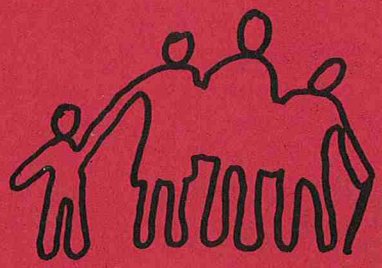
DYING: A FINAL LIFE PROCESS

June, 1977

Ronald H. Albert



Robert Entin, Advisor

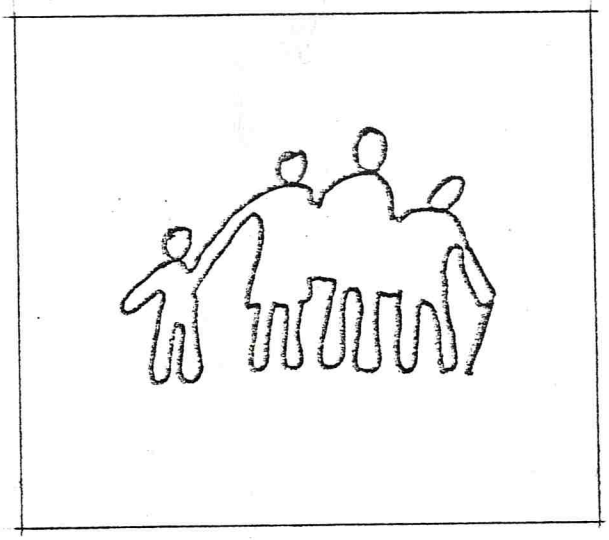
William McQueen
Thesis Committee Rep.

SEGMENT III THESIS

Boston Architectural Center
School of Architecture

Subject

DYING: A FINAL LIFE PROCESS



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To Donna and Jennifer who have given me enough joy in living, to help me design for the dying.

Dedication

Contents

Contents

SCHEDULE	June 14, 1976	Preliminary Thesis development with Advisor.
	Sept. 13, 1976	Thesis Review Committee presentation of Thesis Proposal.
	Feb. 28, 1977	Preliminary Submission.
	Apr. 25, 1977	Intermediate Submission.
	June 1, 1977	Final Submission.

PROPOSAL AND METHODOLOGY

PHASE I
INTRODUCTORY
OBSERVATIONS

Investigate through historical research how people have looked at the quality of life and death. I intend to study the attitudes, customs, and beliefs on the question of death as it related to global cultures, disparate cultures, and the individual person himself, looking for the positive ways of how people have approached this final life process.

How do existing facilities deal with the dying person? Do hospitals, nursing homes, and acute care centers provide adequate service? Are their goals and objectives cure oriented or do they deal directly with the dying person? Consider the environmental and behavioral influences of conditions as they now exist and what they mean to the individual.

Why can't people be given a chance to react to death? Is the death in the dying or can you 'live' until you die? To live is to be aware of what is around you, and to perceive the positive aspects of your surroundings is to deal with the question on an architectural level.

This study will involve personal interviews with experts in the related professional fields associated with the dying person. It will also include extensive reading of materials listed under the resource areas.

PHASE II
CONCEPTURAL
PARAMETERS

Study the dying person through the eyes of the people around him, namely, family, clergy, and staff. From this I intend to assess and interpret the particulars of the 'user' needs. Also, investigate current work in the field, such as, medical research and new trends or attitudes.

I plan to carry out this phase by including personal interviews, observations, and recorded data i.e., possible use of slides, video tape and tape recorder.

PHASE III
THESIS
CONCLUSIONS

In studying the emotional and psychological perseptions of a dying person, I expect that the value of this thesis lies in the question of whether or not 'design' can be used as a therapeutic tool.... I believe it can. I intend, therefore, to develop alternative programming and design criteria

to be used as a model by architects and interior designers working with the care, the desires, and the dignity of persons experiencing this final life process.

Included in the criteria will be my own conclusions, values, diagrams and sketches.

Thesis Review Committee
Boston Architectural Center
School of Architecture
Boston, Massachusetts

October 12, 1976

Dear Committee Members,

Persuant to the presentation of my thesis proposal ("Dying: A Final Life Process") on 9-13-76, I am sending this letter as a statement of intent on the goals and objectives of said thesis and the methods by which they may be realized.

As a guideline to project content, the project can be divided into two prime areas,ie; research and design. The emphasis in the area of research will deal with the dying person, his environment, and that of his family and attending staff. The major objective here is to improve the quality of life for all involved. These improvements will come about as a direct result of the design phase. The above catagories of patient, family, and ataff will be dealt with directly on an Architectural level, but will not necessarily be site specific.

It is my intent therefore, that the thesis serve as a prototypical workbook or benchmark to be used by Architects and Interior Designers dealing with the final life process.

Schedule shall be as follows:

PRELIMINARY SUBMISSION:

A. Research...photographs, sketches, reading material.
B. Alaysis and conclusions... diagrams, charts, value judgements, organizational concepts, verbal and written support.
C. Architectural solutions... schematic design, conceptural parameters, presented in graphic standard format.

Subsequent work to include feedback loop and directional emphasis of Review Panel.

INTERMEDIATE SUBMISSION:

A. Documentation of feedback loop... revised or additional emphasis as required, graphic format.
B. Concurrent research... addition written information, alternative concepts, diagrams.
C. Architectural specifics... details of alternative design, further development of design as a therapeutic tool, graphic and written format.

FINAL SUBMISSION:

A. Design work... final drawings, written information and conclusions.

Sincerely,

Ronald H. Albert

Ronald H. Albert

THESIS ADVISOR

Robert Entin is a Space Planner and Interior Designer, specializing in commercial and institutional environments. Mr. Entin was graduated from Pratt Institute in 1964 receiving the Bachelor of Fine Arts Degree.

Convinced that keen observation of a problem is the key to the solution, Mr. Entin has strived to envolve the end user and his client's ideas into the total fabric of the project. In this way, a closer relationship is formed from within the total design, not necessarily imposed from without.

Mr. Entin is now Senior Design Manager with ISD Incorporated, Boston, Massachusetts.

THESIS EXPERTS

William Redpath, Instructor at the Boston Architectural Center, and Instructor at McLean Hospital.

Art Smith, Boston Architectural Center, 320 Newbury Street, Boston, Massachusetts.

PRACTICING PROFESSIONAL EXPERTS

Sandy Bertman, Member of Equinox Institute, Boston, Massachusetts.

Rev. Dr. Ned Cassem, Director of Counseling, Youville Hospital, Cambridge, Mass.

Lo-Yi Chan, Architect for Hospice, New Haven, Connecticutt. Prentice & Chan, Ohlhausen, Architects and Planners, 500 Fifth Avenue, New York, New York 10036.

Rev. Edward F. Dobihal, Jr., Ph.D., Chaplin, Yale-New Haven Hospital.

David Dolins, Associate Director at Beth Israel Hospital, 330 Brookline Avenue, Boston, Massachusetts 02215.

Rabbi Earl Grollman, Author, Temple Beth El, Belmont, Massachusetts.

Dr. Allan Kliman, Director of Hematology and Onocology at Massachusetts Rehabilitation Hospital, Boston, Massachusetts.

Frank Kryza, Public Relations, Hospice, 183 Cold Springs Street, New Haven, Connecticutt 06511.

John McAward, Universal Unitarian Service Committee, Boston, Massachusetts.

Mrs. Frances Mervyn, Institute of Human Relations Service, Wellesly, Massachusetts.

Judi Paroli, Boston College faculty, School of Nursing.

Dr. Mitchell D. Rabkin, General Director Beth Israel Hospital, 330 Brookline Avenue, Boston, Massachusetts 02215.

Patti Seidman, Teaching Assistant to Lo-Yi Chan, Massachusetts Institute of Technology, Boston, Massachusetts.

Patrick J. Slattery, Architect, 129 Leominster Road, Lunenburg, Massachusetts.

THESIS SUBJECT

DYING: A FINAL LIFE PROCESS

Dying is a natural, universal process of life. The process involves the breaking down of human organs. But, more importantly, it is the superstitution, fear of pain and the unknown associated with this natural process that have created most of the negative attitudes towards death and the dying person.

It is my purpose to discover the relationship between the physical/psycological aspects of the patient's needs, the involvement of the family as a unit, and the importance of staff sensitivity in the dying process and ultimately how these relate to Architecture.

In studying the physical/psycological perceptions of people, I expect that the value of this thesis lies in the question of whether or not 'design' can be used as a therapeutic tool.... I believe it can.

I intend, therefore, to develop alternative programming and design criteria to be

used as a guide by Architects and Interior Designers working with the care, the desires, and the dignity of persons experiencing this final life process.

NEED FOR TERMINAL CARE FACILITY

Recently there has been an increasing amount of attention paid to death and dying as a significant part of the process of life. This has been noted in the increased number of articles and books written for professional and public consumption. Television and radio air time has been devoted to the subject, as well as symposiums, special lectures, and many seminars in medical schools and medical-care facilities.

From a designer's standpoint, a glossary of terms for dealing with terminally ill patients might serve as a way to humanize the experience so that people could at least talk about it.

To achieve properly planned buildings for terminally ill people, it is necessary to raise the consciousness of the people who are going to use them and to educate the architects who are going to design them. The subject is so new that this phase of gathering research and translating it to concrete architectural theory and design must be the first step to be taken by

someone like myself as an Architect.

Certainly, this is an indication of the need to provide the most appropriate care to the terminal patient and his family, combined with opportunities for health care professionals and health care workers to learn from the terminally ill and the bereaved. Special attention should be paid to the personal attitudes that we have developed about death that may be standing in the way of providing the best care to the dying. Within the scope of such an endeavor is the specific input to be supplied by the Architect which must consider all of the available information on this subjict to date, in this and other diciplines.

