Passages

A Hospice for New York City

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Abstract

At the beginning of the 20th century most Americans died at home from diseases whose onset was quick and aggressive. The average life expectancy was only 50 years. Antibiotics first appeared in the 1940’s and when the baby boomers were born medicine entered an unprecedented age of transformation, one where illness could be prevented, treated and cured. Unfortunately, along with this progress have also come slower and often more painful deaths. The most common causes of death today are degenerative diseases such as cancer and heart disease. Thus, it appears that the ability to treat disease has altered medical philosophy from a platform of maintaining health to one of preventing death at almost any cost. It is into this environment that the concept of hospice care has emerged as an alternative way of thinking about death and dying, a reaction to the existing biomedical model of care. Hospice has put a humane focus on dying by creating a setting where pain is managed allowing the patient to move onto the hard work of dying, the psychological and spiritual dimension of the process.

While the philosophical concept of hospice developed in the United States during the 1970’s the questions surrounding the appropriate hospice environment have not yet been answered successfully. This thesis attempts to give form to the notion of hospice. It attempts to create a place where dying exists within the natural processes of life and is celebrated and sanctified as such.
Passage

1 a: the action or process of passing from one place, condition, or stage to another
   b: DEATH
   c: a continuous movement or flow (the passage of time)

2 a: a way of exit or entrance: a road, path, channel, or course by which something passes
   b: a corridor or lobby giving access to the different rooms or parts of a building or apartment

3 a: a right, liberty, or permission to pass

4 a: something that happens or is done: INCIDENT
   b: something that takes place between two persons mutually

5 a: a usually brief portion of a written work or speech that is relevant to a point under
discussion or noteworthy for content or style
   b: a phrase or short section of a musical composition
   c: a detail of a work of art (as a painting)

(Merriam-Webster Dictionary)
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>5</td>
</tr>
<tr>
<td>Introduction: history of hospice stories</td>
<td>8-13</td>
</tr>
<tr>
<td>Process: poetics</td>
<td>38-45</td>
</tr>
<tr>
<td>pragmatics</td>
<td>46-56</td>
</tr>
<tr>
<td>design iterations</td>
<td>57-70</td>
</tr>
<tr>
<td>Final Design</td>
<td>71-90</td>
</tr>
<tr>
<td>bibliography</td>
<td>91</td>
</tr>
<tr>
<td>illustration credits</td>
<td>92</td>
</tr>
<tr>
<td>acknowledgements</td>
<td>93</td>
</tr>
</tbody>
</table>
Introduction

history of hospice
At the beginning of the 20th century most Americans died at home from diseases whose onset was quick and aggressive. The average life expectancy was only 50 years. Antibiotics first appeared in the 1940's and when the baby boomers were born medicine had entered an unprecedented age of transformation, one where illness could be prevented, treated and cured. Unfortunately, along with this progress have also come slower and often more painful deaths. The most common causes of death today are degenerative diseases such as cancer and heart disease. Thus, it appears that the ability to treat disease has altered medical philosophy from a platform of maintaining health to one of preventing death at almost any cost. It is into this environment that the concept of hospice care has emerged as an alternative way of thinking about death and dying, a reaction to the existing biomedical model of care. Hospice has put a humane focus on dying by creating a setting where pain is managed allowing the patient to move onto the hard work of dying, the psychological and spiritual dimension of the process.

Hospice is not a building but rather a philosophy of care that accepts dying as a natural part of life. When death is inevitable, hospice seeks neither to hasten nor postpone it. It is based on the notion of palliative care and is humanistic at heart. Palliative care can be defined as treatment that maximizes comfort during the last phase of life. It does not promote any one therapeutic philosophy but rather is based on a flexible notion of therapy where every option is considered. When the concept of palliative care is applied to hospice it means that rather than curative treatments there is an agreement between the individual, physician, primary caregiver, and the hospice team that the expected outcome is relief and ultimately death. The decision to intervene with active palliative care is based on an ability to meet a set of stated goals rather than to affect the underlying disease. Throughout the treatment, the individual’s needs are continually assessed.

