁵ Kathy Graham, “Lets talk about Death”, *ABC Science*. <http://www.abc.net.au/science/articles/2006/05/18/2809176.htm> 2006 (Accessed October 18, 2015)

²⁶ Ibid

²⁷ Elizabeth Niven, *Living Toward Death: the enduring work of terminally ill people* Doctoral Thesis of, Massey University, 2001), 227.

3.0 PRECEDENT STUDIES

I want to go further than current hospice goes in caring for a sick patient. I want architecture and services to aid in preparing a person for death.

3.1 Hospice Precedents

It is important to note that each Hospice precedent study has been chosen not for their entirety but for key design features I wish to use throughout my design process. There is a key design feature that has been derived from each design. Each is suggestive of a rejection to the long monotonous corridor, which is often associated with institutional buildings.

3.1.1 Hospice LaGrange

On arrival visitors enter the main admin wing and core social areas of the hospice, leading to a walkway, which connects the four residences. The four inpatient units cluster around a central courtyard almost as though on a radial axis, connected by an enclosed circular spine. Each residence consists of four private 'rooms' configured around a living room and an adjoining porch. Each pair of rooms shares a second patio. The inboard side of the residences houses patient support, including a kitchen and dining area, hydrotherapy room, dayroom, and laundry. A meditation room is located at the end of the administration building, with a circular outdoor patio with screen wall.

The key reason this building has been chosen for my precedent study is because the plan starts to break away from the long institutional double loaded corridors so often seen in hospitals and nursing homes. The architect made the decision to 'eschew' the halls after many visits to other hospices revealed that dayrooms at the end of a long hallway often remained unused. "*In response, circulation paths are enlivened with window seats and visual connections to social activity spaces.*"²⁸

The interior still carries a neutral feel – although there is nature around the building – I feel like it is lacking connection – the patient rooms are also very small, and there is no availability for adapting the space.

²⁸ Verderber, Stephen & Refuerzo, Ben J., *Innovations in Hospice Architecture*, (Oxon, Taylor & Francis, 2006), 132.

- Key:
- 1 reception
 - 2 administration area
 - 3 staff living
 - 4 office
 - 5 conference
 - 6 volunteers
 - 7 day room
 - 8 meditation
 - 9 shower
 - 10 whirlpool
 - 11 salon
 - 12 nurse's station
 - 13 family pantry
 - 14 dining
 - 15 kitchen
 - 16 laundry area
 - 17 patient room
 - 18 living
 - 19 patio
 - 20 porch
 - 21 courtyard
 - 22 trellis

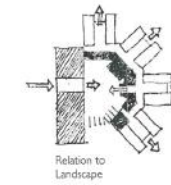
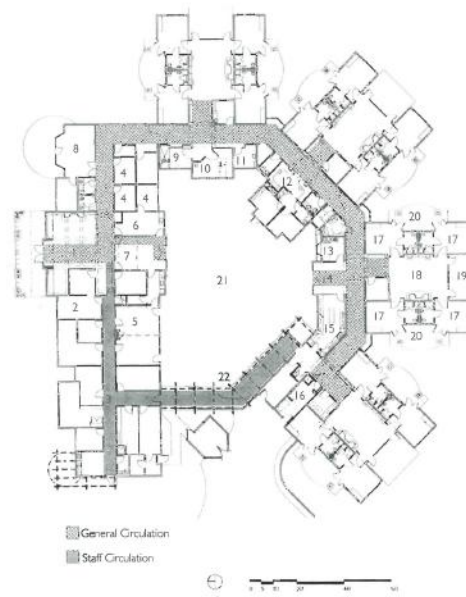


Figure 3.1.1.1: Layout of Hospice LaGrange

3.1.3 Hospice Hawaii

Hospice Hawaii is a case study project of a proposed Hospice in Maui, Hawaii. The concept derived from the idea of wanting to create a strong connection with the beauty of the natural surroundings. Culturally the Hawaiian people have a strong bond with their natural environment, so this was a convincing driver for the design process. Another key aspect of the project was the use of local vernacular. “*the hospices architectural vocabulary is embedded in the indigenous vernacular of the Hawaiian Islands*”²⁹. Materials of construction, colour palettes, and landscape design concepts are integrated into the immediate site environment and surrounding tropical landscape. In keeping with the dictates of the tropical climate, transforms enhance cross-ventilation and the overhangs shield direct sunlight and glare.

Metaphorically, the administration and arrival areas of Hospice Hawaii symbolise the branches and root system of a tree, whose branches reach out in a sense of embrace. The long hallway is broken up by as it shifts axis and the start of each inpatient wing.

The 12 in patient rooms can be transformed from private to semi-private residences via partition walls and furniture that is easily movable to accommodate careers who want to stay with a patient overnight. All rooms open directly onto a semi-private restorative garden.

²⁹ Verderber, Stephen & Refuerzo, Ben J., *Innovations in Hospice Architecture*, (Oxon, Taylor & Francis, 2006), 84.

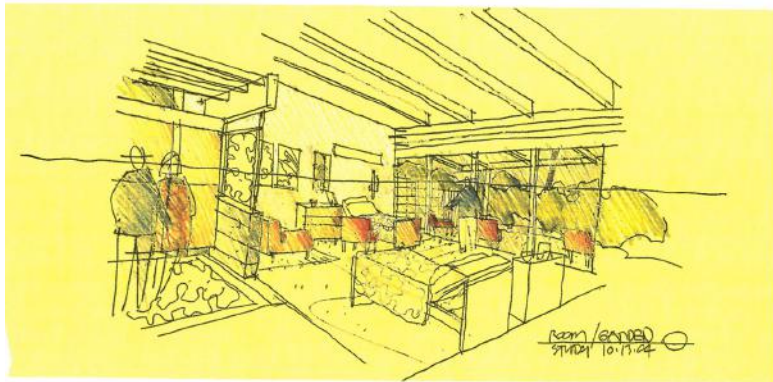


Figure 3.1.3.1: Sketch of room and adjacent restorative garden



Figure 3.1.3.2: Rendering of the main arrival sequence to Hospice Hawaii

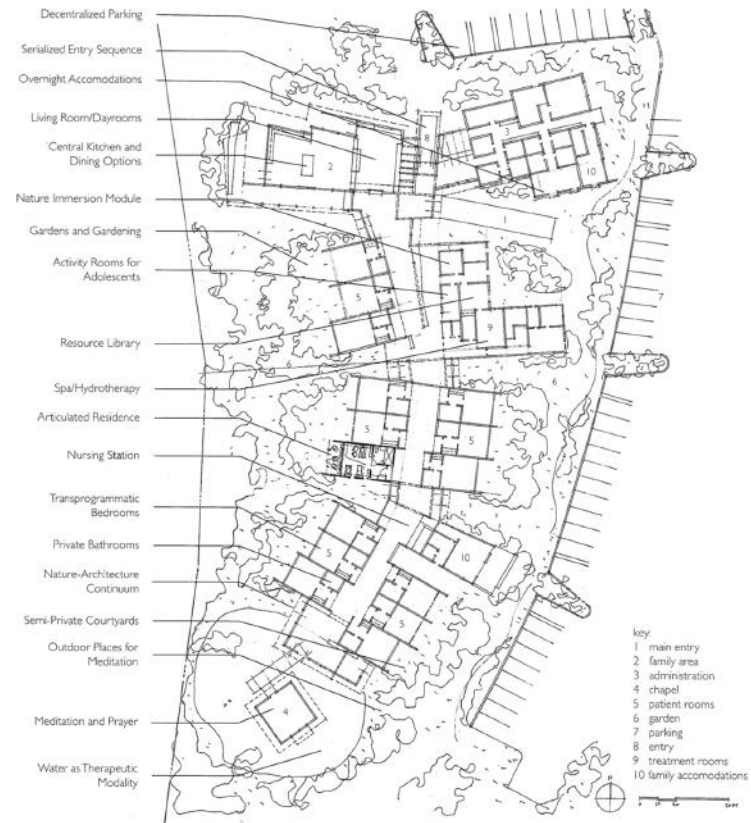


Figure 3.1.3.3: Annotated floor plan of Hospice Hawaii

3.2 Kings Road House, California, 1923-22

There are many aspects of this building that are informative to my design research, which I will endeavour to address. One of the key features of this building is its connection to nature and relationship to the site. It seamlessly integrates indoors with outdoors. The floor plan works itself around several interlinking L-shapes creating a series of indoor and outdoor rooms.

Tilt-up concrete panels give the building a sense of weight, which grounds it to the site; this heaviness is in contrast with the more 'open' walls of redwood and glass. The generous, inward facing glazed openings contrast with the slot windows in the thick, flaring, concrete outer walls creating moments of spirituality, through light and shadow. The materiality has a rawness and expression of truth in structure and form. The overall effect is at once simple and rich, the richness largely deriving from the use of pattern, repetition and texture.

Integration of both social and architectural concepts, “*it unfolds formally, spatially and intellectually with coherence unparalleled in early modern architecture.*”³⁰ The house was imagined as an experiment in communal living for both Rudolf and his wife Pauline to be shared with another couple. At the heart of the building sits a shared kitchen, the spaces seem to branch out from this one central communal area. There were four rooms, one for each person to “express one’s own individuality”. A “guest” wing with its own bathroom and courtyard extended from the central kitchen. The sequence of spaces are arranged so that the eye is led always on, even though the body’s tendency is to feel still and calm. A gradual transition from public to private is apparent. Although there were issues with its practicality - its spatial quality and sequencing stand as a success.

The house was a shared vision of both Schindler and his wife, Pauline. In a letter to her mother, Pauline wrote of her vision for a home that would have a sense of openness and exclusiveness while still having a connection to the city. A place to escape to... a sanctuary for all who wished to experience it.

³⁰ Robert Sweeney, Mak center for Art and Architecture, <http://makcenter.org/sites/schindler-house/>, (Accessed August 16, 2015).

“One of my dreams, mother, is to have, some day, a little joy of a bungalow, on the edge of woods and mountains and near a crowded city, which shall be open just as some people’s hearts are open, to friends of all classes and types.”³¹ ~ Pauline Schindler

A flat eave projects beyond the glass walls creating a form of protection and transition. At the edge where the ceiling and overhang meet, Schindler has placed a vertical band of glass forming a clearstory where light filters in from above. Planes come together at right angles, frequently in the building as truncated U-shaped unit, or in the landscape as individual elements, which do not meet at corners establishing a sense of enclosure and mass. Visual axis constantly shifts as one moves through the space.

³¹ Rudolph M. Schindler, Elizabeth A. T. Smith, Michael Darling, *The architecture of R.M. Schindler* / organized by Elizabeth A.T. Smith and Michael Darling; essays by Michael Darling, (Museum of contemporary art, Los Angeles, Calif, 2001), 87.