In order to develop design criteria, it is necessary for the Architect to carefully list his goals and onjectives. I believe that the integrity of the family unit must be maintained, and to that end the goal of sustaining emotionally, as well as physically, the patient-family, with regards to the acute nature of the illness,

demands a new type of facility.

GOALS AND OBJECTIVES

The following then is a list of goals and objectives that will be a guide in trying to deal with the problems that involve the patient, the 'family unit' and the acute-care staff.

1. To sustain the 'family unit' within a new type of acute care facility.
2. To raise the conciousness of those involved so that relationships are strengthened, lived out, and concluded as productively as possible.
3. To create the most appropriate homelike-atmosphere to meet the specific needs of the patient-family under acute stress situation in order to feel in a more homelike environment.
4. To allow for the different stages of dying* by providing specific architectural environments and

* Kubler-Ross, 1. denial and isolation, 2. anger, 3. bargaining, 4. depression, 5. acceptance.

elements which would help the users to move through each phase of the final life process with better understanding.

5. To include specific design elements which encourage and help the staff to overcome the acute stress associated with working within this environment and professional field.

INTENT

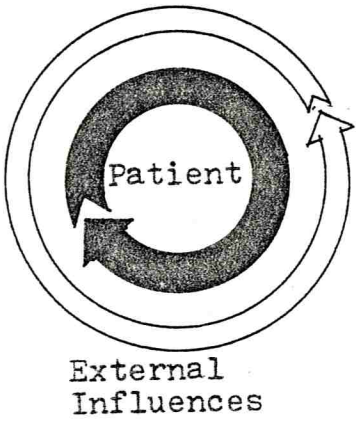
All of these architectural elements are designed to provide therapeutic benefit to the patient, family and staff. These benefits are intended to be physical, psychological and emotional.

The elements are designed to:

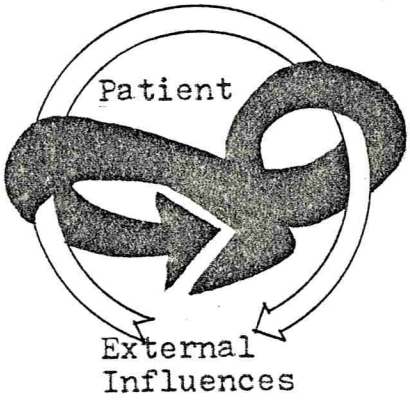
1. Encourage expression of the normal defenses of the individual, which act as a barrier in what could be a more helpful and positive approach to the process of life.
2. Encourage the positive beneficial aspects of talking about or dealing directly with death and those things related to acute care.
3. Promote the "Circle of Peace" (new term by R.H.A., see diagram)
4. Show by example the positive experiences of others as modified behavior models.
5. Provide reassurance to all involved that they may move through the process and that a specific facility and open attitude has been provided

for them because of their special needs.

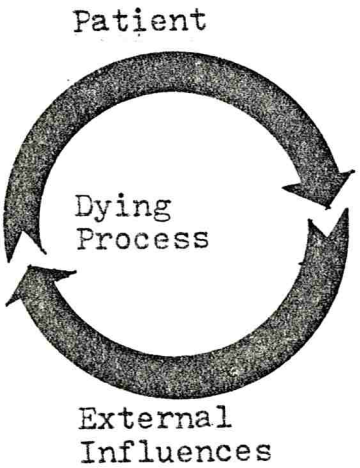
DEVELOPMENT OF 'CIRCLE OF PEACE'



In this stage, the patient feels a complete inward orientation. At this point, he may be the only one who knows of his terminal condition. There is usually a withdrawal or rejection as relates to other people.



A communication between the patient and others begins. People are beginning to understand their feelings with the help of the facility and staff guidence. The patient allows external influences to expand and an interaction begins.



Ideally for the patient, all of the people around him must help him by allowing him to settle his affairs and to die in peace. As relates to the environment then, it is up to the designer to provide for the needs of the patient and those around him as they move through these stages.

As the people involved are able to gain the necessary and beneficial therapeutic value provided by the design of the facility, they will find it easier to fulfill each others psychological and emotional needs. Specifically, the patient can be honest and open as related to his inevitable separation from life. Accordingly, if the family is afforded the opportunity to express their feelings, they will not suffer as much from guilt feelings connected with the death of others and the grieving process will be less of a problem.

With these things in mind, the 'Circle of Peace' should be self perpetuating and no longer shall the dying be shunned or forgotten.

INTRODUCTION

I first became interested in looking at the problems associated with the design for the terminally ill and its relationship to architecture about mid summer of 1976. Originally, I had considered a thesis dealing with the architectural problems of sightless people and their very special needs. During ensuing discussions with my advisor it was mutually agreed to set my thesis goals towards a slightly different target, one where less time had been spent by others in our profession, but one certainly all encompassing and worthy of initiating my thesis study: the terminally ill patient.

In the preliminary stages it was clear that available documented information on this subject would be difficult to obtain.. ..... historically, research studies are perhaps only four to five years old. In a way, this helped form my primary research philosophy, its basis being "not taking a piece of information as a given truth until such time as it had been

proven as a design axiom by being held up to my criteria of investigation for this problem alone", ie., when studied against a background of the problems of the terminally ill patient. Which is to say, nothing that now exists, or that has been designed in the past, could be viewed as valid, unless it had been justified.

One of the basic underlying questions I asked myself is "What is the quality of care that existing hospitals provide in the case of terminally ill patients?" The answer simply stated is that..... philosophically and by design, hospital health care facilities are "cure oriented", therefore, in treatment of the terminally ill patient, the hospital's goals and objectives are no longer valid. Typically, the terminally ill patient will be quietly isolated from other patients, communication between patient and staff will decrease and eventually he will be left alone, shunned because of his lack of response to the cureative treatments being

administered by a non-caring staff.

Too often in the past, severly ill patients have been treated like inanimate objects with no rights or feelings. They have become little more than painful reminders of their progress charts, manifesting treatment without staff sensitivity from test to test and x-ray to x-ray. Sick people do have feelings, desires, opinions, dignity, and most of all, the right to be heard.

The truest test of any ideal model is in its application to the built architectural environment. My Design Workbook will be a "graphic standard" source model which considers emotional, as well as physical user needs (patient, family, staff). This will hopefully transfer the relevant background data needed by those striving for design concepts and solutions specifically intended to deal more sensitively with those experiencing this final life process.

CONCEPT

The concept of this thesis is clearly that terminal patient care must deal with the reality of death, and the complex emotional transitions being experienced by each member of the "family unit".

Its basis is that the patient and members of the family be allowed to move through and experience these emotional, as well as environmental stepping-stones* within a structured framework, sympathetically designed to enhance learning and understanding of the dying process.

The "family encounter" type of learning which takes place then becomes the key to permitting, whenever possible, the patient and family to return to their home, hopefully better equipped to live more constructively with the reality of this final life process.

The facility being considered here is in-

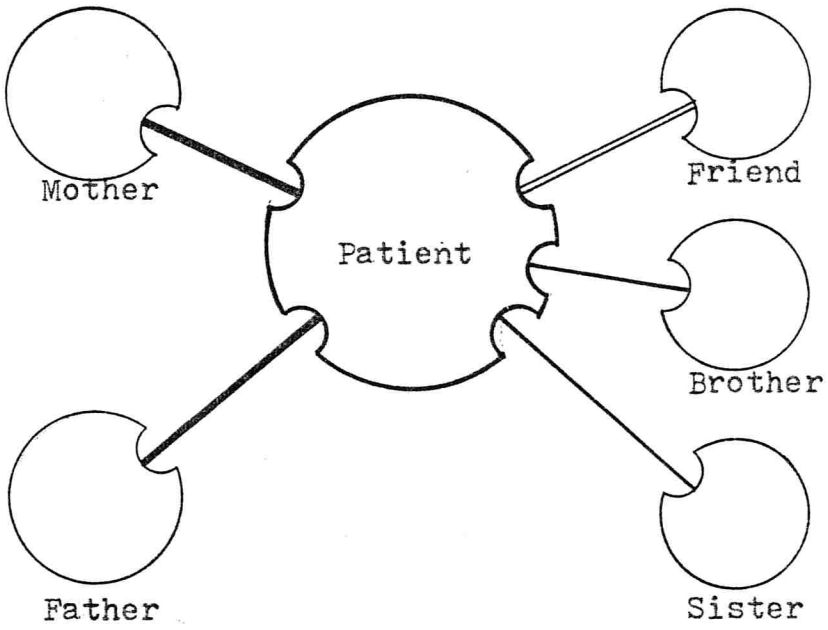
*more appropriate architectural elements, spaces and conditions aimed at the specific psycological, emotional and physical problems of terminally ill, their family and staff.

tended to be as flexible as possible in attending to the specific needs of its users. Therefore, the benefit lies in a twofold commitment. First, that of a short term seminar/care family experience can occur, and secondly, its extended use as a terminal, long stay facility, geared towards the "family unit" structure.