At the center of hospice and palliative care is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so. The stigma associated with hospice is that it is place people go to die. The notion of palliative care attempts to alter the stigma by extending the principles of hospice to a broader population that could benefit from receiving this type of care earlier in the illness or disease process. Thus, it is not a way of dying, but rather a way of living with a terminal illness. An individual’s needs must be continually assessed and treatment
options are explored and evaluated in the context of the individual’s values and symptoms. Palliative care, ideally, would segue into hospice care as the illness progresses.

While the philosophical concept of hospice developed in the United States in the 1970's the questions surrounding the appropriate inpatient hospice environment have not yet been answered successfully. This thesis attempts to give form to the notion of hospice. It attempts to create a place where dying exists within the natural processes of life and is celebrated and sanctified as such.
The word "hospice" stems from the Latin word "hospitium" meaning guesthouse. It was originally used to describe a place of shelter for weary and sick travelers returning from religious pilgrimages. In the early 12th century hospices were attached to monasteries. The gradual divorce of palliative care from medical care was concomitant with the secularization of society. "The monks who provided the first hospice care were barred by the edict of 1163 from performing operations, and the surgery developed later became the profession of barbers and eventually doctors. However, the Catholic orders retained their mission of ministering to the sick and homeless into the twentieth century (Carey 16.)"  

Sister Mary Aikenhead was the first to use the term hospice. In late 19th Century Dublin she founded a center for the incurably ill (Carey 16). The modern hospice movement began in 1960's London with Dr. Cicely Saunders. Her goal was to combine quality care giving with the best in modern pain management. "She discovered a blend of heroin or morphine, cocaine, alcohol, and anitnausea medication, named 'Brompton Cocktail' after the British Hospital that created it; she would become a pioneer in giving it in steady doses round the clock, so pain never had a chance to peak (Hospice 8)." In 1967 Dr. Saunders established the first modern hospice, St. Christopher's, near London. St. Christopher's organized a team approach to professional care giving, and was the first program to use modern pain management techniques to compassionately care for the dying. St. Christopher's primary goal was pain management so that the patients reached a level of comfort. Once this was accomplished the secondary goal was to enhance the quality of the last days of life and through art, music, friends, family and love.

The hospice mission is to help the terminally ill do their own work of dying, that means coming to terms with who you are, what the world is about, and what your place in it is- the search for meaning.

Dr. Cicely Saunders, Founder of the Hospice Movement

Saunders introduced the idea of specialized care for the dying to the United States during a 1963 visit with Yale University. Her lecture, given to medical students, nurses, social workers, and chaplains about the concept of holistic hospice care, included photos of terminally ill cancer patients and their families in which she showed the dramatic
differences before and after the symptom control care. Florence Wald, then Dean of the Yale School of Nursing, invited Saunders to become a visiting faculty member of the school for the spring term. Three years later Wald went over to St. Christopher's to learn about hospice firsthand.

Concomitant with this, Elizabeth Kubler-Ross brought questions about death to the forefront in the United States with her book *On Death and Dying*. Based on more than 500 interviews with dying patients, it identified the five stages through which many terminally ill patients progress: denial and isolation; anger; bargaining; depression; acceptance. In it, Kubler-Ross made a plea for home care as opposed to treatment in an institutional setting and argued that patients should have a choice and the ability to participate in the decisions that affect their destiny. In 1972 the first national hearing on the subject of death with dignity was conducted by the U.S. Senate Special Committee on Aging. Kubler-Ross stated the following in her testimony: “We live in a very particular death-denying society. We isolate both the dying and the old, and it serves a purpose. They are reminders of our own mortality. We should not institutionalize people. We can give families more help with home care and visiting nurses, giving the families and the patients the spiritual, emotional, and financial help in order to facilitate the final care at home (National Hospice and Palliative Care Organization).”

The transition of palliative care from Europe to America wasn’t completely seamless. The hospital system in America is more centralized than in Great Britain and the notion of palliative care was considered by some to be un-American. The notion of hospice care in the home was more easily accepted. In 1974, the first hospice in the United States was established in New Haven, Connecticut, as a home-care facility. That same year, the first hospice legislation was introduced by Senators Frank Church and Frank E. Moss to provide federal funds for hospice programs; however, it was not until 1979 that the Health Care Financing Administration (HCFA) initiated demonstration programs at 26 hospices across the country to assess the cost effectiveness of hospice care and to help determine what a hospice is and what it should provide. In 1980, the first freestanding in-patient hospice facility
was completed in the United States, again in New Haven. The Connecticut Hospice’s position as a leader in the American hospice field has helped to establish the freestanding in-patient hospice as a desirable alternative to home hospice care (Carey 17). In 1982 Congress included a provision to create a Medicare hospice benefit in the Tax Equity and Fiscal Responsibility Act of 1982 (made permanent in 1986.) Hospices were given a 10% increase in reimbursement rates and States were given the option of including hospice in their Medicaid programs. Additionally, hospice care became available to terminally ill nursing home residents.