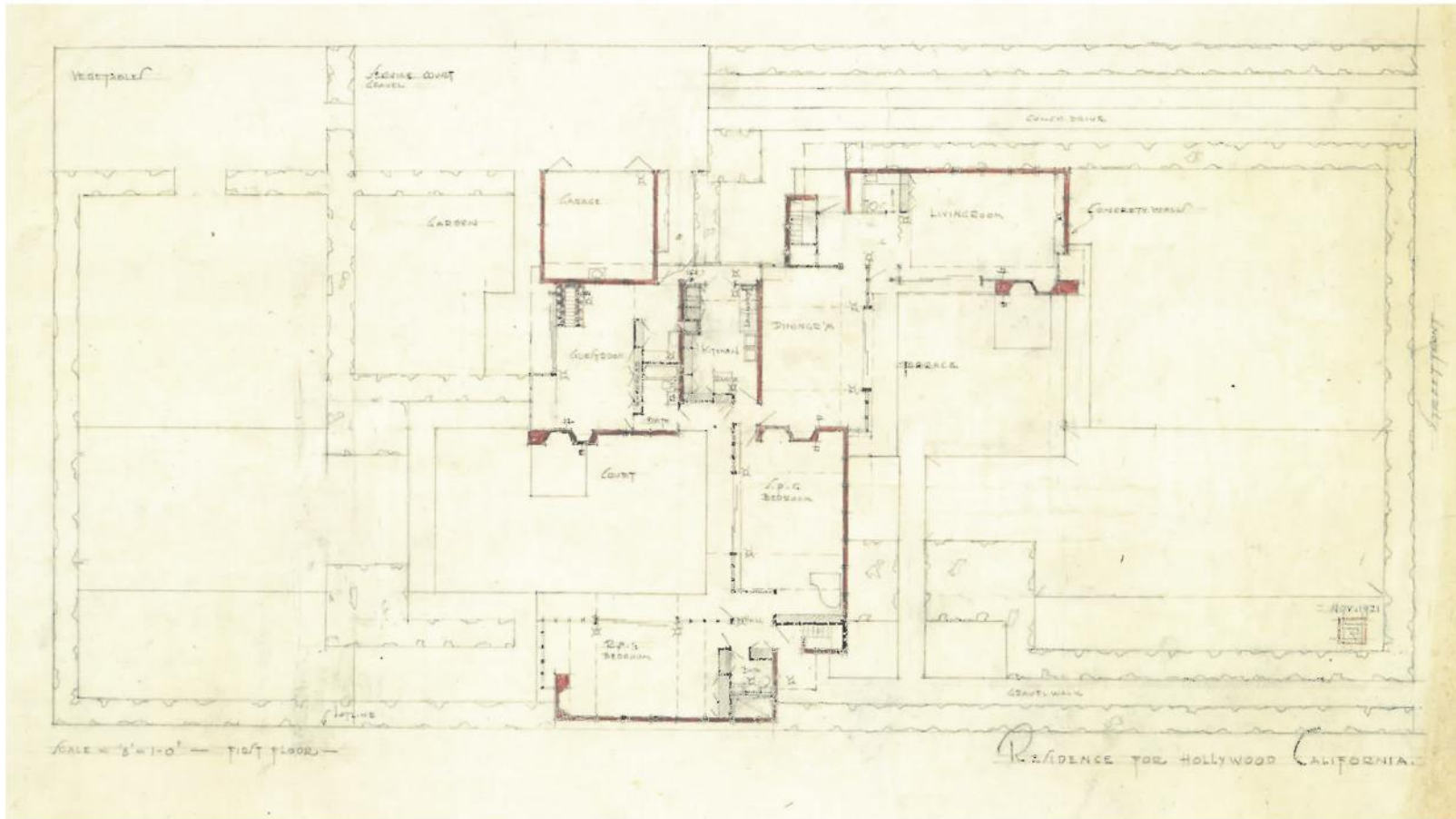


Figure 3.2.1: Floor plan of Kings Road house



Figure 3.2.2: Images of the Guest wing



Figure 3.2.3: Image of R.M.Schindlers studio.



Figure 3.2.4: Image from R.M.Schindlers studio overlooking courtyard.



Figure 3.2.5: Image of studio lwith light filtering into back of space through clearstory window.



Figure 3.2.6: Images looking into courtyard.



Figure 3.2.7: Intergration with nature and site.

3.3 Architecture of Hope

The Maggie's Centers are based on the idea of a new hybrid architecture that seeks to steer away from the "healing machine" with a focus being on creating places that give social and physiological support for cancer patients and their carers. Charles Jencks described the centres in a seminar by stating "*Maggie's is a hybrid building. It is a house which is not a home, a hospital which is not institutional, a museum which isn't a gallery it has art in it, and a church because you have to confront fundamental questions, but it's not denominational it's not religious.*"³²

Both Jencks and his wife Maggie, who was suffering from breast cancer at the time, established the Maggie's Centers. Her journey and desire to keep fighting the disease inspired the vision for creating an atmosphere and space separate from that of the sterile and unattached "machine for healing". It contains an informal atmosphere arranged around the kitchen, allowing patients to come and go as they please without having to report in or out. It focuses more on supporting the attitudes of its occupants than simply their functional needs. In a culture where cancer is usually hidden and sufferers become impotent in their choices, this architecture gives recognition and acknowledges their plight and worth.

*"It makes the long haul of healing and dealing with cancer a direct part of the rest of life, of everyday culture, not a rarefied or taboo experience."*³³

³² Charles Jencks, Architecture and Health: A Symposium, 21 May 2010 <http://www.youtube.com/watch?v=SyV04vnTVO0>, (Accessed October 26, 2010).

³³ Charles Jencks & Edwin Heathcote, *Architecture of Hope: Maggie's cancer caring centers*, (London, Frances Lincoln, 2010), 13.



Figure 2.1.4.1: Proposal for a Maggie's center in Cardiff, Wales. Dow Architects. Entry



Figure 2.1.4.2: Proposal for a Maggie's center in Cardiff, Wales. Dow Architects. Informal Kitchen Space.

4.0 PROJECT DEVELOPMENT

4.1 *Project Intention*

My primary aim is to focus on the people the building will accommodate (dying that is supported by the architecture), secondary to the services the building will provide. “*A hospice needs not wrap itself around its own tectonic armamentarium,*” (reference) instead the emphasis will be on human contact and social interaction rather than spaces devoted to high-tech diagnostic and testing machinery, hospices can be planned and designed nearly entirely for human inhabitation and social interaction. The hospice is often the background that the final days of a person’s life are played out in front of; the scenes that surround the act of dying can happen and be honoured by the spaces, lighting, material and colour all adding up to an atmosphere that honours the end of a person’s life.

This project proposes the design of a small-scale palliative care facility and hospice and its supportive context that seeks to nurture and prepare a terminally ill individual for their death. Situated in the urban fringes of Auckland city the design of the “room” will be the core focus for this project. Patients will live and die in these rooms and for most it will be their last contact before departing this world. Particular emphasis will be on the ‘room’ in which the dying person will spend their final moments, space, lighting, material, colour all adding up to an atmosphere that honours the end of a person’s life.

A death that is supported by architecture, the notion of the ‘room’ as a metaphor of the stage on which on which the dying moments play out. A place in which beautiful rituals can take place that connects to the surrounding nature. I will be exploring intimate space, through the connection with the built form to the natural landscape will be created through significant visual and corporeal experiences, views out to nature, as well as exposed natural materials & textures. Architecture that seeks to assist us in a reconnection to nature, that with which we belong.

I will be exploring harmonious sequencing of spaces to create a sense of wholeness and unity and that of community. A metaphor of the procession towards the end, the design process will seek to explore a progression through spaces that offer at different times both uplifting places as well as places for repose and sanctuary. Open and close, interior and exterior inward and outward.

Although there will be distinct spaces allocated for holy and spiritual connection, it is my intention for the whole building to be imbued with a sense of spirituality and empowerment. It is important to allow for moments of detachment for all who will inhabit this building.

It was important that the building remained on a small scale with the hope of creating a more personal 'homely' feeling. Creating a sense of homeliness affords a sense of belonging, of intimacy with care exchanges as central to this 'borrowed' space.

While the facility will offer full medical care, there will also be a focus on spaces for holistic therapies similar to what is offered at the Dove House. These spaces will facilitate both the day care patients and those who will inhabit the facility until their departure. Professionals, who offer a range of complementary therapies with it necessary at these consultations to discuss details of disease status, change in symptoms and current medication.

The building will endeavour to mirror the sites innate sense of timelessness a connection to the lifecycle of death and renewal, water, trees nature, etc.

4.2 *Brief / Program*

Bellow is a list of spaces and functions the building will accommodate:

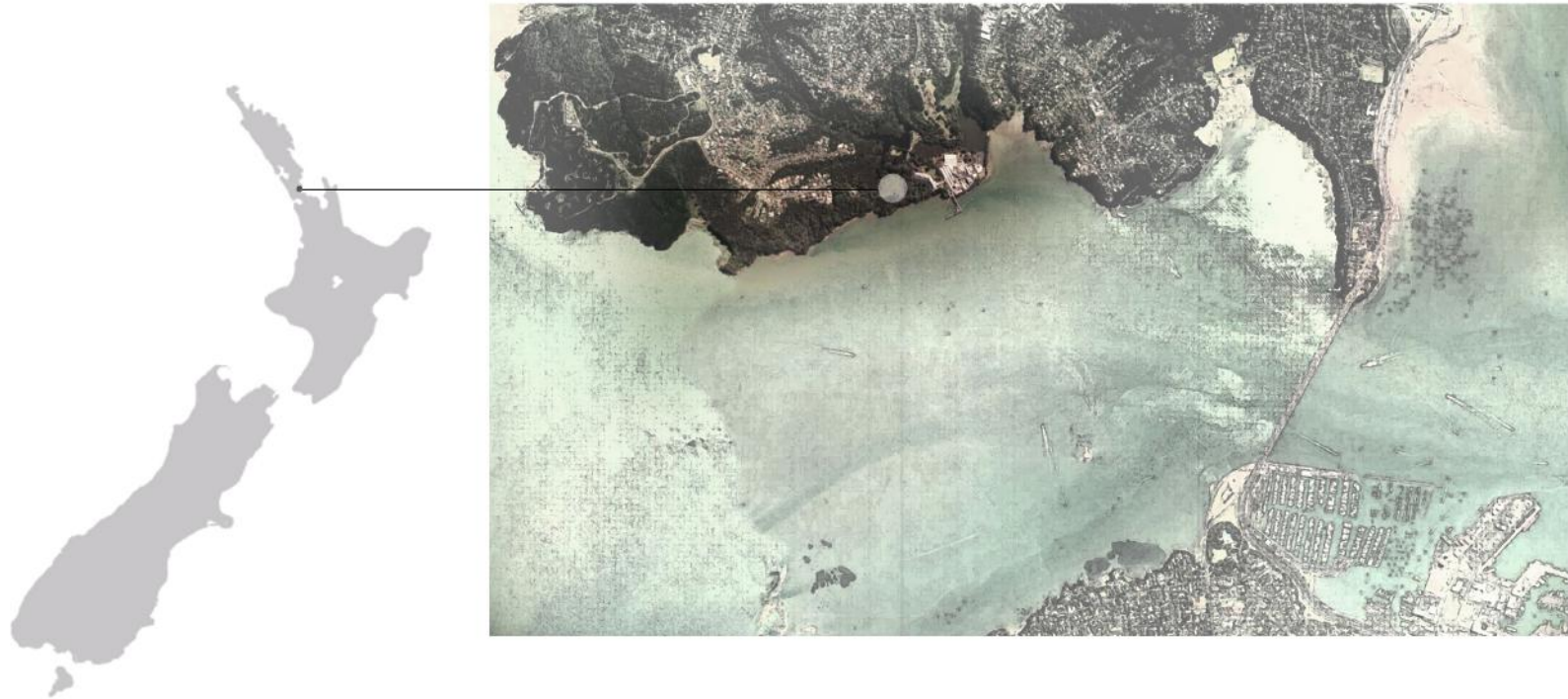
- Eight inpatient 'rooms' each with own bathroom facilities
- Entry
- A centralised kitchen & dining area
- Educational space (community outreach)
- Family & support overnight accommodation
- Nurses accommodation
- Nurses office
- Art Therapy – (reflection – creating objects of memories)
- Hydrotherapy and Spa
- Massage
- Meditation / Reflection space / Spiritual realm
- Pre – and post-bereavement counselling spaces (for both family/supporters & nurses)

Treatments

- Aromatherapy
- Meditation & Breathing
- Oncology Massage
- Skin and nail therapy

4.3 *Site Location*

4.3.1 *Context Criteria*



The site for this Proposed dwelling is situated on the North shore in Birkenhead. In choosing a site for this program, it was important to have a connection with nature and a sense of place and community. An urban site poses some problems especially when it comes to creating architecture, with a need for outward looking as much as inward. Creating an outward looking atmosphere and connection to nature is an important part of natural therapeutic healing. Although I intend to choose a site within an urban context, it is still important to have some contact with nature and enough space for outdoor environments. The purpose of a Hospice is to offer terminal patients as much quality of life and dignity as possible in the concluding part of life. The physical surroundings should be dignifying and inspiring – regardless if you are a patient, nurse or relative.

The chosen site is within proximity to North Shore Hospital and the City Hospital.

4.3.2 *Site Analysis*

History of the site

Although there is no specific historical settlement data for the actual proposed site, there is an indication that the land and area surrounding the proposed site had significance to the local Iwi. Kauri Point was a major focus of Maori settlement for several hundred years. Historically the land was settled by the Kawerau Tribe, with three pa sites in the area. The pa on the point itself is the only remaining example of a fortified headland pa on the Waitemata Harbour.³⁴

Te Kawerau a Maki are the Tangata Whenua (people of the land) of Waitakere City, who hold customary authority or manawhenua within the city. Te Kawerau a Maki descend from the earliest inhabitants of the area. However, the Kawerau a Maki people have been a distinct tribal entity since the beginning of the 1600s, when their ancestor Maki and his people conquered and settled the district. Maki and a large group of his Ngati Awa followers from Taranaki migrated northward to the Auckland isthmus. Ultimately Maki and his people conquered the Auckland isthmus and the land as far north as the Kaipara Harbour. The people of Waitakere retained the name of Te Kawerau a Maki as their tribal name.³⁵

³⁴ Kauri Point Centennial Park, http://www.northshorecity.govt.nz/our_environment/PDFs/parks/brochures/kauri-point-brochure.pdf, (Accessed August 3, 2015).

³⁵ Te Kawerau a Maki, <http://www.tekawerau.iwi.nz/history>, (Accessed August 3, 2015).

In 1882 over 82 hectares of flat land was purchased by the New Zealand Sugar Company The site of Chelsea Estate Heritage Park was purchased in 1883, formerly occupying 160 acres. Today the Estate covers 54 hectares and from 1884 has been the site of the iconic Chelsea Sugar Refinery, which is still functioning today.

Nature of the site



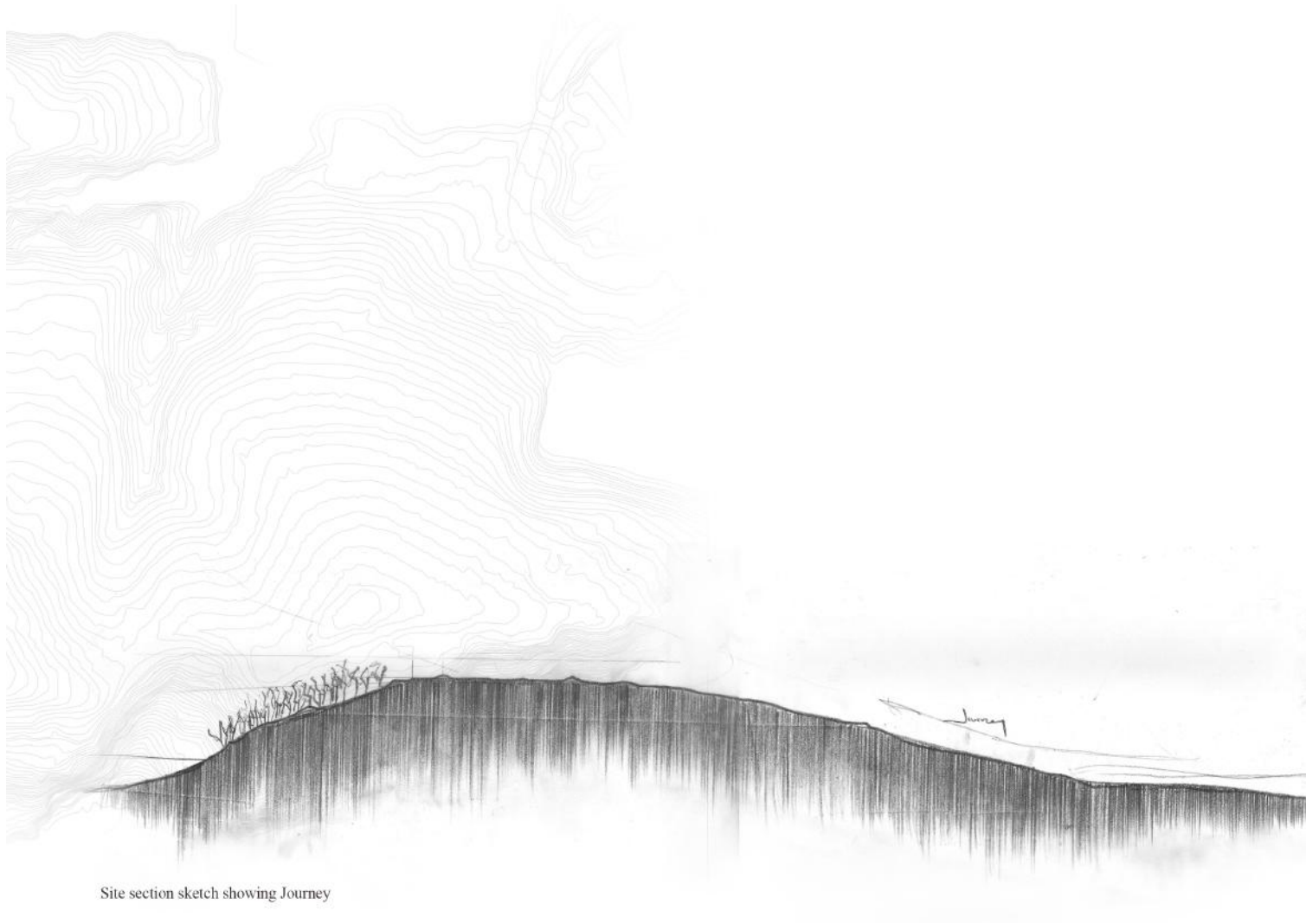
Panoramic of proposed site looking North/West

The proposed site had many attributes when considering the aptness of the proposal for the scheme. Situated within a clearing wrapped by a layer of tall embracing trees which create/act as an important acoustic buffer. There is an otherworldly feeling when the site is inhabited offering a sense of escape even though it remains very much within the Auckland realm. There is a sense of stillness within as the layer of trees enclosing the site filters the sounds of the distant city and the ocean. This lends to a gradual detachment of the dying person from this world they are not completely isolated from civilisation, just gently cradled within it. In essence, the site offers a peaceful return to nature to the place to belong.

“We want meaning in our lives and in the places that we inhabit. Retreating to nature in some form, to reconnect with its simple, tranquil, and reflective presence, alters the mind.”³⁶

The topography of the site slopes gently up then flattens near the top before it drops 50m down to the ocean – this intensity is softened by the fact that the cliff face is covered in trees offering a layer of protection and a subtle reveal can be achieved rather than an instant vastness of an open cliff face. Selected Zen views looking out over the ocean.

³⁶ Barbara Crisp, *Human Spaces: Life-Enhancing Designs for Healing, Working and Living*, (United States Of America, Rockport publishers, 1998), 106.



Site section sketch showing Journey



Site photos looking south over ocean through trees

Though it was not an essential condition to this project, it seemed apt that the site had a connection to the sea. The ocean is of spiritual significance, especially to Maori. This was highlighted in Anahera's paper, *Protocols and Customs at the time of a Maori Death* "*My hapu lives on the water's edge of Whangape harbour and we have seen that many of our people die at the turning of the tide, so we watch for that.*"³⁷ I also believe in a wider sense that the ocean is a strong connection to the abiding cycles of life and death.

*"Though accustomed to thinking of nature as something outside us, it is also part of us. We are warm-blooded, solid but about two thirds water, and linked by the air we breath and the moods it brings to every other being."*³⁸

It could be said, "*water is the central source of our beings. It is part of every cell and fibre in us; it is our very essence. Water is the common denominator that weaves us all together and carries many entrained messages, especially when we consider that there has been the same water and the same amount, on the earth for millions of years. This is provocative of an idea that when we make contact with a body of water could it be connecting us with messages from our ancestors.*"³⁹

The quotes above provoke a notion that the building should have a sense of timelessness a connection to life's cycle of death and renewal – which the site has – water, trees nature, etc.