'Blood Family Unit'

'Professional Family Unit'

'Peer Group Family Unit'



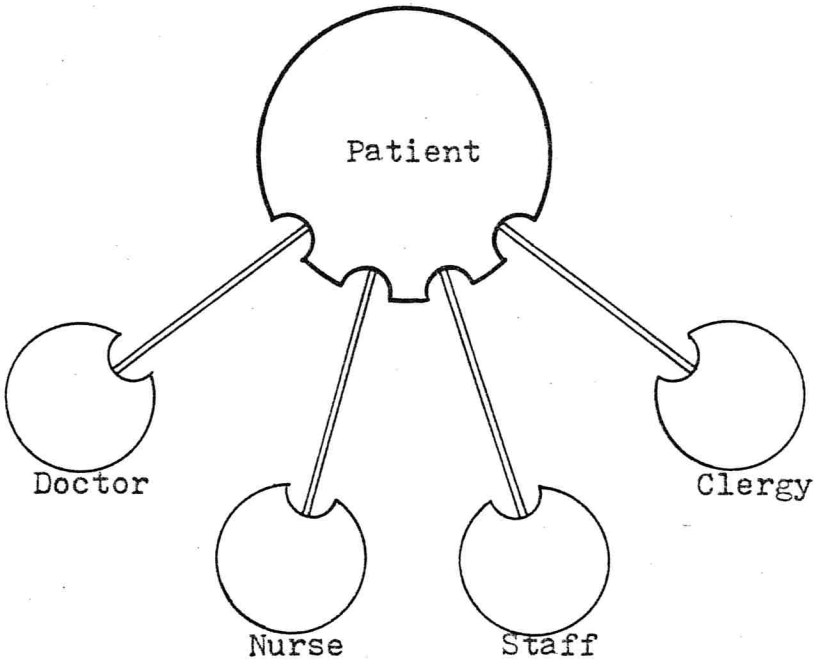
'BLOOD FAMILY UNIT'

This includes the group of persons connected by blood or marriage, forming a household. This 'Family Unit', as I understand it, is the most basic of all social environments and is the nucleus around which other bodies of society are gathered.

It is the understanding of this 'Family Unit' that makes up the basis of my personal views regarding the problems of designing for the needs of a terminally ill person. Kubler-Ross states, "We cannot help the terminally ill patient in a

really meaningful way if we do not include his family". Therefore, it is critical to the dying person to feel the reinforcement of the family of which he is a part, and in this sense, they share in the resolution of the psychological and emotional experiences as they relate to this final life process.

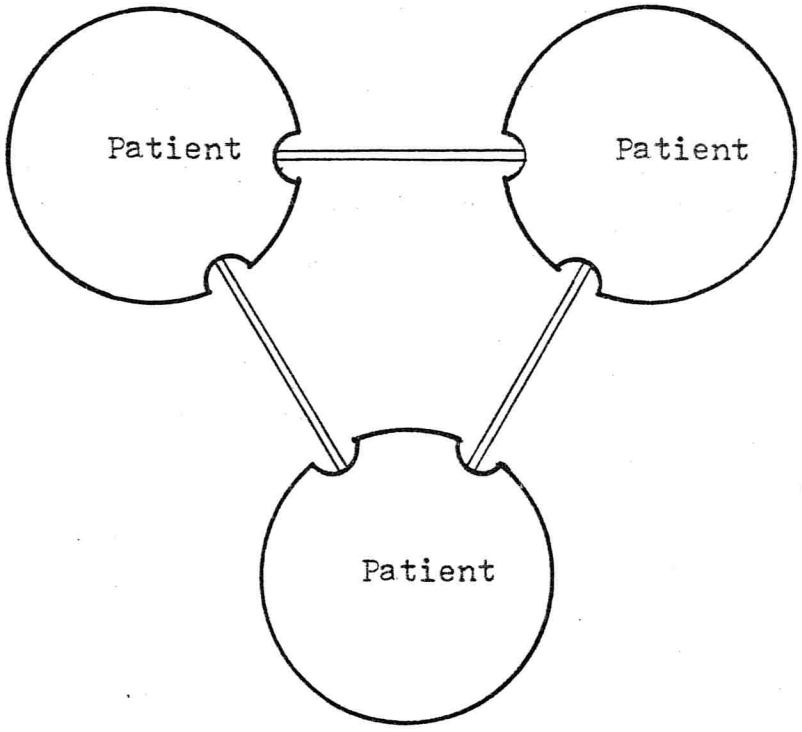
note: In some cases friends have closer psychological ties than found in a blood relationship.



'PROFESSIONAL FAMILY UNIT'

This includes the doctor, nurse, volunteer staff, clergy, etc., who because of their involvement with the patient, establish and sustain a psychological and emotional relationship. This relationship forms another sphere of kinship and understanding within which a patient may act out his need for this type of embodiment. Kubler-Ross states, "An understanding person will have no difficulty in eliciting the cause of a particular depression, for example, and in alleviating some of the unrealistic guilt or shame which often accompanies the depression",

Because of their training, understanding, experience and concern, the 'Professional Family Unit' could prove to be the key in this terminal care situation. "It is the discrepancy between the patient's wish and the expectation of those in his environment which causes the greatest grief and turmoil in the patient". Too often this discrepancy goes unnoticed from the 'Blood Family Unit' point of view. However, "If the members of the helping professions could be made more aware of the discrepancy or conflict between the patient and his environment, they could share their awareness with the patients' families and be of great assistance to them and to the patients".



'PEER GROUP FAMILY UNIT'

This group includes other terminal patients, all of which are bonded together because of their common situation. It is this group of people who can learn from one another and share some very personal feelings because of their identification with each others problems. Accordingly, it is the only group that can lend peer support to a dying person. The interaction of these individuals can often lead to a special type of understanding and positive exchange because of the strong example of others. Also, the peer group individual is most likely to recognize

the need of others "to live to the end with dignity" as they themselves experience the same vital need.

SUMMARY OF PRELIMINARY SUBMISSION

A short slide presentation along with a tape recorded segment were presented simultaneously. The intent of this carefully structured delivery was to capture and reorient the attention of the viewer as related to the chaotic nature of the material, that is, design for dying. In other words it was to act as a transitional experience to help raise the consciousness of those present as it related to the introduction of research findings dealing with alternative programming and design criteria necessary to provide architectural solutions for a terminal care facility.

The graphic illustrations presented were schematic in nature and were used as a basis for the workbook section of this Thesis.

ANALYSIS AND CONCLUSIONS OF "PRELIMINARY SUBMISSION"

Presented studied approach to developing design elements for workbook guide, with the possibility of integrating elements and testing them in a design. Conclusion: more would be learned by applying these elements to the test of a total design than to deal simply with elements themselves.

Background and research material is difficult to put out to review panel. The issue of Death as a chaotic experience and how one should deal with it for the first time, is critical to understanding the complexities of the problem. Conclusion: the designer should take special care in attempting to transfer his knowledge of background and research material to any such panel members or to other designers by first describing what his philosophy is and by putting his information out slowly enough for others to absorb.

A difference exists between the terminal patient and a curable patient. Once that difference is perceived, the terminal patients' needs become very different than those of others.

for example:

A. His perseption of space changes because his condition is irreversible.
B. His awareness of the passage of time is heightened because of terminal condition.
C. Inevitabe grief that the patient and family must face.
D. Other peoples' view of patient changes when they find out that his condition is terminal.

Conclusion: the Architect is now compelled by this new set of critical, emotional criteria to shape his understanding of the design process to meet these needs head on and to provide the necessary elements and facilities which help directly with this problem. Also, to help deal specifically with problems that arise, an understanding of the "Stages of Death"* as they may relate to individuals is necessary at this point. Furthermore, a breakdown of elements can now be listed to offer direct "solutions" to the problems of the people who pass through these stages and to those around them.

*Kubler-Ross, 1. denial and isolation, 2. anger, 3. bargaining, 4. depression, 5. acceptance.

BOSTON ARCHITECTURAL CENTER
320 Newbury Street
Boston, Massachusetts 02115

SEGMENT III REVIEW PANEL REPORT

(PRELIMINARY/~~INTERMEDIATE/FINAL~~)

STUDENT NAME: RON ALBERT DATE: FEB. 28, 1977

SEGMENT III REP. Peter Smith * GRADE: Pass

ADVISOR: R. ENTIN * GRADE: Pass

EXPERTS: Art Smith * GRADE: Pass

William Redpath * GRADE: Pass

* OVERALL GRADE: Pass

The Faculty Advisor, as Chairman of the Review Panel, will record a concensus of the Review Panel on the following items and submit this form to the Segment III Committee:

1. Description of project and areas of strengths in work thus far:

See attached sheet

2. Areas in need of further investigation:

See attached sheet

3. Items to be completed prior to next review:

See attached sheet

4. General Comments:

See attached sheet

* Grades are to be either PASS, FAIL, OR COMMEND.

PV/MS

Rev. 8/3/76

1. Dying: A Final Life Process — Designing for the special needs of the Terminal Patient

Ron's commitment to his subject and his direct interaction with advisor, subject experts and the Review Panel are the main areas of strength to date in dealing with this exceptionelly controversel subject matter: Death. Slides presented helped create mood, but advisor introduction of subject was lacking & should be required by request from Review Panel Rep.

2. More advanced thought with emphasis on precisely those things which distinguish the Terminal Patient from other patients is needed. Specific stages of the dying process, emotionally and physically, are to be dealt with through the application of special solutions and design elements. Proper delivery and presentation of materials is to be considered the key to the eventual sucess of this thesis. ie. presentation of the ideas dealing with death and dying.

3. Immediate focus of research data applied to the following:

   a - Graphic Standard Workbook
   b - Design of Special Facility to test Workbook ideas.
   c - Presentation Techniques

4. The close interaction between members of the Review Panel was stimulating. It was the educational process at its best: Learning took place. Positive criticism, exchange of ideas, student encouragement were all in evidence; elements of learning which one wishes were always observed at the BAC, but unfortunatly are at times absent. In all, an excellent session for everyone. Session duration: 3 hours.