Since 1986 the hospice movement in America has continued to develop, but awareness and funding is still not adequate. The growing end-of-life movement that occurred throughout the 1990’s focused national attention on quality of life as well as physician education. The hospice philosophy and concept of care became central to these discussions of palliative and end-of-life care. Yet, even with an increased public awareness, in 1998 hospices nationwide reported rapidly declining average and median lengths of stay. Additionally, the percentage of hospice non-cancer admissions decreased dramatically, reflecting the problems associated with determining a six-month prognosis for these patients.

Today there are more than 3,100 hospice programs in the United States and more than 90% of hospices in the United States are certified by Medicare. Of those 3,100 hospice programs, 4.5% or approximately 140 are freestanding in-patient facilities. While home hospice care increased during the 1990’s, the inpatient hospice facility is just begging its evolution. Today, there are nearly 40 million seniors in the U.S. In the next 30 years, that number is expected to double, as baby boomers reach age 65. These individuals will place importance on the process of dying in comfort, just as they have emphasized living. This is an ideal time for the Architect to get involved in the definition of the inpatient hospice.
Because I could not stop for Death --
He kindly stopped for me --
The Carriage held but just Ourselves --
And Immortality.

We slowly drove -- He knew no haste
And I had put away
My labor and my leisure too.
For His Civility --

We passed the School, where Children strove
At Recess -- in the Ring --
We passed the Fields of Gazing Grain --
We passed the Setting Sun --

Or rather -- He passed Us --
The Dews drew quivering and chill --
For only Gossamer, my Gown --
My Tippet -- only Tulle --

We paused before a House that seemed
A Swelling of the Ground --
The Roof was scarcely visible --
The Cornice -- in the Ground --

Since then -- 'tis Centuries -- and yet
Feels shorter than the Day
I first surmised the Horses' Heads
Were toward Eternity --

Emily Dickinson
Death

Morning meds for Sam
"This is it. No more denial. They are giving in but it helps them. The ones that don’t accept it have the hardest time."

Judy, hospice care-giver
"When we first built this hospice there was a group of four patients that would eat every meal together. For three weeks they didn’t touch their food until all four were there. Then one morning one of them died before breakfast. By the end of the day there others were gone as well. They had waited together until it was their time.” Mary Anne Hospice Director
Joan tells me that the hospice is more often about the families than the patient. After the patient has died, the families are so thankful for the help the hospice has provided. “Do they come back and visit?” I ask. “Sometimes they come back and visit or they write notes and bring us little gifts. The wind chime on the porch was given by the family of a patient. They do nice things like that.”
Outside Vivian's window I could see the swing. It was just at bed height so Vivian could only see her daughter when she was propped up by pillows.
The flowers common name is morning, noon and night. It buds each morning and blooms in the afternoon. At night the flowers fall off. The next morning the cycle begins again.
Setting Sun

Death is natural of course, and beautiful if you think about it. Why not die with dignity.” Judy, hospice care-giver
Gossamer

Rita’s room was filled with icons, photos and memorabilia. While it seemed crowded and messy at first I realized it was in fact perfect, it was her life. Even through the veil of trees, screen, objects and lace you could still feel the sun’s warmth.
What amazed me most about my experience with the hospice was the life that was going on inside it. The residence was tranquil and solemn but not a place of death. The people who worked there were happy and friendly. Susan, one of the care-givers, talked a lot about the experience. She'd been doing hospice work for 10 years. She was laughing and telling me stories. “You have to find the fun and happiness otherwise you can’t do this type of work,” she said.
Several patients wish to see the gravestone of loved ones before they die.
Eternity

Susan believes there are spirits in the hospice. She tells me about the angle pin. It was given to her by the daughter of a patient. She had him medication one morning and they had talked about dying and taking his last breath. For two years the pin has stayed with Susan. She has lost it several times but keeps on finding it, often shining at her from a quiet corner somewhere in the hospice.
Process

peotics
My process was twofold, looking from the start at both the poetics and the pragmatics of the hospice. The process was not linear but rather iterative.