³⁷ Anahera Herbert, '*Protocols and Customs At the time of a Maori Death*, A paper prepared by Anahera Herbert to assist those working with Maori at the time of a death. (June 2001), 6.

³⁸ Christopher Day, *Spirit and Place: Healing our Environment*, (Great Britain, Routledge, 2002), 29.

³⁹ Phylameana Lila Desy, '*Water as a Spiritual Element*', http://healing.about.com/od/water/a/water_abbond.htm, (Accessed January 5, 2016).

Journey to the site and accessibility

The site access is from Colonial Road, which passes through Chelsea's Estate Heritage Park the road then starts to curve gently through the trees as the site draws nearer. As the approach the bottom of the hill the road passes over a body of water as though into another realm.

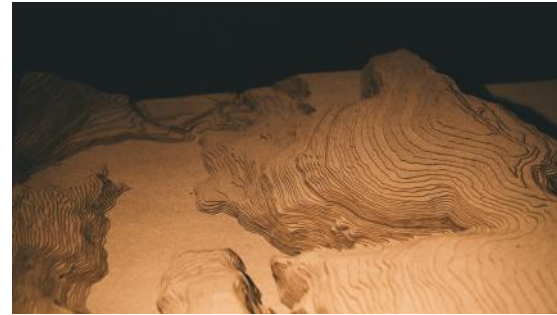




Site photo illustrating afternoon light – site carries spiritual qualities



Site photo looking North/West



1:1000 Site Model allowed me to study the topography in more depth

5.0 DEVELOPMENT OF SPATIAL EXPERIENCES

5.1 *Development of the 'room.'*

The 'room' is the central most important space within this building. This space sets the scene for one's final journey. The quality of time is paramount (light from the sun?)

The orientation of each room proposed an architectural challenge. It was important that each room had an outlook on nature and good light. In order to consider creating a space of this level it was important to investigate atmospheric qualities of a space that imbue a space with a sense of spirituality, connectedness and heightened senses

During the design process there were a number of design features I considered during my design process, which I will discuss, bellow.

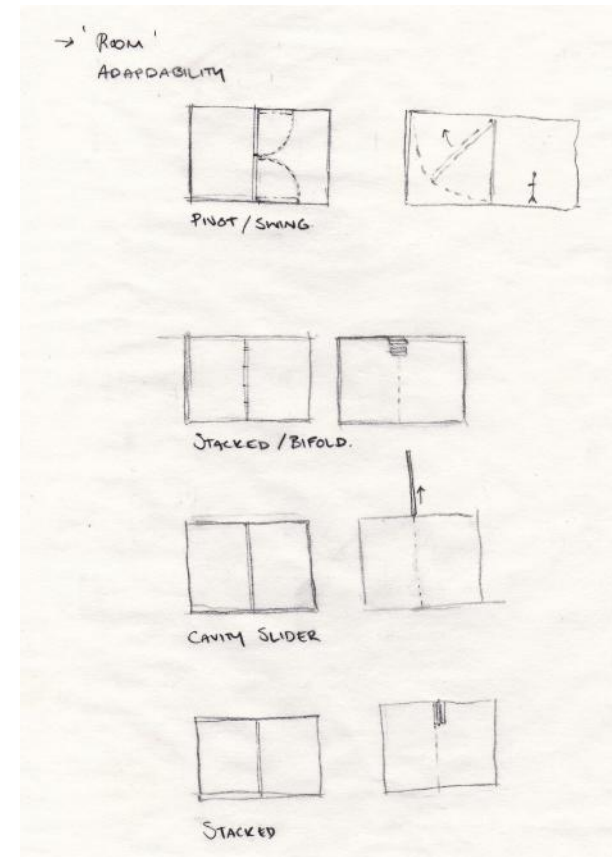
Adaptability

In order to accommodate for diverse cultures, the idea of an adaptable space is proposed via a movable wall or walls allowing for the space to be divided into two functioning rooms or one large room. Often in Maori and Pacific cultures with larger families, they tend to have a particular way of doing things and will often have large groups of family members around the dying person. Like that of the Hawaii Hospice that addresses this design issue in their scheme design by proposing light movable walls to allow for the possibility of creating a more open space to accommodate family members or space can be made more intimate.

Through my feeling and perception of space, I felt that something more solid and with intention rather than something that is light and temporal. An intimate space is not achievable, as the room will always have a sense of openness and 'bigness' - in larger spaces, the sound is felt further away - it is hard to create the intimacy so many dying people will crave during this time.

To accommodate for diverse cultures, the idea of adaptable space is proposed via a movable wall or walls allowing for the space to be divided into two functioning rooms or one large room.

I struggled with the idea of creating a space that could be adaptable – for me the importance of being in a space that felt safe and secure was paramount to providing temporal components. When you are dying the world becomes smaller and smaller, and I felt the importance of intimate rooms that are solid – not light panelled walls as I had previously explored. I chose instead to design a beautifully proportioned space. To still be receptive to various cultural traditions I decided to create and offer two rooms that were of a larger proportion to accommodate rituals that involve larger gatherings of family and friends. In fact, most patients when at their last stages need intimacy and closeness, and this could not be achieved by

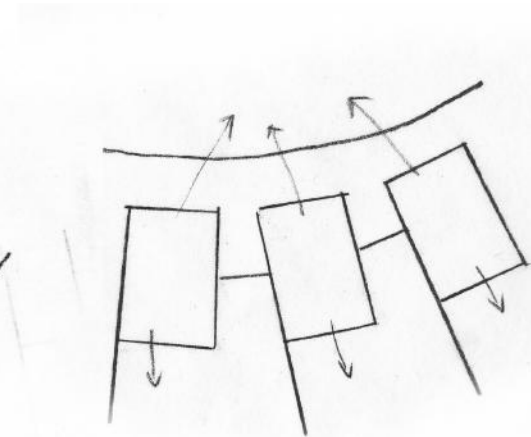
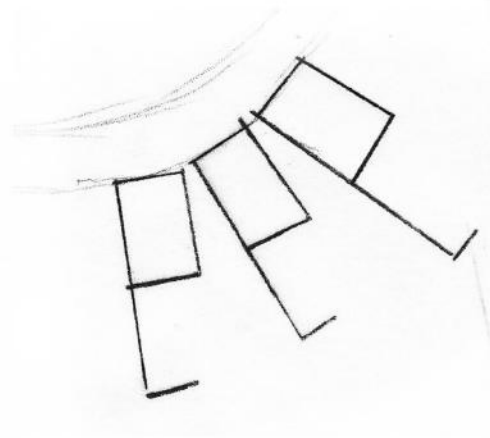
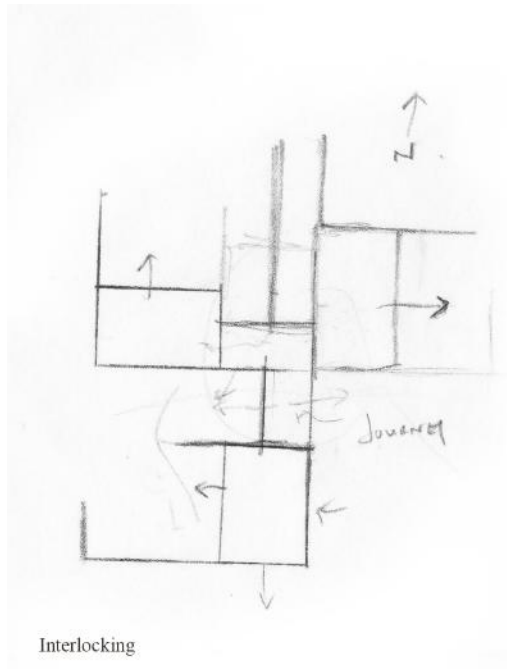
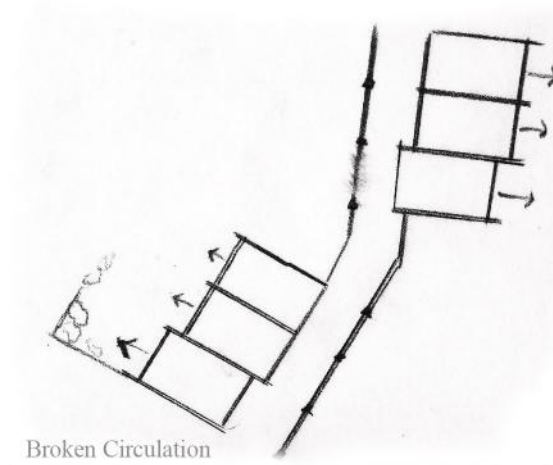


creating large rooms where many would gather around. Instead, I chose to offer mostly so that each individual or small group could have a closeness to their loved one a moment of familiarity.

While interviewing Janine from Dove House she told me of a scenario where a patient was surrounded by a large group of family and in this instant, the dying person was wailing and very agitated. After asking the group to leave apart from those very close, there was a sudden calmness that came over the room and the dying person was able to find the peace and quiet they so desperately needed.