PROGRAM

PROGRAM REQUIREMENTS FOR DESIGN OF A FACILITY FOR THE TERMINALLY ILL:

Location: Northeastern United States

Capacity: 30 guests

Age of Guest: 8 to 30 years old

Culture: Open to all cultures

Staff: Full and part time staff and volunteers.

Economic Support: 1/3 Government Grants
1/3 Community Organizations (United Fund, etc.)
1/3 Fees and Donations

Design Breakdown:

A. Site Development
1. access road or drive
2. parking
3. access to building
4. walks
5. activity areas

B. Building Development
1. entry
2. lobby/foyer/commons room
3. gift shop
4. dining room and kitchen
5. counceling room
6. visitor rest rooms
7. patient - bulk storage area
8. administrator's office
9. pharmacy
10. clergy-social worker office
11. nurse station
12. staff lounge
13. medical director's office
14. examination rooms
15. doctor's offices
16. community room
17. nursery
18. solarium

19. barber/beauty shop
20. housekeeping storage area
21. seminar room
22. guest room
23. family encounter room
24. noise room
25. whirlpool/exercise room
26. holding area for body
27. chapel

SUMMARY OF INTERMEDIATE SUBMISSION

The following is the documentation of the written and graphic information of the important elements which were discussed at the Intermediate Submission.

ARCHITECTURAL PRESENTATION SYNOPSIS:

On approaching the site, the visitor parks his car in the area provided. From there, the physical approach to the facility is accomplished by individual 'capsules' similar in nature to a mini-bus vehicle or enclosed golf cart. A member of the Greeting Committee meets the first time visitor at the Orientation Center to begin their trip. By a series of interconnecting pathways the visitor or user may approach the Entrance directly or may chose to explore the grounds first. The important thing to remember here is the value of this approach as it relates to a design tool acting as a transition between ones existing consciousness and his impending new experiences.

The organizational concept for the plan of the building was an "L" parti with a repetative wing as shown. This type of spinal circulation allows for many of the design

considerations that I considered valuable as a result of my research and analysis of users' needs. For example:

1. It allows for a variety of spaces.
2. Clear circulation spine.
3. Offers many vistas.
4. Chance to delineate public vs. private space.
5. Includes strong nodes of activity or special events, i.e., inside and outside corners and termination of axial processions.
6. Implication of separate zoning qualities for either side of spine.

The decision to develop this spinal concept enabled me to implement those architectural elements which I felt would focus most directly on my understanding of these user needs.

PARKING

ORIENTATION CENTER

DEPRESSED SERVICE ROAD

ENTRANCE

BUILDING

DEPRESSED SERVICE ROAD

"PLAYGROUND"

STORAGE STATION

PROPERTY LINE

"PRIVACY" STATION

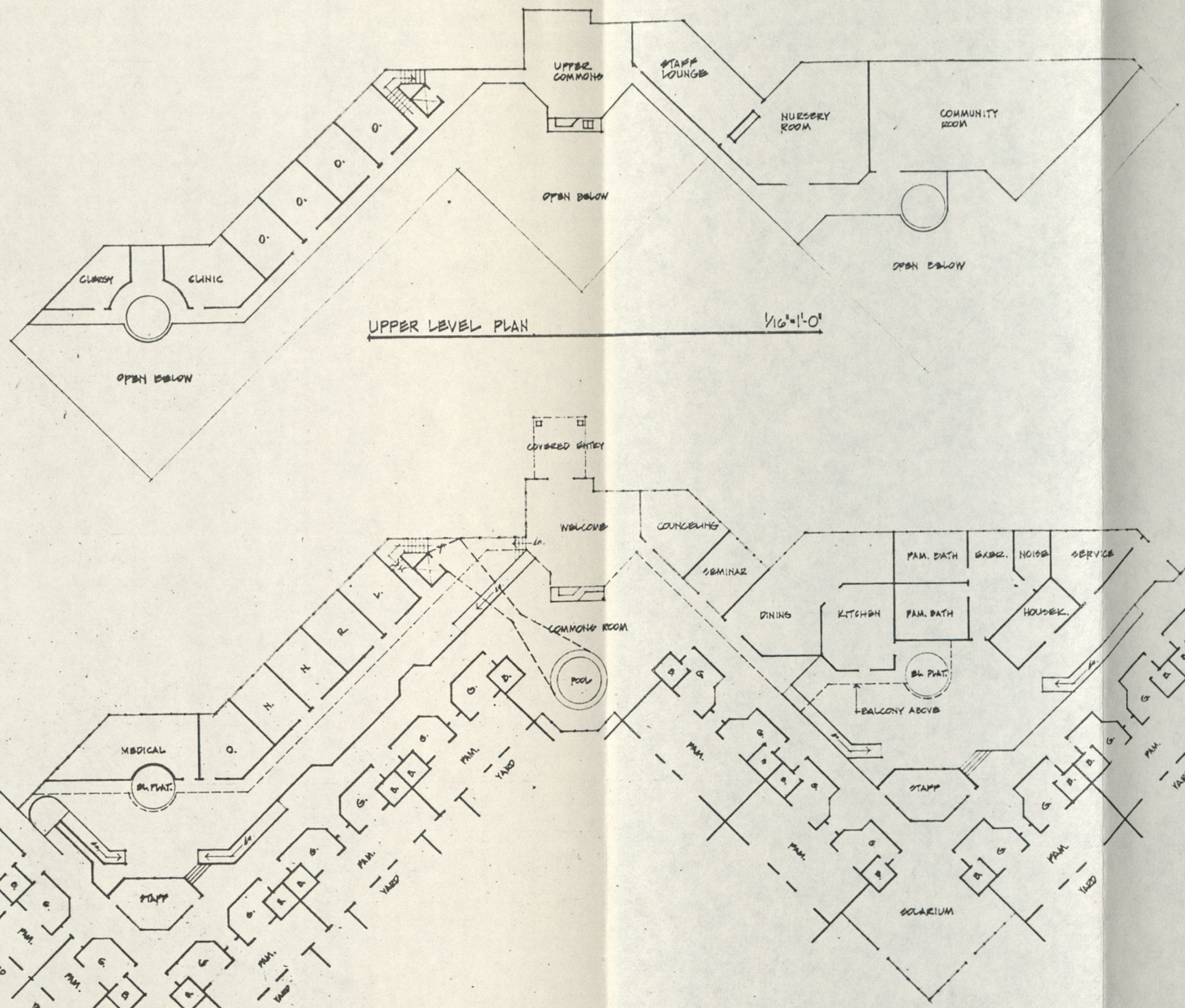
NORTH

"ISLAND"

LAKE

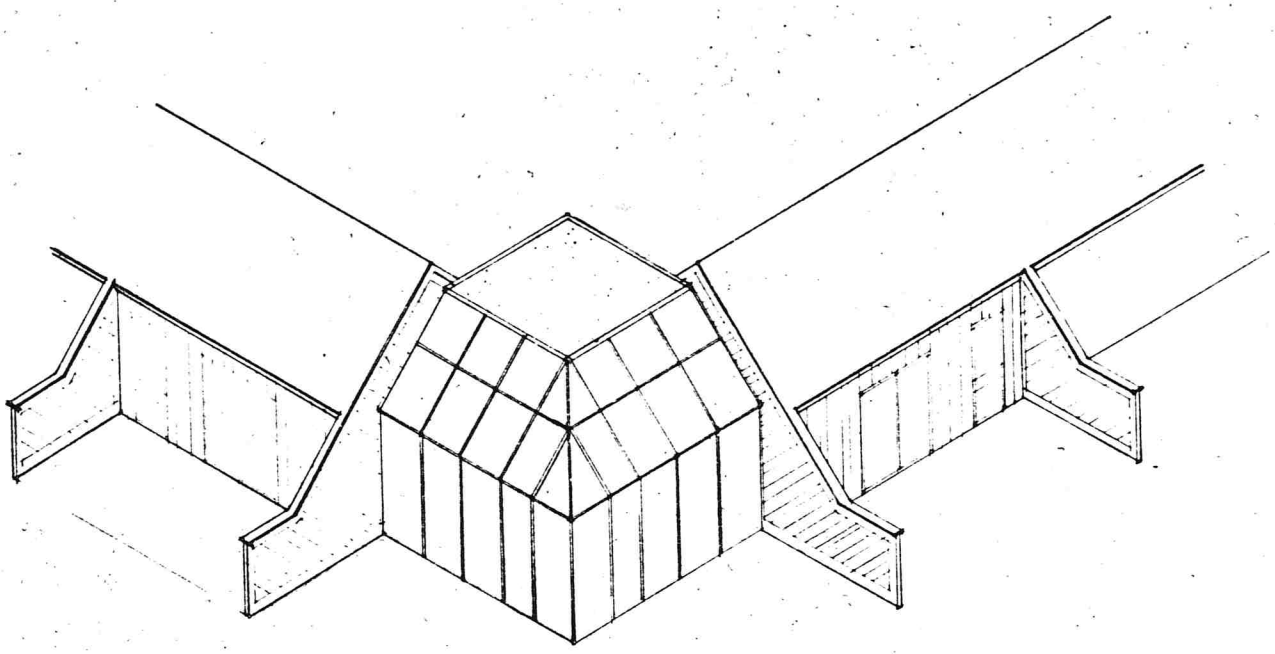
"PRIVACY" STATION

SITE PLAN 1"=40'