I began with Emily Dickinson’s poem, *Because I could not stop for death.* In the poem the Dickenson describes the ordering of the temporal world within the spiritual universe. While not familiar with hospice care herself, Dickinson’s poems represents a response to part of Dr. Saunders search for meaning in life and death by allowing the reader momentarily to glimpse a universe in which the seemingly distinct and discontinuous stages of existence are holistically implicated and purposed. She connects the natural cycles to stages and cycles of human life. This connection was a starting point for my thinking about the atmosphere of the hospice.
Often the process of death is compared to the stages of birth and infancy, a process of gaining or loosing faculties and independence. This work consists of 64 squares which are 3” x 3” each. The image on each square is the same, Black-Eyed Susan's in a garden. Starting from the bottom right corner and moving to the left and then up, each consecutive square is a xerox of the previous one. As the collage progresses the picture of the flowers became less clear but the pixels that made up the image became more distinct. The final product has no definite beginning or end but is representative of the cycle of life. The clarity of the pixels diffuses into a cacophony of grey just as the clarity of the image on the other end disintegrates into a series of black dots.
When one is faced with death, often the everyday experiences of life take on new meaning. This mapping talks about periodicity and the relative experiences of individuals as they are involved with the hospice. The vertical axis refers to time: first in hours, then days, weeks, months, and years. The horizontal axis relates to place within the program of the hospice. The experience of a doctor, nurse, care-giver, volunteer, patient, and visitor is mapped out along the two axes. In addition natural rhythms are mapped along the axes. One notes that the sunrise and sunset each day and the blooming of an annual flower relate to a patient whose typical stay at the hospice is about fourteen days. In addition to the sun and the flowers, the phases of the moon are period markers for visitors and volunteers who may be involved with hospice for 1 to 3 months. On the other hand the cycles of the dogwood tree and the biennial tulip are of significance to the care-giver or nurse who might be involved with the hospice for several years.
Although I have chosen to locate the hospice in Manhattan, being a part of the city does not mean denying nature. The urban garden in its most literal form can range in size from a window box to central park. In ancient civilizations and in medieval Europe the garden was considered to be like an outdoor room: ‘a room with no ceiling’. While nature can be seen in the plants and animals that make the urban landscape their habitat, it can also be found in the connection people have with one another, the noise of the taxis and subways, the cycles of the day and the seasons. When one looks at an aerial view of Manhattan one finds not only many parks and gardens but also streets lined with Ginko trees and alleys filled with foliage. I wanted to bring this connection with nature, both traditional notions of nature as well as the culture of the city, into the hospice design. I pursued this goal through site location, programmatic organization, and design development. One of the most fundamental design decisions was to incorporate the garden into the hospice.

In the past, the garden was frequently constructed as a sanctuary for mediation and life contemplation… a place where we could learn how to integrate the results of that rethinking into the fabric of our daily lives. By developing the hospice garden to help people cope with the issues of death and dying, we are reintroducing this kind of therapeutic garden-sanctuary to the healing institution (Healy 45).
figures 2, 3, and 4. Shigeru Ban- Ivy Structure House