Spatial Relationship of the room

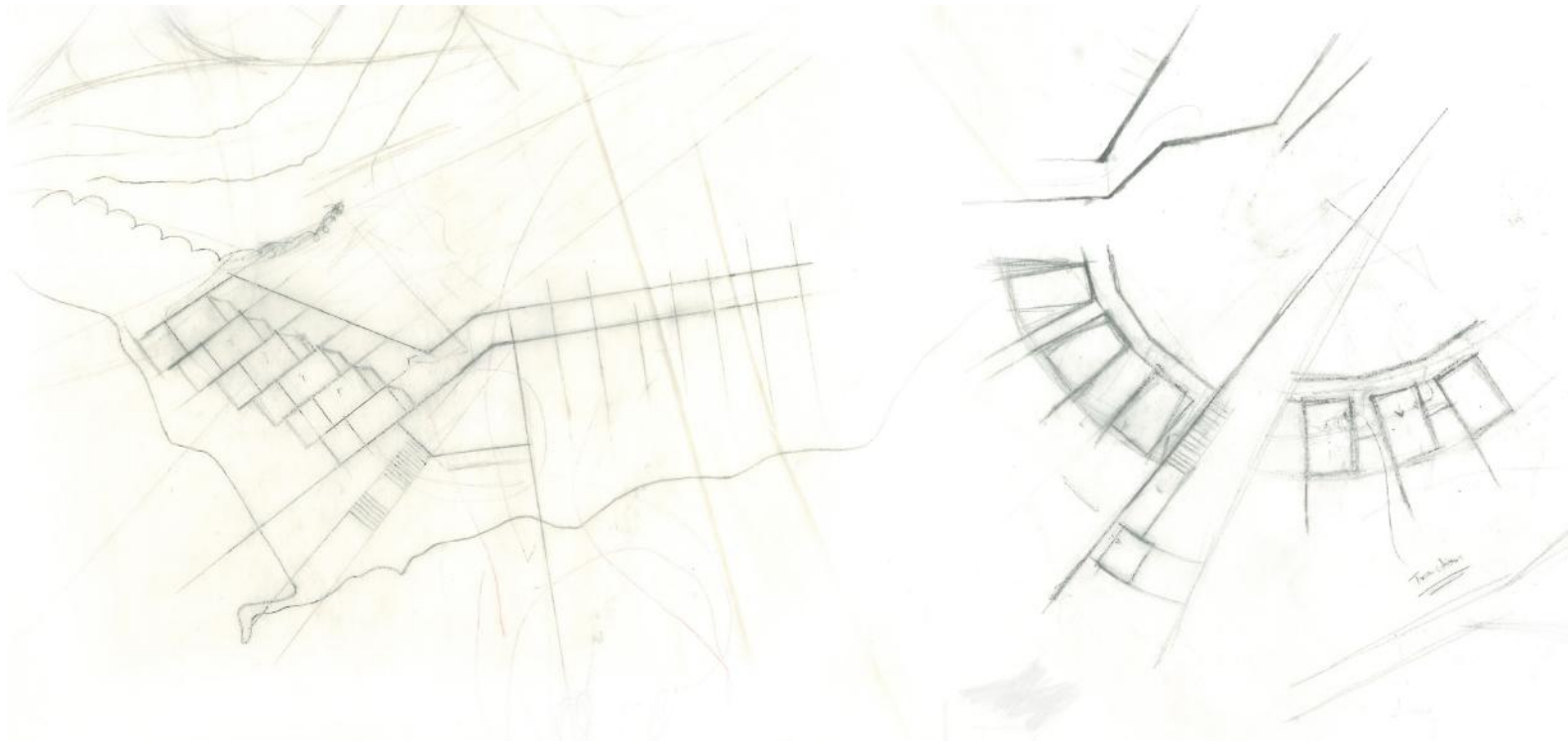
These sketches start to explore the spatial relationship of the rooms with each other and looking at ways of breaking from the long monotonous hallway through.

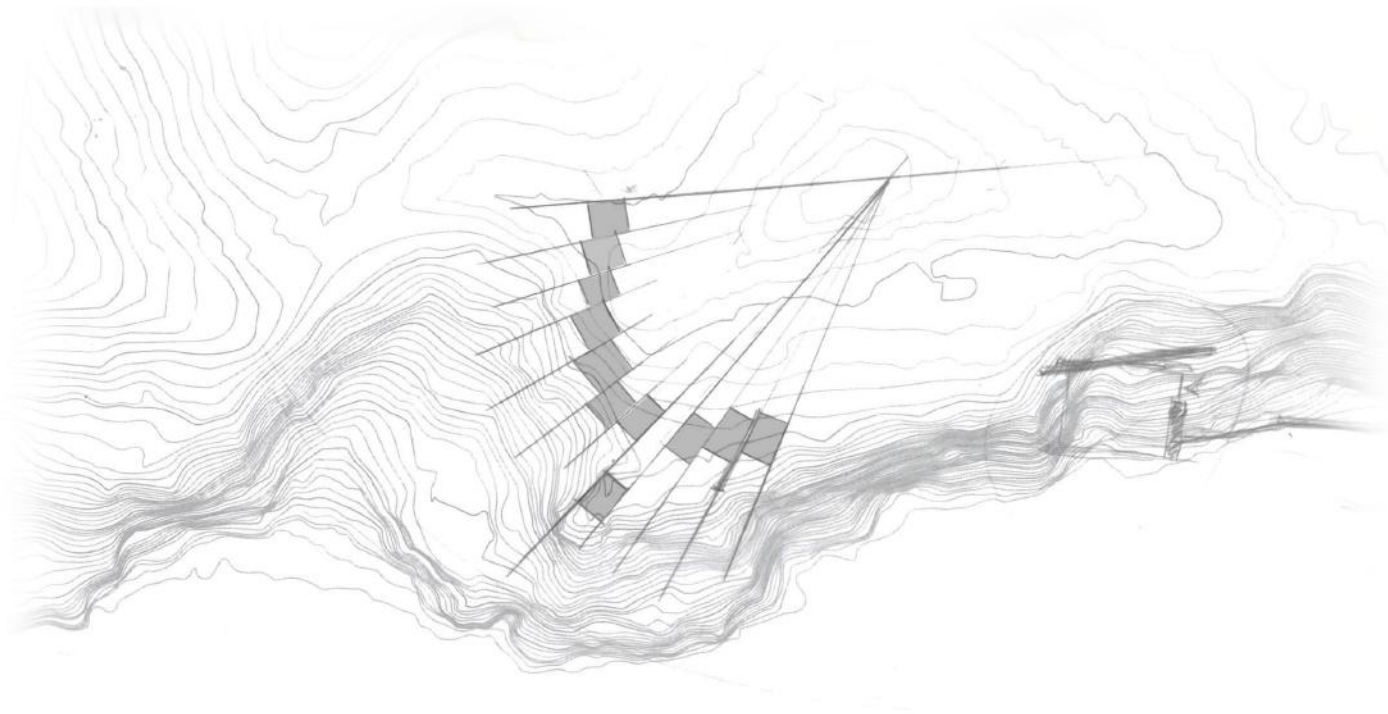


Interlocking

Axial layout of rooms

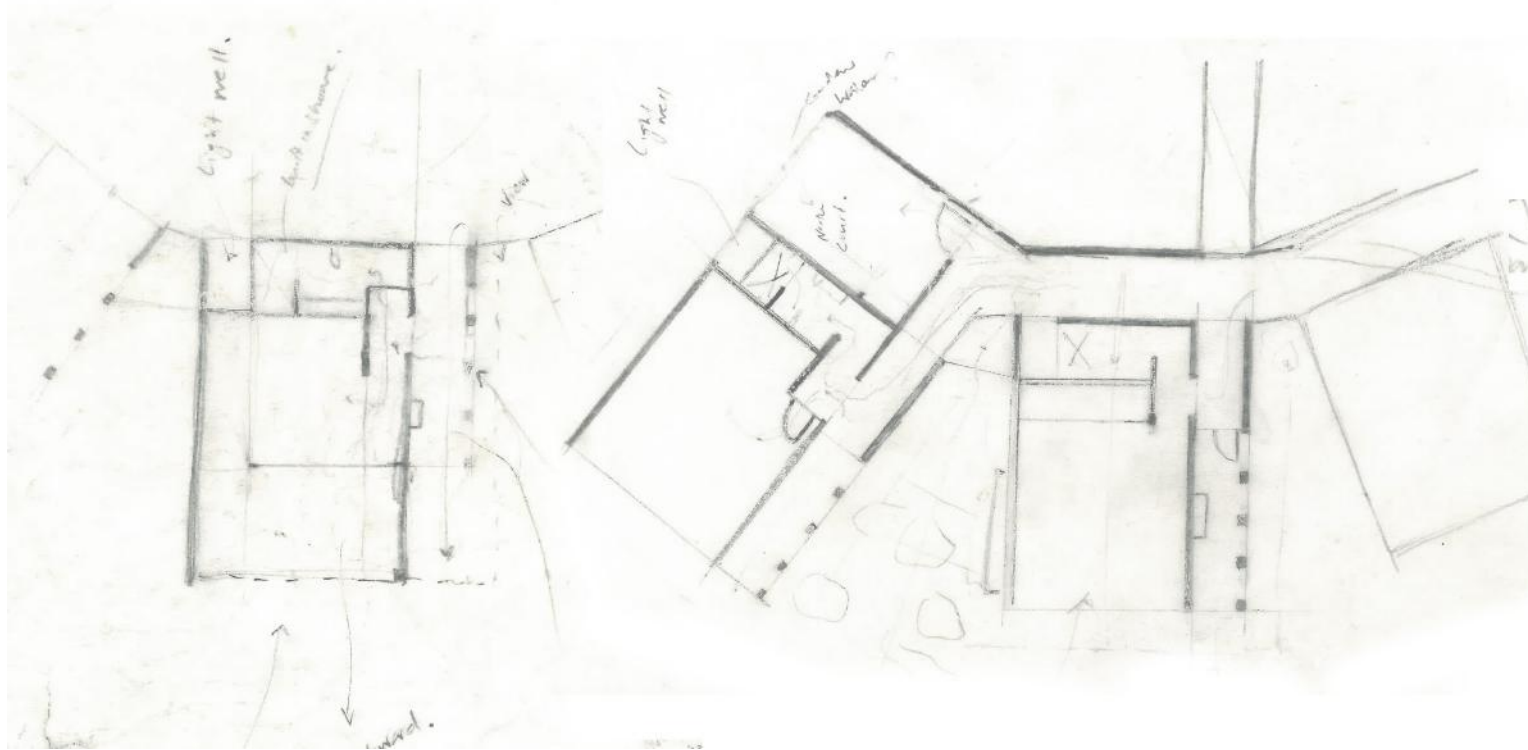
These sketches begin to explore the application of the room layouts on the chosen site. The left sketch illustrates each room slightly offset from the next along a diagonal axis. The right sketch illustrates rooms on a radial axis. The initial orientation of the rooms was facing South/West to maximise the ocean views. Although during my design process I felt it was not a suitable to orientate the rooms in a direction they will receive little sunlight.





Initial design sketch which, explores the spatial layout of rooms on site.

In these sketches, I have started to explore the interior layout of the room, and suggestion of how the circulation can be broken up in order to move away from the long monotonous hallway. The institutional. The rooms start to take on a character of their own, not sharing partition walls and opening out to little courtyard gardens with outlooks, creating more of a connection with nature. Spatial sequence is addressed in the design of the 'room' entrance, which is not accessed directly from the main hallway creating a transition from public to private. Without feeling removed the room takes on its own space while still have a connection to the public realm.



Proportion

It was important to consider the proportions of the 'room' in my design process. A level of intimacy can be determined by the right depth, length and ceiling height in a room. If the room is too big it can feel uncomfortable for a person in this vulnerable state, they need to feel protected and reassured. The human being is too insignificant beside the power of architectural scale.

Symmetry can tend to be rigid and formal. One of the requests from Janine at Dove Hospice was that the bed should be off center so as to seem less formal.