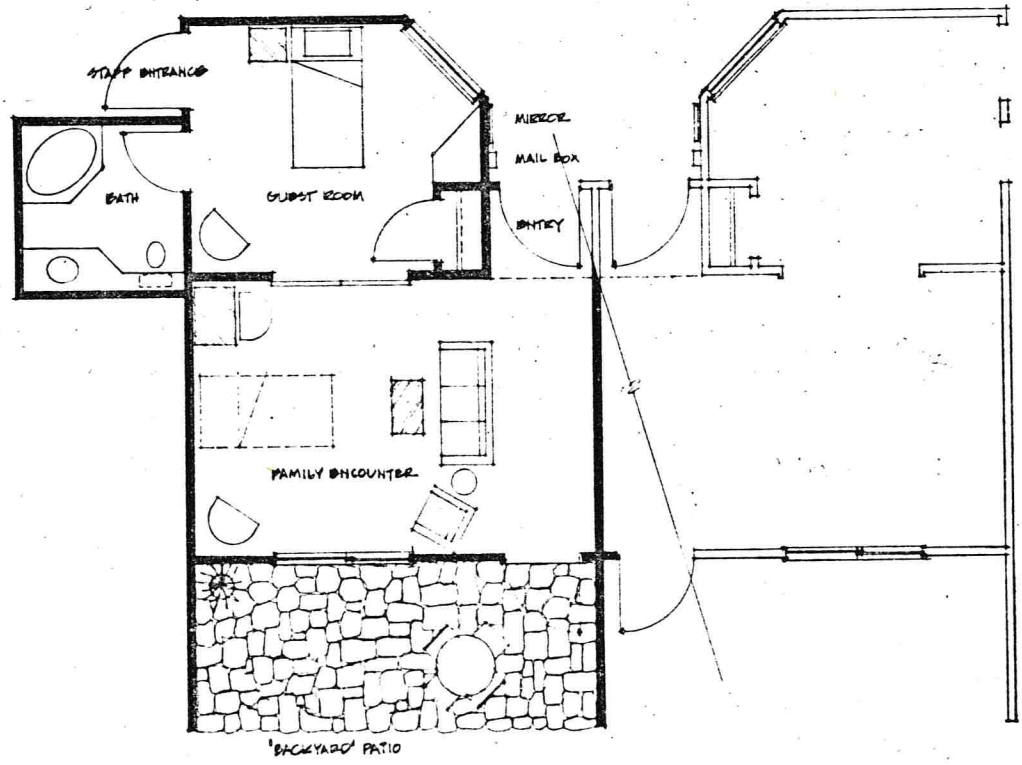


UPPER LEVEL PLAN 1/16"=1'-0"

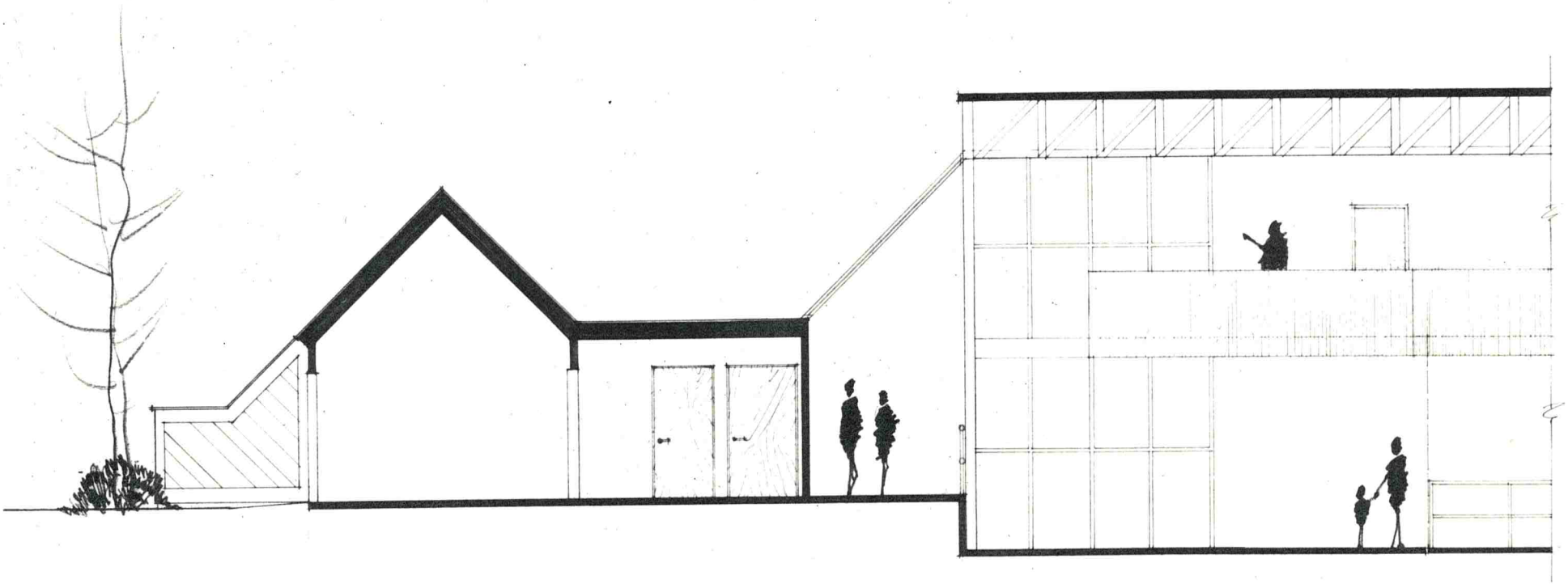
MAIN LEVEL PLAN 1/16"=1'-0"



SKETCH @ "SOLARIUM" NO SCALE



TYPICAL 'SINGLE FAMILY' UNIT 1/4"=1'-0"



SECTION @ UNIT 1/4"=1'-0"

GLOSSARY OF TERMS

Please note that throughout the Workbook, an attempt has been made to humanize the terms used when dealing with the needs and environment of the terminal patient.

The names given to specific rooms and areas of the facility, as mentioned on the following pages, were carefully chosen in order to help the users of the facility feel more at ease.

PLANNING AND DESIGN CONSIDERATIONS

Site:

1. Approach Vehicle- Will provide necessary transition for all arriving users and visitors.

2. Pathways- Will provide a degree of options or choice as to which one to follow.. Some may be dimly lit for those who do not care to be seen.

3. Playground- Outdoor play area for use by the younger patients, visitor's childrens and children of staff and volunteers.

4. Backyards- Are provided to reinforce family idea of occupying outdoor private space similar to that of a private dwelling unit.

5. Vegetable Gardens- Will provide for hobby and outdoor activity. This will also help with the passage of time and will symbolize the living process as the antithesis of having to deal only with the dying process.

6. Privacy Stations- Certain areas of the site are set aside to allow for individual or family privacy.

7. Lake- Will act as a separator and as a gap, on the other side of which a person can leave his problems.

8. Island- Will act as an oasis on which the people are made to feel secure. The idea suggests a positive emotional experience as relates to privacy or hiding place.

note: see workbook ideas for details.

All of the above site related design con-

siderations as well as the building consideration are intended to reflect a more sympathetic, human, slow-paced, 'homelike' character than is currently available.

Building:

1. Entrance- Designed to include such familiar elements as fireplace, informal seating, glass and plants, in order to allow people to identify with a homelike attitude and to feel psycologically, emotionally and physically comfortable.

2. Counceling Room- This room is especially for first time visitors and its function is to orient the potential user and his family to the facility.

3. Guest Room- Is a private room similar to a bedroom at home.

4. Family Encounter Room- Room where family can feel at home, similar to a living room. Also acts as a transitional space before entering guest room.

5. Grieving Room- Provided specifically to allow for preparatory and continuing grief.

6. Hiding Place- Area intended to allow for hiding and a place for people to be alone.

7. Noise Room- This room could have the same use as the grieving room except that it would be completely soundproof with pillows and cushions for hitting, to vent frustrations.

8. People Path- A sky lit connector which would make people aware of where they are in relation to the passage of time and weather.

9. Talk Shop- A room outside of individual's room- just for talking.

10. Nursery- Would serve as a day care facility for staff and volunteers' children. This would act as a refresher for those under stress.

11. Proud Path- Designed as a second level balcony that overlooks their environments. This architectural element would allow users of the facility to identify with their new home.

12. Seminar Room- For use by the professional staff to provide and work on data, program and design concepts to help improve on what exists in terms of terminal care facilities.

13. Doctor Office- Will be located so as to allow the patient to make a visit to the doctor or the doctor to make a 'housecall' to the patient. This planning element of movement and the therapeutic value of the doctor coming to them.

14. Exercise Room- Will allow for structured physical exercise for use by all and will allow for idea of positive activity.

15. Community Room- Provided specifically to encourage the exchange of the community which exists outside of facility with that of internal facility community, a learning experience for all.

16. Chapel- A non-denominational place of worship, ceremony or ritual connected with the spiritual needs of user.

note: see workbook ideas for details.

ANALYSIS AND CONCLUSIONS OF "INTERMEDIATE SUBMISSION"

The graphic presentation consisted of a ner building type with site, floor plans, building section and sketches. This was used as a model to illustrate a specific architectural organizational concept a-round which the elements were gathered and tested to see how they work individual-ly, and as a whole. My presentation de-livery was structured to allow for the statement and reinforcement of my design concepts and philosophy. (see Subject, Jus-tification, Concept and Intent) Discussion centered on several of the "Elements of Architecture" as they relate to the differ-ent stages of dying and to the individual's feelings. For example, the need for tran-sition, community and privacy spaces and the specific architectural solutions which are more appropriate than others in meeting these needs were discussed in depth. (see breakdown of work elements) Conclusion: Panel asked for alternatives as they relate to building type as well as a continued development of the building type presented. The method of testing out design solution elements against a building type is a valid

one. The written documentation of goals, analysis and solutions was requested by the Review Panel. (see workbook section) These are all to be included in the Library Abstract and Workbook. Progress to date was acceptable to Review Panel and work toward a final submission was to commence. (see segment III Review Panel Report for Intermediate Submission).