Watanabe- Niki Club Part II

Sejima and Nishizawa- Weekend House
Process
As I began the design process I realized there was a dearth of precedents for my project. As a relatively new concept of care (and building concept) there were few resources I could pull from as a starting point. Most current in-patient hospice units have not been designed from scratch but rather have been retrofitted to fit existing buildings or wings of existing building. This has done a great disservice to the hospice on two levels. First, the patient doesn't get the full benefit of the hospice philosophy of care when the building he or she is living in has not been conceived of holistically and philosophically. Second, the notion of hospice becomes misunderstood as a hospital or nursing home when it is retrofitted into portions of these buildings. I decided to begin learning the basic programmatic functions of the hospice by visiting three in-patient residences. What I learned was that the hospice was not at all like a hospital. There was no medical equipment, buzzers, blinking lights or sterile corridors. The kitchen was not an industrial kitchen but one sized for a typical home. Caregivers or patient's family members bought and prepared the food. The facilities were as much for the patients' families as for the patient. Patient rooms needed to be spacious and comfortable for the patient and family members. The living room became very important as a refuge from the patient room and a place community could begin. Additionally I noted the importance of a connection with nature whether it was the open window letting in air and noise or a view of the trees and lake beyond. The patient wanted to be touched by both the community of people and the nature that surrounded him. On one level it was like a large house for one big family, yet there were some staff and patient requirements that reminded me that this was also an institution. The research resulted in the definition of the hospice as a hybrid typology existing somewhere between residential and institutional.
figures 5, 6, and 7.

Street at Night

Subway

5th Avenue
With a population of over 1.5 million people, Manhattan has a very real need for a facility of this kind. Nearly 500,000 of Manhattan's residents are over 50. Currently, in-patient hospice care is only offered on hospice dedicated floors in a few Manhattan hospitals. While the intentions of such floors are laudable they do not properly serve the notion of hospice within an urban context.

Most in-patient hospices are located in the suburbs. Such places offer bucolic settings that provide a peaceful environment; however, they can often be very different from how the patient is accustomed to living. Taking the patient out of a comfort zone in the final months of life seems to work against the primary philosophy of hospice. A freestanding hospice facility within Manhattan allows the patient to experience the last days or months in the same environment that he/she has chosen for the other important stages of life. Many hospice patients are ambulatory, particularly in the beginning stages of their treatment. The city setting allows them to enjoy activities such as dining out, walking on the city streets, or trips to museums and galleries, pastimes which have already become important in their life. Even for those who are not mobile, the city provides easy access to friends and family and a familiar and comfortable environment. In deciding on a site within Manhattan, I concentrated on lower Manhattan where the streets shift from a regular grid to a more organic one. This physical moment of transition echoes the transition the patient experiences, a transition from this world to the next. Of additional importance was proximity to hospitals, parks and gardens, street life, and public transportation.
The sighting of the hospice within the urban center posed an exciting challenge. While most hospices take advantage of their bucolic setting in order to create a peaceful environment, in this situation the design had to create that environment on its own without the benefit of a pastoral landscape. In Manhattan the design could take advantage of not only traditional notions of nature but also those that arise from the culture of the city.

The hybrid typology of the hospice led to a design investigation on two separate sites. The brownstone site allowed for an inquiry into the hospice’s propensity to be home like while the industrial site allowed an investigation into the hospice’s propensity to be institutional. One each site I began with a set of prerequisites imposed by the site size and surrounding buildings. I then worked to incorporate the missing half of the hospice concept on these respective sites. Ultimately this process allowed me to come up with one set of the rules that could be manipulated onto either site.
The brownstone site runs width of one block on 9th and 10th street between 5th and 6th avenues. The location in the West village provides a residential neighborhood setting within proximity to all subways, Washington Square Park, and St. Vincent's Hospital. The site itself is long but very narrow at 184' x 26'.
9th and 10th Streets between 5th and 6th Avenue
The industrial site runs the width of one block on 10th avenue between 18th and 19th and abuts the former elevated rail system known as the High Line. The lot size is the same length as the brownstone site at 184' but it is much wider at 92'. Since it is a corner lot three facades are exposed to the street. The location is convenient to both the Broadway and Eight Avenue subways as well as St. Vincent’s Hospital. Currently, the High Line is abandoned but there are proposals to transform the 1.45 mile long rail system into an elevated greenway. My proposal for this site assumes this elevated greenway to be the case.