Entrance into room

A door that is recessed rather than aligned with the corridor creates a proper threshold between the public and private domain. The size of the door has some significance also in that the smaller the door, the less significant the room and its inhabitant will appear. The door size also needed to accommodate for easy accessibility of large equipment, bed and wheelchair. Through my design, I have explored having a hallway which runs alongside the room with a direct visual connection to the garden or courtyard. This space offers a place to dwell especially for the carer. By creating extra circulation space from the main hall, it establishes a more private entrance and transition as one enters the room.

Window / Natural light

A well-placed window has the power to transform a space. A portal and escape connecting to.... a reference to memories. Light as a non-static design element and is forever changing.

Roger Ulrich conducted a study in 1984 addressing the importance of a window in the process of healing.

*“ Maybe windows exert their effect by allowing the patient to step into a space of meditation-a reverie that brings not just distraction but relief. And relief could bring healing, through all those beneficial chemicals that flow from the brain through the body and change illness into wellness.”*⁴⁰

Not only does a window allow us to escape out into nature but also brings allows nature into a space. As Zumthor poignantly states...

*“Daylight, the light on things, is so moving to me that I feel it almost as a spiritual quality. When the sun comes up in the morning – which I always find so marvellous, absolutely fantastic the way it comes back every morning – and casts its light on things, it doesn’t feel as if it quite belongs in the world. I don’t understand light. It gives me the feeling that there’s something beyond me, something beyond all understanding. And I am very glad, very grateful there is such a thing.”*⁴¹

It gives life to a space, revealing a texture on a wall or illuminating I believe this is when a space takes on a spiritual essence.

*“Architecture that transforms raw, earthly materials into compositions so powerful they evoke something beyond our world.”*⁴²

⁴⁰ Esther M. Sternberg, M.D, *Healing Spaces – The science of place and Well-Being*, (United states of America, 2009), 9.

⁴¹ Peter Zumthor, *Atmospheres: Architectural Environments, Surrounding Objects*, (Basel: Birkhäuser, 2006), 61.

⁴² Tim Mckeough, Posted January 31, 2013, Architectural Digest: *Churches, Synagogues, Mosques, and Temples with Amazing Architecture*, <http://www.architecturaldigest.com/story/spiritual-building-architecture-churches-mosques-synagogues-temples-article>. (Accessed November 3, 2015).

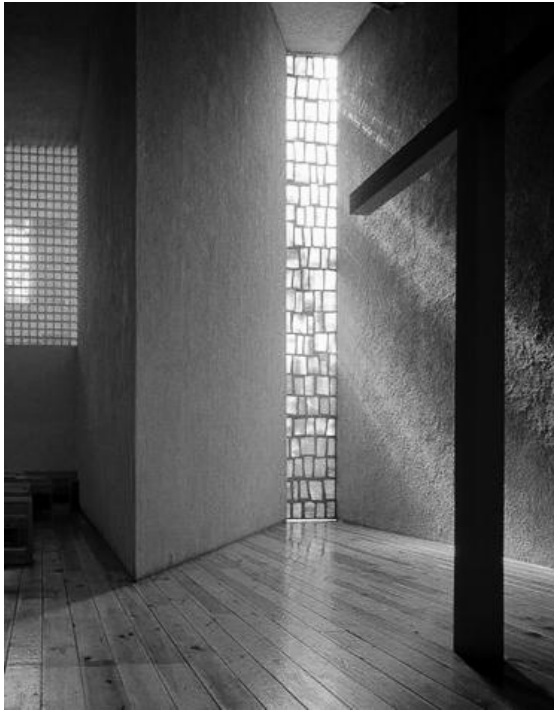


Figure 5.1.2.1

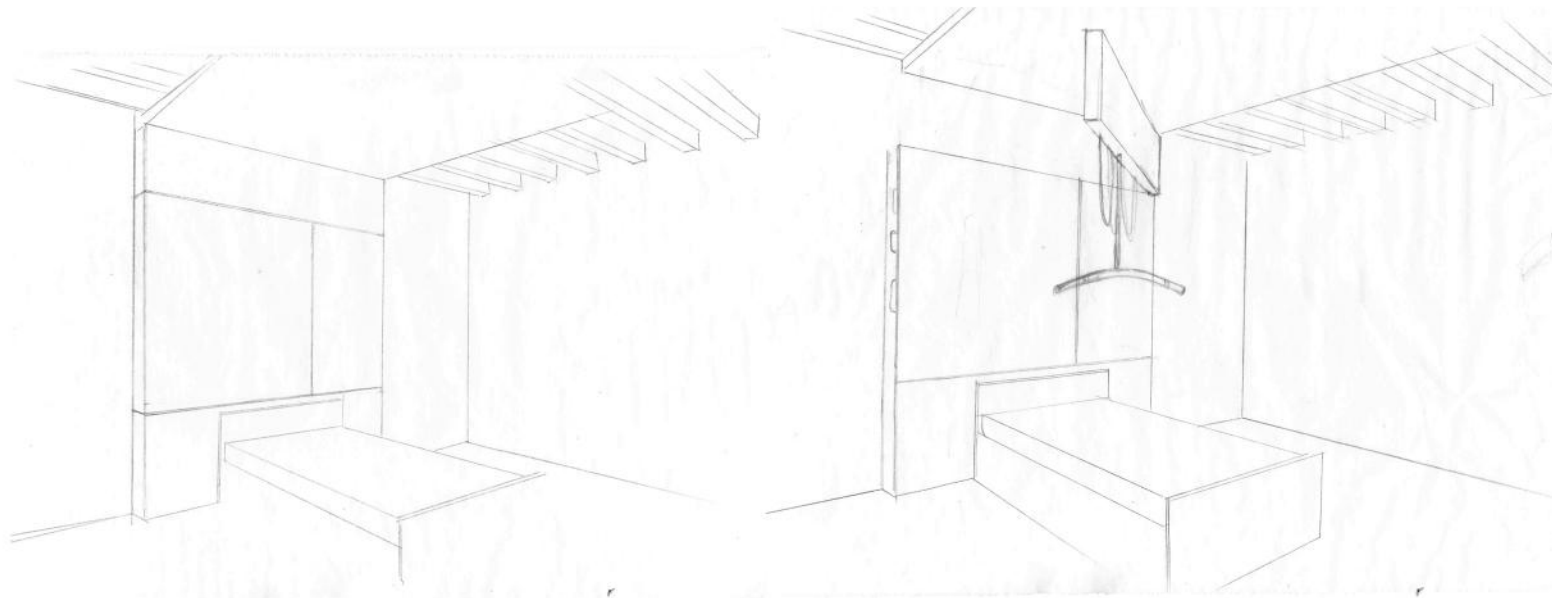


Figure 5.1.2.2

Equipment

The consideration of technical equipment was an important part when considering the design of the room. How can this be accommodated for without being of an intrusive nature to the atmosphere of the room? How can the equipment like a hoist become a beautifully articulated part of the design?

The spaces will be designed to have adequate space in order to accommodate medical or large equipment such as hoists. A timber panel has been designed to sit behind and above the patient bed in order to accommodate the necessary medical equipment and hoists in the ceiling. This has been designed so that the equipment can be easily tucked away from sight when not being used.



5.2 *Journey - Sequencing of spaces*

Once the brief had been established, and I had a clearer idea of the atmosphere of the room the next step was to make a connection with the outward context (Site & supporting environments).

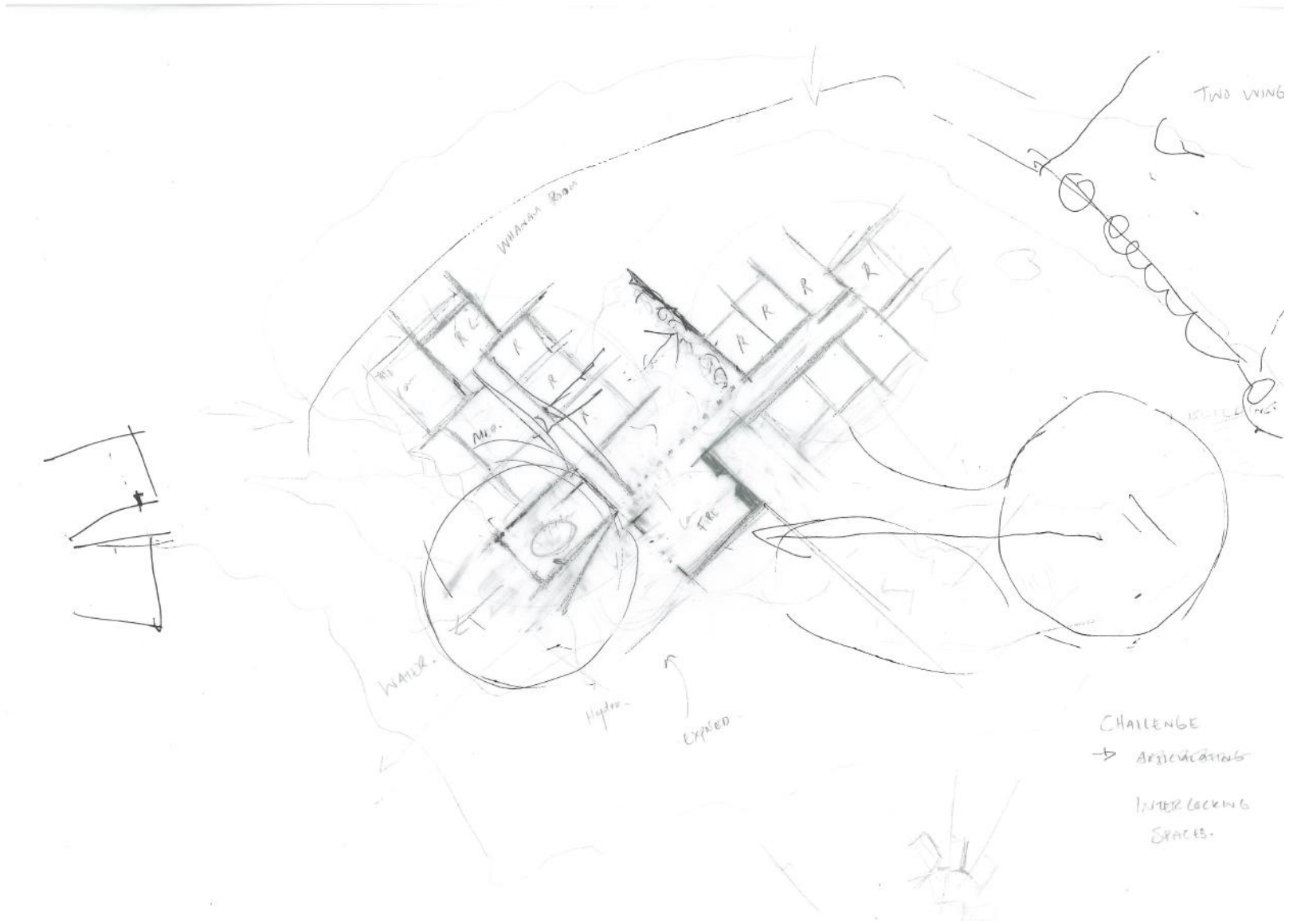
When designing I always begins with a site analysis, which consists of a sun study sketches, and context models both physical and digital to gain a thorough understanding of the site topography. My initial design is guided by the approach to the building how I want the occupier to begin their journey. It is also important that the building have a sense of belonging to the place. After my initial site visit I proceeded to visit the site 3 more times during different times of the day in order to experience the different atmospheric qualities – the shift of light throughout the day – how the light would move through the site.