BOSTON ARCHITECTURAL CENTER
320 Newbury Street
Boston, Massachusetts 02115

SEGMENT III REVIEW PANEL REPORT

(~~XXXXXX XXXXXX~~/INTERMEDIATE/~~FINAL~~)

STUDENT NAME: RON ALBERT DATE: APRIL 25, 1977

SEGMENT III REP. BILL MCQUEEN * GRADE: Pass

ADVISOR: R. ENTIN * GRADE: Commend

EXPERTS: A. SMITH * GRADE: Pass

W. REDPATH * GRADE: Pass

SEGMENT III REP.: P. SMITH (ALTERNATE) * OVERALL GRADE: ~~Pass~~ Pass

The Faculty Advisor, as Chairman of the Review Panel, will record a concensus of the Review Panel on the following items and submit this form to the Segment III Committee:

1. Description of project and areas of strengths in work thus far:

   Dying: A Final Life Process – Designing for the special needs of the Terminal Patient.
   Ron's presentation was very strong and dealt directly with the specific items of facility design requested at the previous review meeting, as well as with new material to date.

2. Areas in need of further investigation:

   More documentation of alternative design solutions, specifically with regard to the Staff spaces, and the mix of both "residential" & "institutional" aspects of the complex. Particular attention to shapes & massing. More written documentation of goals, reason for emphasis, & solutions and relationships are needed.

3. Items to be completed prior to next review:

   1. Advanced design of facility.
   2. Workbook
   3. "Abstract documentation"
   4. Continuing Contact with Experts.

4. General Comments:

   Ron demonstrated a very refined and sensitive grasp of the specialized nature of this project. He has progressed both technically with the tools of the architect, design of space, but more importantly he has been able to communicate his strong ideas with relative ease and shows much compassion as a designer for the needs of the end users: family & staff.
   Session duration: 3 hours

* Grades are to be either PASS, FAIL, OR COMMEND.

PV/MS

Rev. 8/3/76

WORKBOOK

The Workbook is structured in two parts.

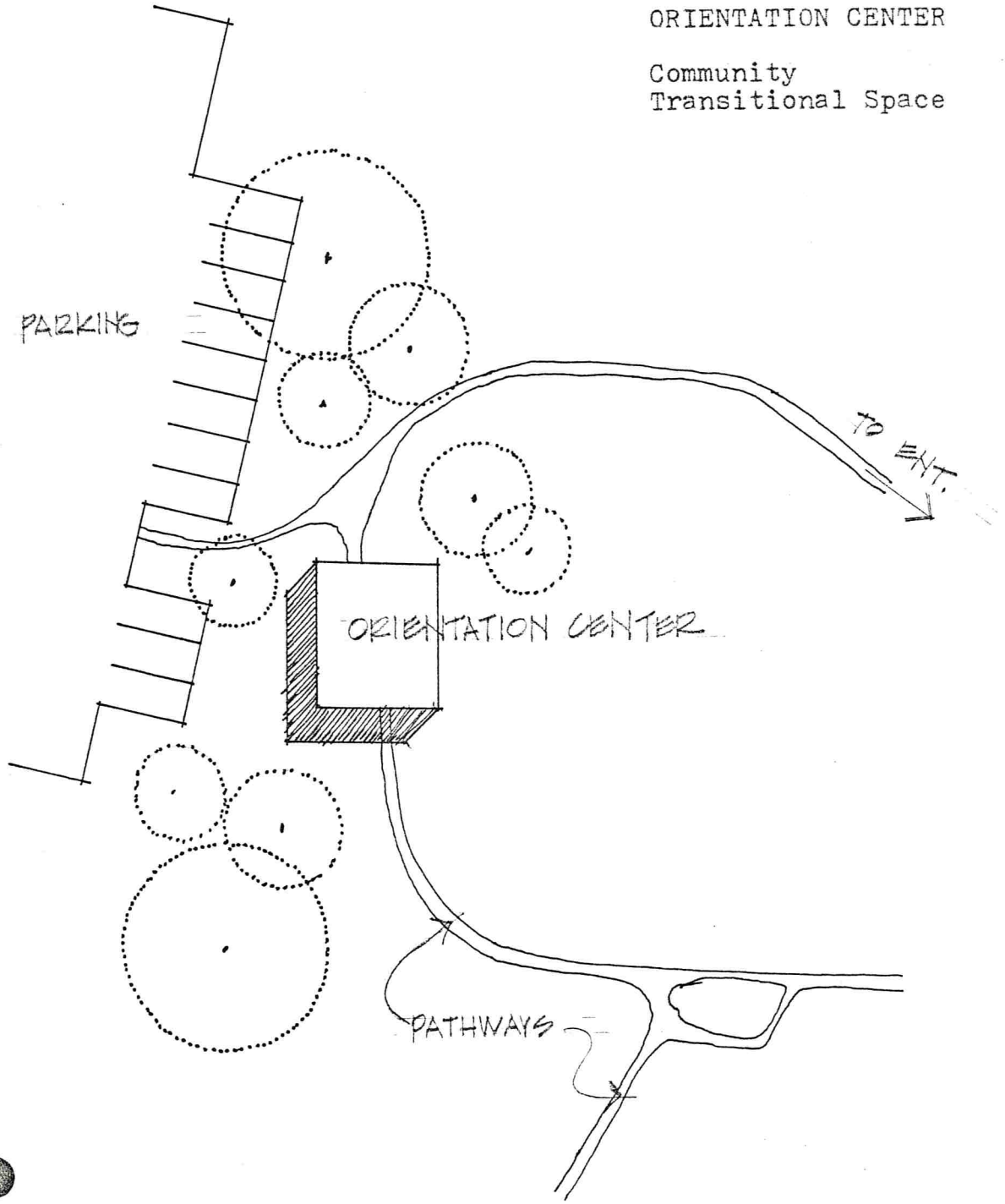
Part I: Architectural Diagrams

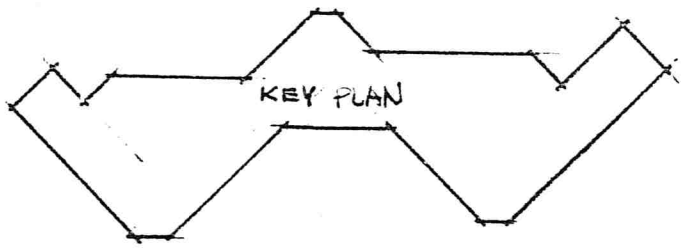
Part II: Written Documentation

Indicated on the diagrams is a list of appropriate emotional/environmental experiences. The explanation of these experiences is documented in Part II.