10th Street between 5th and 6th Avenue
9th and 10th Streets between 5th and 6th Avenue
Process

__________________________________________

design iterations
I began first working on the residential site. Because it was smaller in scale it allowed me to really begin to understand the program and the way it would work holistically for the hospice. The typical hospice has between 4 and 16 beds. As such, the size of a typical hospice suited a residential site quite well. As I began to collage the programmatic elements I realized that the section was of great importance because it would dictate how these spaces would work together as a whole.
Programmatic Elements

Patient Rooms with private bath
Family Space
Living Room
Kitchen
Dining Area
Nursing Station
Therapy Room
Administrative Offices
Outdoor Garden or Terrace
Chapel
Transition Room
Scream Room
The industrial site was much harder to start on because of its size and lack of constrains. I began the same way I had on the residential site but soon realized it needed a different approach. The size of the site and the location next to the highline meant that the gardens could become very important. My first approach to the gardens was a series of public gardens off the High Line that could be used by the patients and their families as well as the public. As I looked back to my earlier mapping diagram the promenade, or contemplative walk, became very important as well.
I continued to work on both sites taking what I had learned from one and adding it to the other. On the residential site I added interior gardens and expanded the courtyard. I also adjusted the size of the two buildings such that the northern one became shorter and the southern one longer. This allowed more light to penetrate into the interior gardens and courtyard. By shifting one building five feet off from the other I was able to including a ramping system that went from floor to floor and thus allowed for an interior promenade.

Rather that keeping patients in one building and living spaces in another, I adjusted the section so that patient floors and living floor alternated in each building. This would allow a patient to take an elevator to a living floor in his/her building or take a ramp to a living space across the way. In essence I created two houses, one an inversion of the other. This section became very important to my final design.
I brought the idea of separate houses to the institutional sight and investigated how they might interact in a larger framework. Instead of 2 houses I played with 3 and 4 houses attempting to connect them in a way that would allow them to function as a whole. Finally, I integrated the garden concept and the sectional ideas onto the site. I moved the gardens from the exterior of the building to the interior prioritizing the individuals using the hospice.
5th iteration
Final Design
view from southeast
The overarching factors in the final design scheme were the atmosphere of the project, the logic of the design and the variability offered within that logic.

I chose to do my final design on the High Line site. Its lack of site constraints posed more challenges and provided for more opportunities. Additionally, the size afforded the best opportunity to creatively explore the research I had already done on both sites. However, in order to accommodate the large square footage while maintaining a high level of intimacy I added a base facility for hospice home care to the program.

The final design is made up of three similar houses connected by a nursing house. The section of the design originated from work I did on the residential site. The ground floor of each patient house contains its own private entry. Base offices for the home care facility including administrative offices and therapy rooms are also located on the ground floor. In addition to the entry floor, each house contains one or more patient floors and a living floor. The patient floor is made up of four generous sized rooms each with their own bath, operable windows at bed height, and a view to the street, gardens or the High Line. Additionally the floor contains a family meeting space as well as an interior garden.
The living floor contains a large living room with separate kitchen and dining area, an interior garden, and a large outdoor patio. The location of the living floor varies in each house such that house 1 has a living floor on the first floor, house 2 on the second, and house 3 on the third. A patient in any room has the ability to take the elevator to the living floor in their own house or to go down the hallway on the same floor to a living floor in a different house. Each living floor is unique providing a different patient experience. The southern living room is set up as a large library with a small den adjacent to it. The eastern living room is a large sunroom and is arranged so that the main views are out onto the second floor terrace or 10th avenue. The focus of the northern most living room is a large double fireplace. The room is enclosed on three sides and made to feel warm and protected. A side patio opens up onto the interior courtyard.

The ground floor of the nursing house is the main entry to the hospice facility. From that entry a visitor has the ability to walk up a series of public stairs such that he can go from living floor to living floor without ever setting foot on a patient floor. In this way the hospice can be read as a grand estate house or a boutique hotel. Visitors also have the ability to enter through the more private entrances of the individual houses for a more intimate experience.

Sectionaly, the two nursing floors are elevated five feet from the house floors. This allows the main entrance to be grander with a 15 foot ceiling. It also provides some privacy and separation between the patients and staff. The nursing floors connect to the patient floors via ramps that move up or down to the respective floors in each house. In this way the nursing unit functions as a knot, tying the three houses together.
The variability of experience within the hospice is instrumental to the success of the facility. While each house started with the same initial logic, the deviations that occurred in each helped to prevent the building from being sterile and institutional. The variation helps the patient locate himself within the hospice in addition to providing the luxury of choice that is often not afforded to patients at this stage in their lives.