Journey - layout - application to the site

When considering the design of the overall building a sense of ‘journey’ has been a reoccurring and important notion for this project, which also relates back to the idea of the traveller. (The earliest form of hospice was a hut in the forest – retreat to nature).

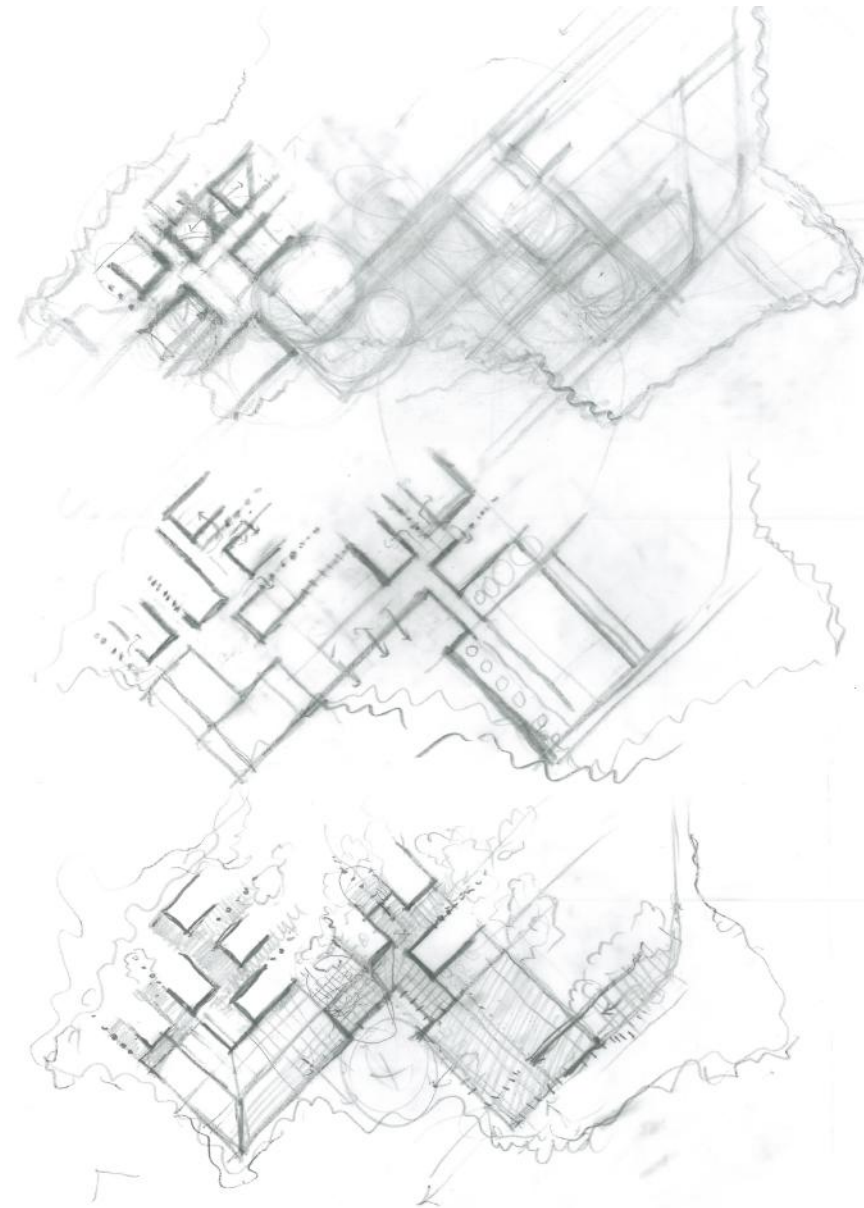
“It is a designed and constructed setting where the quality and harmonious sequencing of the spaces and functions matters more than for almost any other building type. Most hospice staff use the metaphor of the final journey to describe the experience of the patient, and a sense of the stages and rituals involved in dying are ever-present in the design. The quality of time is of the essence, for time is clearly precious to those who know that they are dying.”⁴³

⁴³ Ken Warpole, *Modern hospice design The Architecture of Palliative care*, (Abingdon, Routledge, 2009), 10.



This design process began by roughly laying out the spatial sequencing (journey) of the building. Initially, I had established where the rooms would be located with reference to orientation and most private space within the site. I then established the rest of the supporting context by visualising a journey to the site and entrance. The driveway to the building gently ascends the line of existing trees to the eastern most side of the site. Which I felt was also more public being the side closest to the city.

These sketches illustrate a development of the spatial sequencing. Establishing key formal arrangements of spaces – significant flows between indoor and outdoor spaces – room orientation – spatial sequencing.





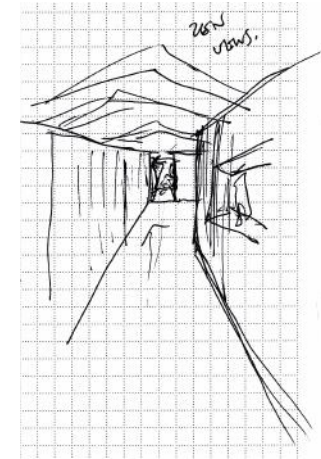
Entrance

The first approach needed a sense of embrace a gentle welcome but not forceful allowing for each person's journey to the building. The building is accessed from the North with a direct visual connection to the ocean through an opening at the end of the entry hall/ gallery space. The placement of this window is to create a sense of intrigue and lasting impression. A gradual reveal of the journey.

As one moves further into the building, there is a direct view to the kitchen to the right establishing a sense of homeliness, warmth and nurture. The driveway runs up past the entrance to a small car park close by, this allows for ease of delivery. Another car park is situated further down the hill at a lower point with planting acting as a visual and sound barrier to the building.

“The experience of entering a building influences the way you feel inside the building. If the transition is too abrupt there is no feeling of arrival, and the inside of the building fails to be a sanctum”⁴⁴

There also needs to be a sense of protection on arrival. I have done this by designing the roof canopy to reach out supported by an extended wall so as to create a gradual transition into the building.



⁴⁴ Christopher Alexander, *A Pattern Language: Towns, Buildings, Construction*, (Oxford University Press, 1977), 112.

Circulation - transition

The circulation spaces Broken with moments in which to dwell and have a connection with nature creating moments of awe and inspiration.

Act also as a gallery for art of reflection – perhaps of those who once inhabited the space.

Windows punctuate the corridors with views out to nature and window seats and small nooks are to be designed into the circulation spaces for one can stop to take rest / a moment to dwell and reflect evoked by the natural view. Breaking the pattern of the monotonous institutional corridor typically experienced in large hospitals or other institutions.

One important design element of the hallway was that it needed to be a sufficient width to allow easy movement of patients and equipment. A key change during the renovation of the Dove House was the hallways were made larger in order for the carer to walk beside not in front or behind the patient reinforcing the idea of a space that reassures and supports.

Atmospheric sketch of proposed hallway moving past the communal area, illustrating exposed natural timber beams, a tapestry of light and dark transitions. A view into a courtyard garden in the distance draws the eye and creates a connection to nature.



Waiting / spaces of contemplation / Meditation

Spaces such as courtyards, window seats and meditative rooms will be throughout the building where one can find a quiet moment to reflect or meditate. We are reminded to be present and in the moment or reflective. Sheltering in Space and time creates a sense of calmness and being in the space becomes an act of meditation.

As Barbara Crisp Illustrates “...space that unites us all, pulling us to run our fingers across a surface, listen to a trickle of water, gaze into a reflection, or simply stand, the contemporary memorial examines our need for contemplation and depth.”⁴⁵

Treatment spaces

Hydrotherapy room

Is situated facing to the South West, the intention to locate the space in this place was so that a view of the ocean could be established. Creating an embodied connection to the water and the dying person can experience Zen views out to the ocean while they have their treatment. This notion links back to the design of an ancient Japanese tea garden that was situated on a dramatic cliff overlooking the inland sea, despite the spectacular view over the murmuring ocean the view was obstructed by a screen of green trees carefully and strategically planted by the Japanese master. In front of the hedge, a slab of stone was placed for the tea ritual of washing hands. Just above the bowl was a small clearing in the hedge so as the visitors knelt down to wash their hands they would catch a fleeting glimpse of the ocean beyond. The profound experience of the limited splash of water compared to the limitless ocean - the part in humbling relation to the whole.

“A bit of water here, There, between the trees – The sea” – Sen no Rikyu

⁴⁵ Barbara Crisp, *Human Spaces, Life Enhancing Design for Healing, Working, and Living*, (United States of America, 1998), 82.

Hydrotherapy treatment provides relief for the dying person helping them to be calm and relax for better rest, there is also perhaps a spiritual connection with water and cleansing of ones body and soul. There are also 4 other treatment rooms that have been allocated for different pain relief therapies.

Courtyard- inward/outward building/ place of contemplation

There are a series of courtyards throughout the building in with people can dwell, meditate and reflect. Strategically placed so as to be strong visual connections as one moves through the building.

Materials

When considering the materiality of the building I was drawn to materials that had a sense of belonging to the site. The notion of using natural materials was a constant topic in my interview with Janet from Dove Hospice. The rawness, texture and imperfections of a material give it life. I will look at using materials such as plaster and timber along with some stone. The Materials need to have a sense of warmth. The notion of using materials that are of the site can add to a feeling of belonging and connectedness.

6.0 Conclusion

I have aimed to diverge from the institutional quality of contemporary New Zealand hospitals and hospices by exploring more intimate spaces on a smaller scale. There is a longing for these building types to have more connection to nature; the strict rules and health regulations often stand in the way. By breaking up the hallway with large panels of fenestration towards key vistas, developing external space around rooms to investigate an inward/outward connection, as well as using materials to create familiar and individualised scenes are means that have been explored to break away from the medicalization of current buildings for the terminally ill.

How the space works for the people that inhabit it has a lasting impact on both the dying persons last moments as well as supporting the family and friends in how they come to accept this life event.