ORIENTATION CENTER

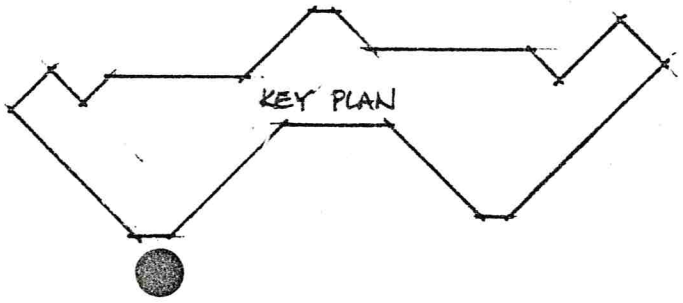
Community
Transitional Space

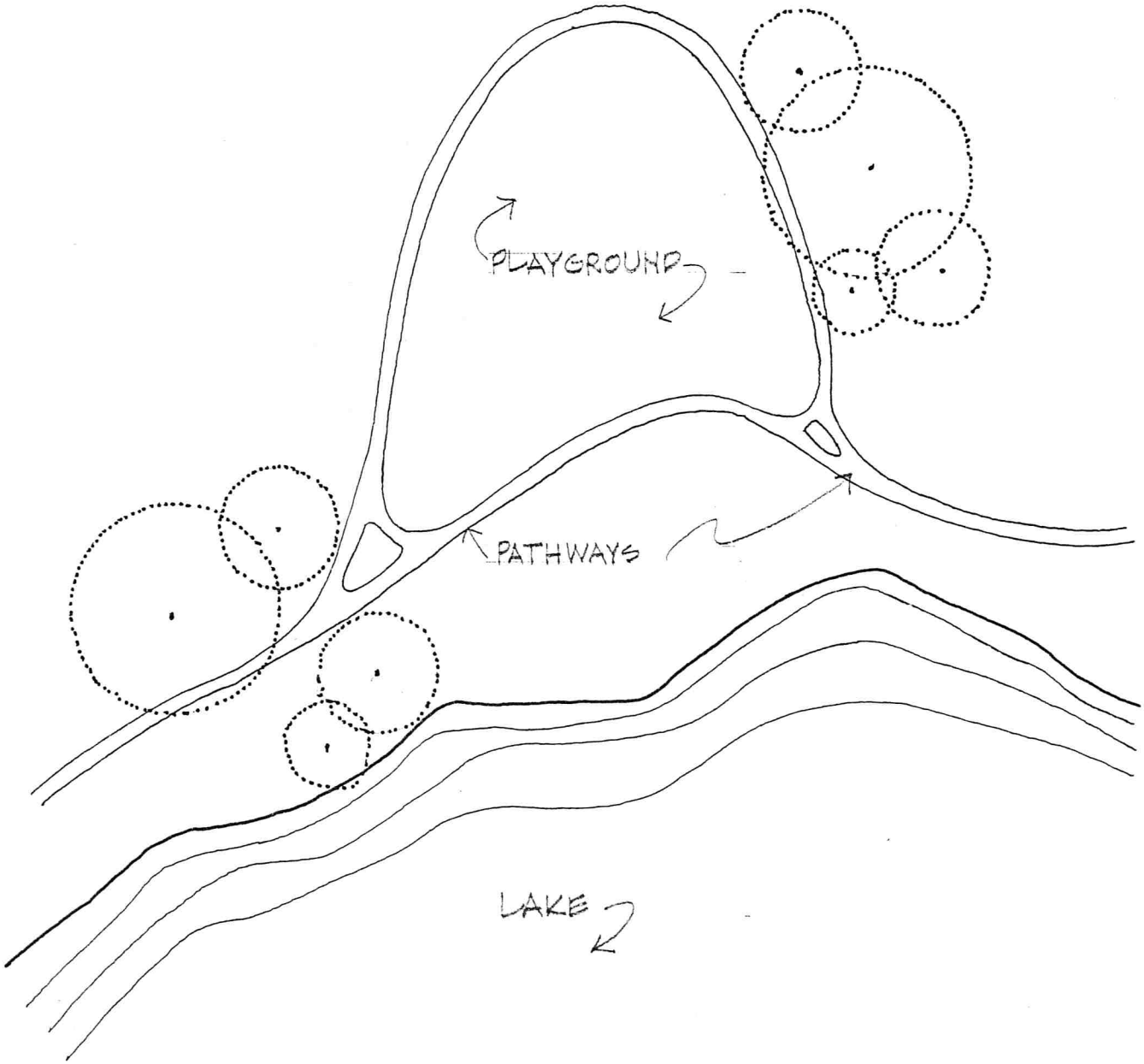


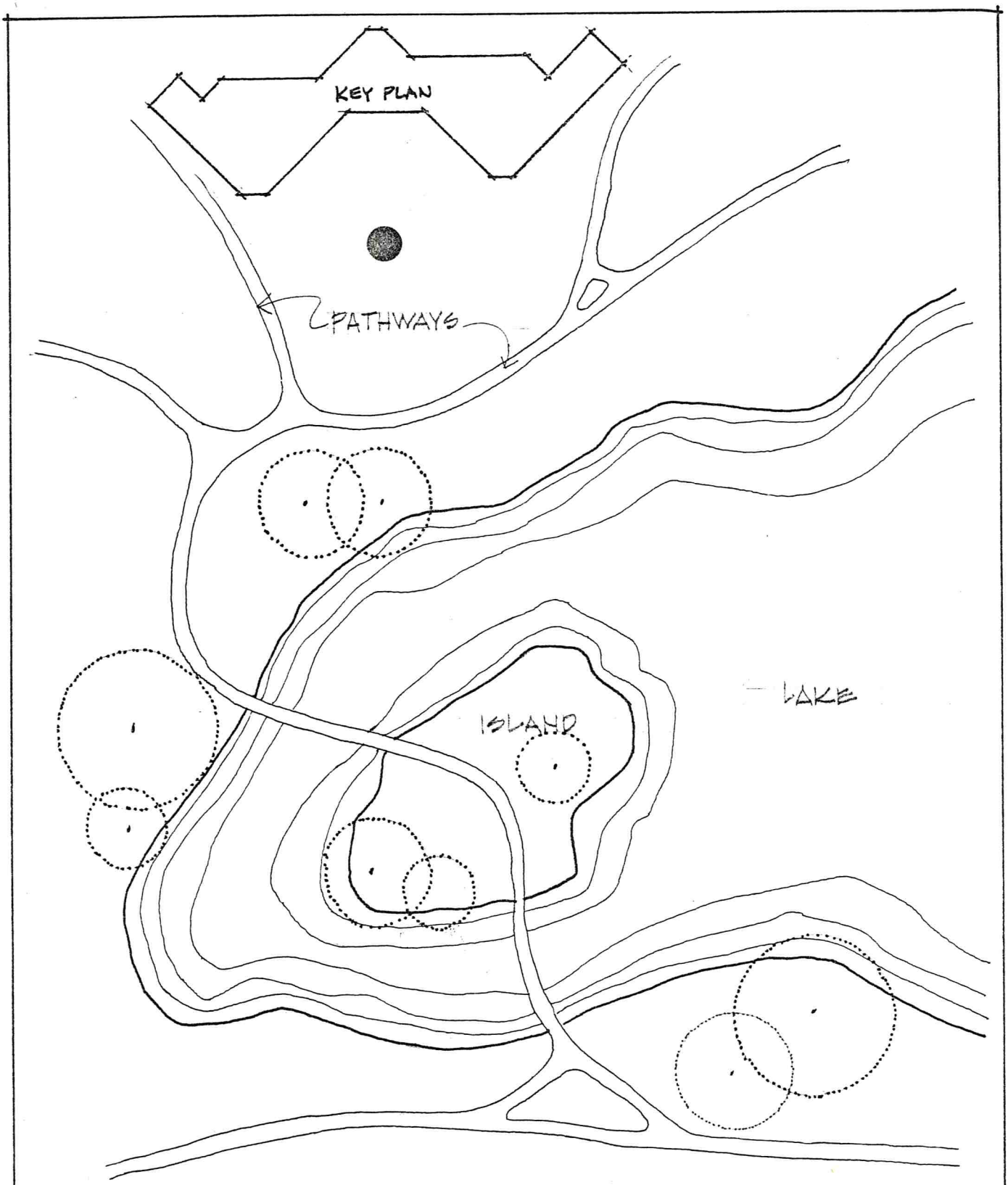


PLAYGROUND

Staff Refresher
Community
Family Unit
Activity
Mobility







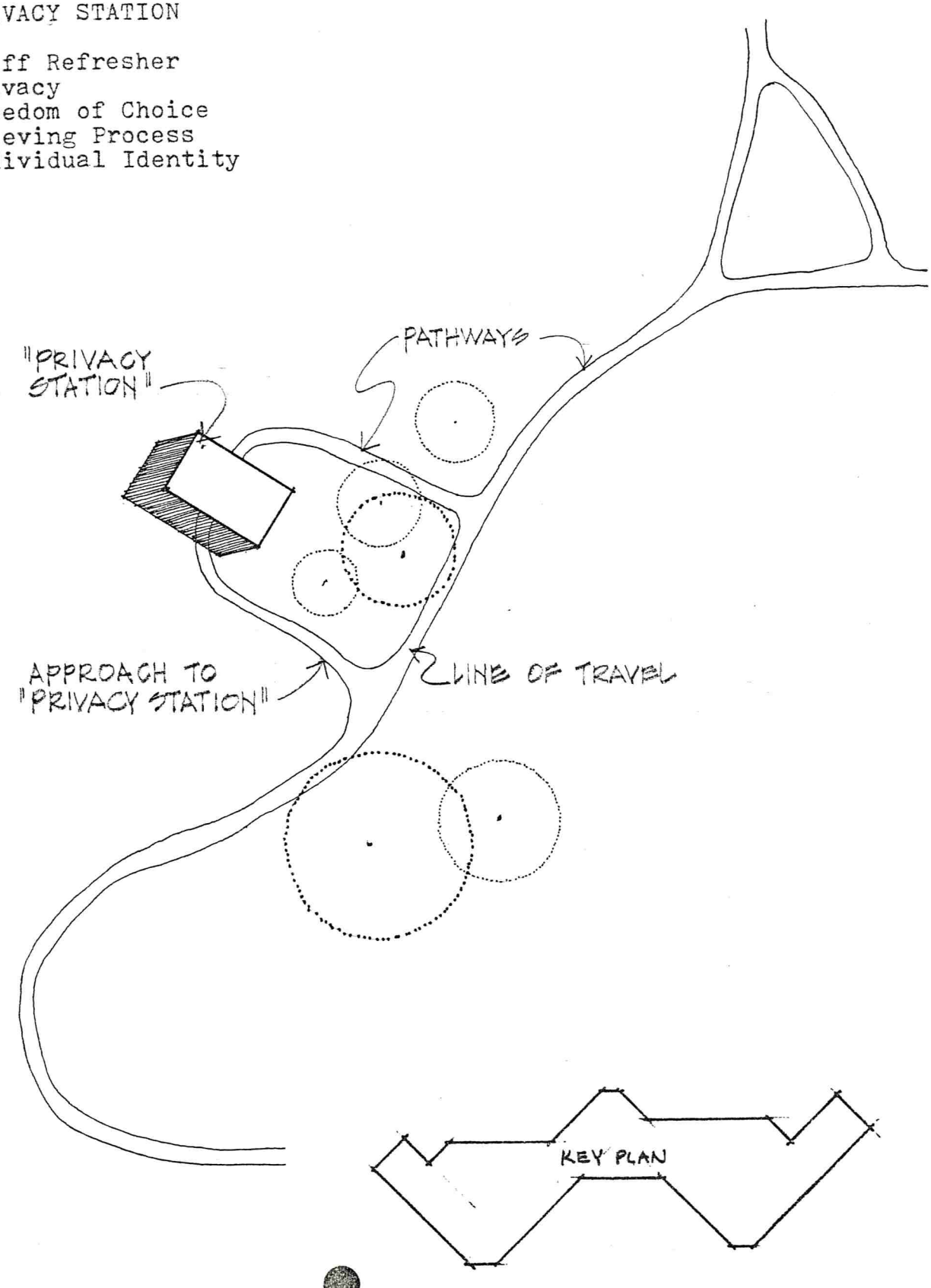
ISLAND

Staff Refresher
Privacy
Freedom of Choice
Grieving Process
Individual Identity

Family Unit
Activity
Transitional Space