While I had already prioritized the garden in some of the previous schemes they were not fully integrated into the building and did not promote the desired atmosphere. I realized that the goal was not to just have gardens, but to pull the outsides into the hospice. The most important function of the garden in the hospice is to respond to the patient’s loss of function and appeal to their unique sensory and psychological needs. As the body deteriorates the patient moves through the hospice in different ways; first walking, then shuffling, walking with a walker or cane, pushed in a wheelchair and finally being confined to bed. Regardless of the patients’ mobility the experience within the hospice is always a journey. The variation of both the architectural environment and the garden environment within and around the hospice is key to the success of this journey. While I didn’t design each specific garden I placed them with the intention that each would be able to serve a unique experience and purpose. This multiplicity of garden types exists in the hospice in order to respond to the needs of the patients, family and staff.
A feeling of connectedness can be obtained as individuals participate in the care and upkeep of the gardens. For the patient, the gardens can respond to their deteriorating condition. Since hearing is the last sense to leave, the juxtaposition of plant types can provide differing sound qualities as the wind passes through their leaves. As the rain hits the leaves or drips slowly from the roof's edge, it creates both acoustic and visual experiences. Although some cancer patients are sensitive to fragrance, the majority of hospice patients can still enjoy the sense of smell. It can be very important in the hospice setting as it often triggers the recollection of distant memories and emotions. Temperature too has a significant impact on the patient. One garden can have the potential to provide a warm sunny place in the winter while another can offer a cool shaded place in the summer.

The viscosity that exists between the exterior and interior in the garden extends to the patient and living spaces. The rooms flow into each other such that the patient can bring the garden into his room or the family can bring the corridor or garden into their space.

The façade of the hospice works with the concept of variability and also brings in some of the ideas from the early mapping diagram. The only constant openings in the façade are the garden insertions that offer the potential to bring the outside into the house in an introverted way. The exterior of the houses are clad with operable shutters starting on the first floor. The patient or his family can open or close these shutters to adjust air quality, light and noise levels. As the display of shutters on the outside changes it provides hints to the passerby as to what is going on inside the hospice, the process of death in the cycle of life. The terraces are surrounded by trellises that will have climbing plants growing on them. This too offers an understanding of periodicity. The life of one flower is registered as it buds, flowers and dies. So too are seasons recorded as leaves change color or fall off. Finally, the longer spans of time are recorded as the vines get denser and longer through the years.
An accessible ramp connects the outdoor ground floor courtyard to the High Line. The chapel in the courtyard is open to the public in hopes that in addition to the family of patients, other visitors will also enjoy the gardens, courtyards and chapel and take a moment to perhaps contemplate their own place in the world.
Floor 1

Floor 2

Floor 3

Living Room
Patient Rooms
Nursing
home
8am arrives at hospice, reviews paperwork
8:30am visits patients
8am nursing station or with patients
11am kitchen
12am breaks in sunny room dining area
1pm nursing station or with patient
2pm dinner
3:30 pm leave

visitor
8am arrives at hospice to visit
10:30am visits patient in garden
12pm lunch in sunny room
1pm visits with patient
3pm takes walk on balcony, runs errands
5:30 pm visits patient in room
7pm light dinner with patient in library
8:30 pm leaves

patients
8am wakes up
9:30am breakfast
11am visits
12pm kitchen
1pm read in library or visit lounge
3pm new in patient floor gardens
5:30pm visit chapel
6pm sit in place room and has supper
8pm bed

use diagram
1. Main Hospice Entrance
2. Private House Entrance
3. Home Care Facility Offices
4. Inpatient Facility Offices
5. Chapel

Ground Floor Plan
1. Library
2. Interior Garden
3. Den
4. Terrace
5. Kitchen/Dining
6. Patient Room
7. Porch
8. Family Lounge

First Floor Plan
1. Sunroom
2. Interior Garden
3. Terrace
4. Kitchen/Dining
5. Family Lounge
6. Patient Room
7. Porch
8. Nursing Lounge
9. Office/Supplies

Second Floor Plan
1. Main Entry
2. Private House Entry
3. Family Lounge
4. Patient Room
5. Public Stair
6. Sun Room
7. Terrace
8. Nursing Ramp
9. Nursing Lounge
10. Scream Room
aerial view from southwest
interior garden family room and corridor
view into courtyard from high line
courtyard and chapel
view from northeast
bibliography

Books


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All images are by the author unless otherwise noted.

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