I found that a spiritual atmosphere is an achievable design objective although it takes some intention to fit the services around the occupants. When a building has soul and character, this is achieved through a connection with its placement in nature, connection with its inhabitants, pockets of sanctuary and use of vistas as well as the way the light may illuminate a texture or space.

I addressed culture not through recreating the vernacular (e.g. the whanau room) but rather through the graceful use of natural materials, the connection to place and the mindful use of light with the aim to transcend specific cultural references in favour of ancient traditions of compassionate care.

I concluded that dying is a time when we need the most nurture and reassurance and to be allowed the opportunity to find a connection. This goes beyond religious or cultural notions of any individual to profound human necessity. It is the people that inevitably create the atmosphere - my job is merely to create a space that I hope unconsciously or consciously draws from them a certain energy that is uplifting and positive – even during a time like this – my research has strengthened my belief that architecture has the power to do this – when it is articulated in the right way.

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9.0 Appendix

9.1 Death and Dying in Contemporary society/ Attitudes towards Death and Dying

It seems that society has reached a point where death is often viewed as an inappropriate and unacceptable phenomenon, particularly in industrialised and post-industrialised nations. The advancement in modern medical technology has led to the discovery of specific causes of and treatments for disease, which have been collectively applied with great success across the world. This has created a situation where the emphasis became more focused on the medical environment and less on the overall needs of the patient.

9.2 Palliative Care In New Zealand

“Hospice is a movement that has condemned the neglect of people who are dying in our society, called for high quality pain and symptom management for all who need it and has sought to reconstruct death as a natural phenomenon rather than a clinical failure.”⁴⁶

There have been a number of research papers written on Palliative care in New Zealand and the needs and requirements of patients and what they provide regarding important care and service. Research has exposed some fundamental points; with communication and awareness around access and use of our health systems and in particular Palliative care by Maori and other non-European ethnicities with similar protocols and customs around the subject of dying.

“A home environment is related to the familiarity of being cared for by their family members, the ‘circle of life’ where they are born and die, gaining energy from family and community in moving across to the other side, and in receiving support for the family to enable caring to take place.”⁴⁷

There is a need to provide more palliative care centres or Hospices especially in and around the cities as the population increases. There are more and more families of all ethnicities here now than ever before, and I feel it is important to work with and implement more ideas focusing on ‘design’ and space that will assist us in addressing cultural and spiritual beliefs. I believe we still have to a fair way to go with this aspect of our care facilities in New Zealand, but it is achievable.

⁴⁶ http://www.carealliance.org.nz/uploads/1/8/9/6/18960817/crown_schumacher.pdf, (Accessed August 20,2015)

⁴⁷ *Palliative Care and Maori From a Health Literacy Perspective*, Health-literacy-in-palliative-care-report.pdf -1.3 Literature Review, ‘, (Wellington, Ministry of Health, August 2014), (Accessed October 14, 2015) Pg 6.

The number of deaths in New Zealand is projected to rise with population growth and ageing and these demographics will in turn result in a greater need for palliative care services. In addition, the ethnic diversity of the New Zealand population will rise exponentially from immigration,⁴⁸ according to Statistics New Zealand⁴⁹.

As research has indicated so far in New Zealand we are already starting to address cultural sensitivity on a communication level and raising our awareness. Are we taking into consideration the power of the building space? I would like to enhance the process of caring in a palliative caring environment by observing more closely and carefully the space, buildings and the surroundings we are in as I believe they have had a profound effect on us; emotionally, physically and spiritually.

“Spiritual care is an important component of palliative care, particularly for those of ethnic minorities. Egan et al.’s study in New Zealand hospices concluded that spirituality may include a search for one’s meaning and purpose in life, ultimate values, a sense of connectedness, identity and awareness, as well as religious beliefs for some.”⁵⁰

⁴⁸ Statistics New Zealand. National Ethnic Population Projections:2006 (base)–2026 update. Statistics New Zealand:Wellington; 2010. (Accessed October 26, 2010).

⁴⁹ Ibid

⁵⁰ Felicity Goodyear-Smith MBChB, MD, FRNZCGP, *QUALITATIVE RESEARCH Patient and family perceptions of hospice services: ‘I knew they weren’t like hospitals’ (Key Findings Discussion)*

9.4 Elizabeth Kubler - Ross

Elizabeth Kubler-Ross, a Swiss psychiatrist spent many years working with dying people; in her book 'On Death and Dying' she established five stages of grief for a person facing their imminent demise and also for the grieving. This breakdown of the human emotions and experiences in such a way can be misconstrued and judged, but it is meant to help us recognise what both the grieving and dying are experiencing. This understanding might perhaps help provide greater care and support around the journey by the care of and provision of the best environment and space.

In her book, Kubler-Ross argued that home-care was preferable over institutional care. She advocated that patients should be able to participate in decisions regarding their treatment. Environmental factors have an important role she emphasised as well, *a "patient's environment can have a great affect on their attitude towards death. A patient in a positive and supportive environment is likely to exhibit very different "stages" of dying than a patient in a negative and unsupportive environment."*

Kubler-Ross's book was controversial at the time as she brought into the open that dying was something that was done only in hospitals away from humans.

"As it has in the past, On Death and Dying will continue to stimulate communities to engage our professionals, and other experts, on the ethical and social dilemmas we must all face in the newly emerging and often-complex forms of end of life care being offered to us in the twenty-first century."

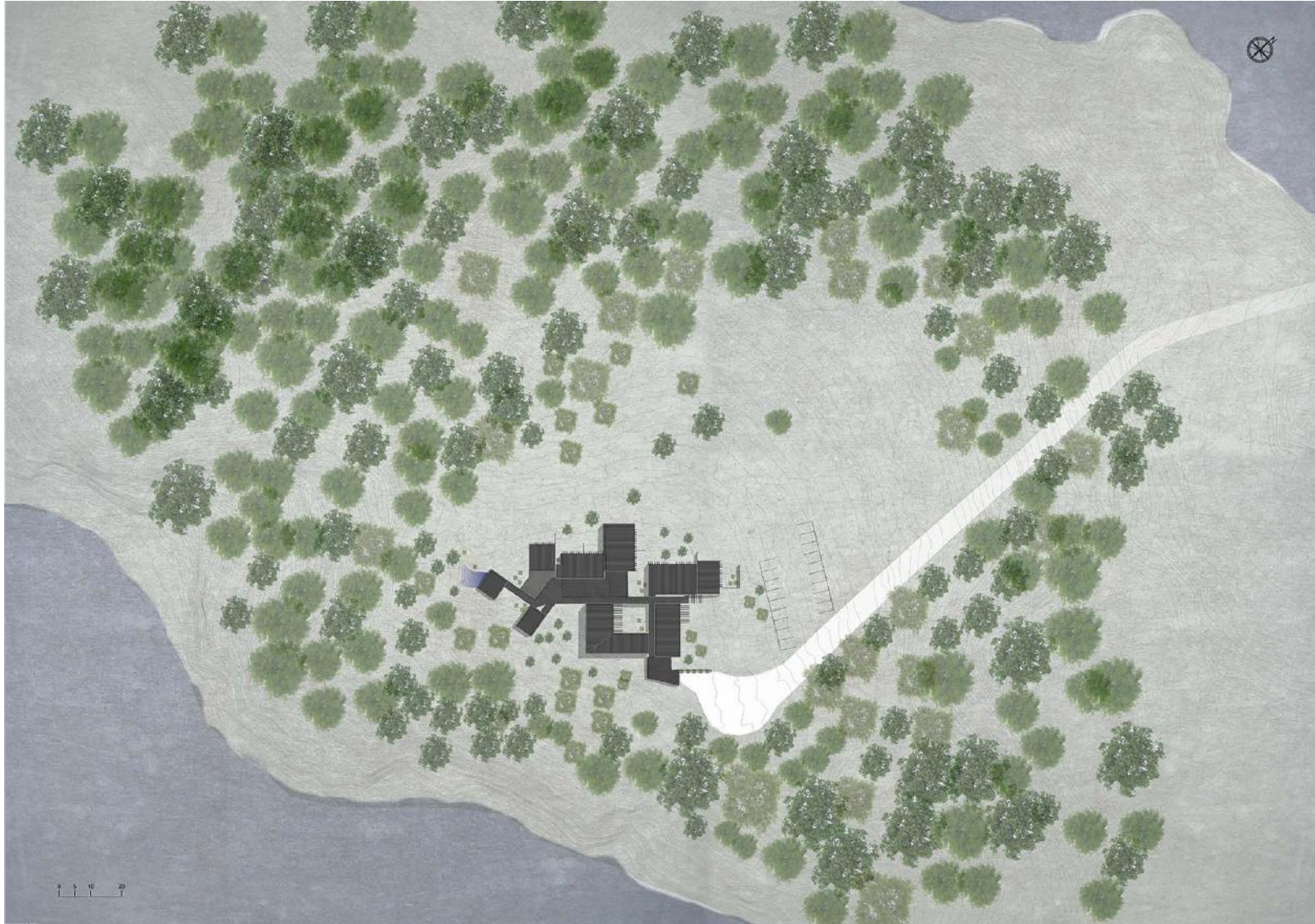
Excerpt is taken from Dr Allan Kellehear's Foreword: *"On Death and Dying" – 40th Anniversary Edition*

*"Not all domestic environments promote instinctive ease, some can be oppressive, but I do agree that 'domestic' as a reflection of 'human-centred' and 'anti-institutional' motives is right. These days the terminally ill will frequently spend only short periods of time as a hospice in-patient, having spent lots of time at home, getting sicker, in a small-scale domestic environment. The hospice might offer an equally re-assuring and hopefully uplifting atmosphere but perhaps with a slightly different ambience to home and offering different things – such as a good view and access to well managed gardens, for example – more about human experience, less about domestic visual clutter perhaps. It is a very interesting design issue."*⁵¹

⁵¹ Used by Ken Warpole, *Modern hospice design: The Architecture of Palliative care*, (Abingdon, Routledge, 2009), 56.

As much as the sequencing of spaces can assist in creating an uplifting and positive atmosphere, it is also, in fact, the people who inhabit these spaces that will define the success of the building and what is trying to be achieved. Death is a personal journey that each individual experiences in his or her own unique way. There are many paths one can take on this journey but all lead to the same destination. In order to have a better understanding of the spiritual realm, we need to think holistically.

9.0 Final Presentation Drawings



SITE PLAN



FLOOR PLAN



ENTRANCE PERSPECTIVE



CARERS LOUNGE



HYDROTHERAPY ROOM PERSPECTIVE



LOUNGE PERSPECTIVE



ROOM PERSPECTIVE



ROOM PERSPECTIVE



SPIRITUAL / MEDITATION SPACE