Mobility

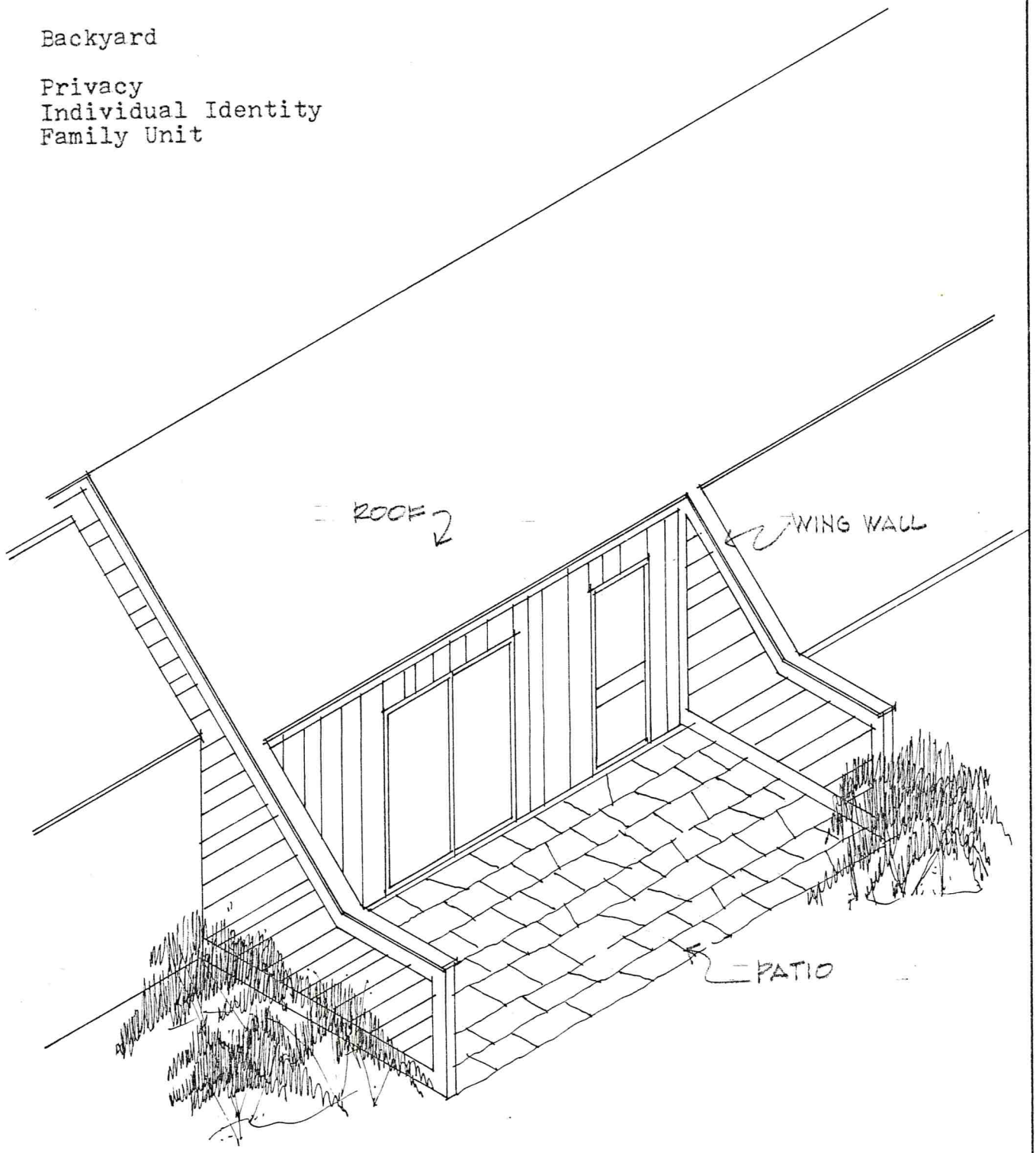
PRIVACY STATION

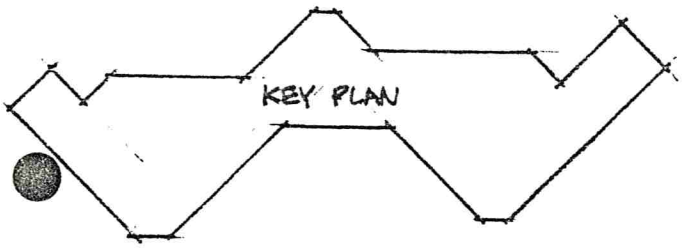
Staff Refresher
Privacy
Freedom of Choice
Grieving Process
Individual Identity

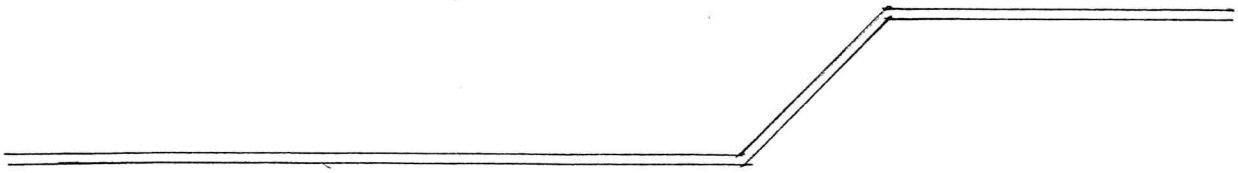


Backyard

Privacy
Individual Identity
Family Unit

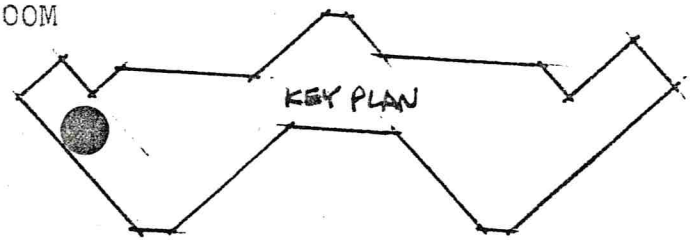


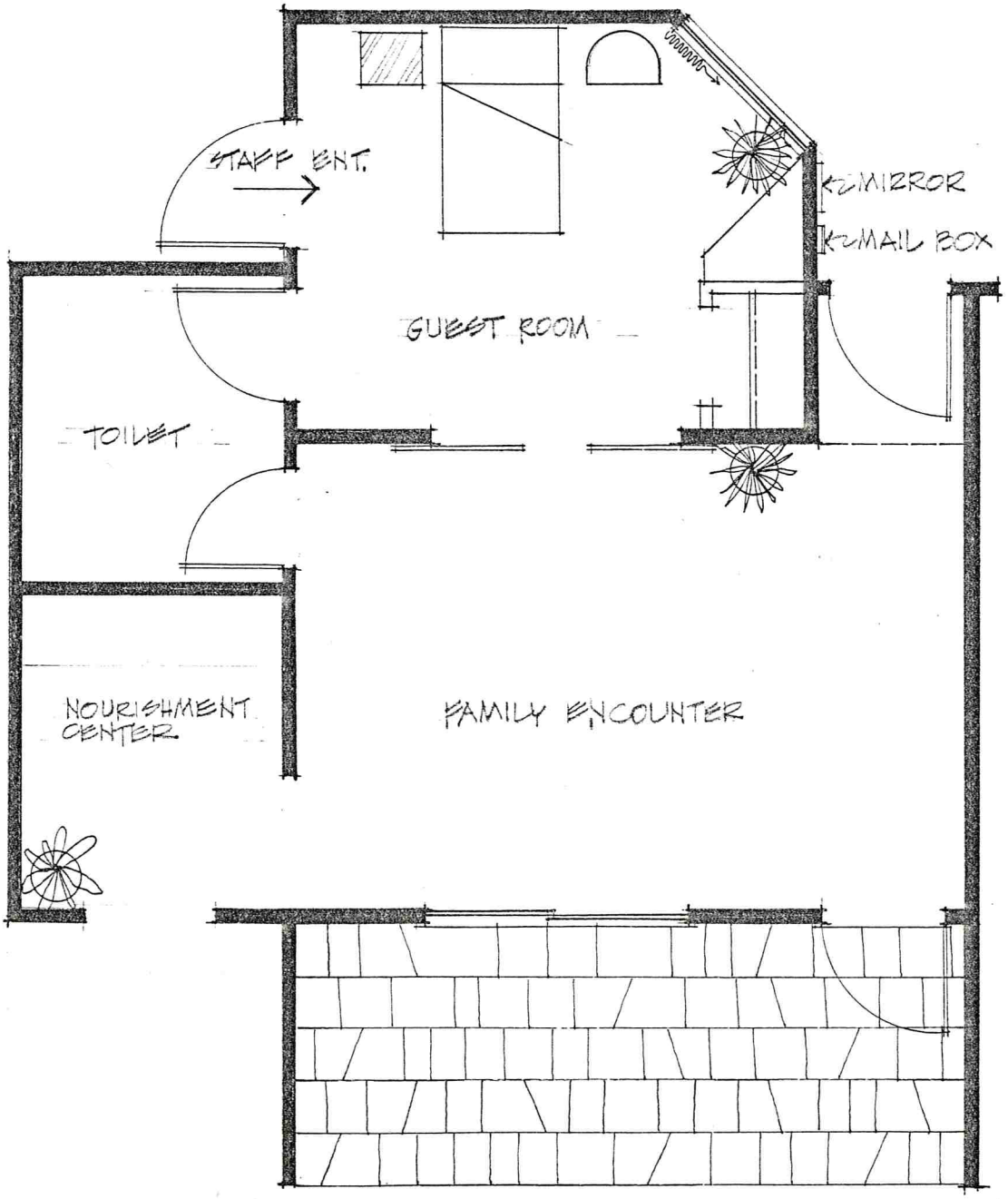




FAMILY ENCOUNTER AND GUEST ROOM

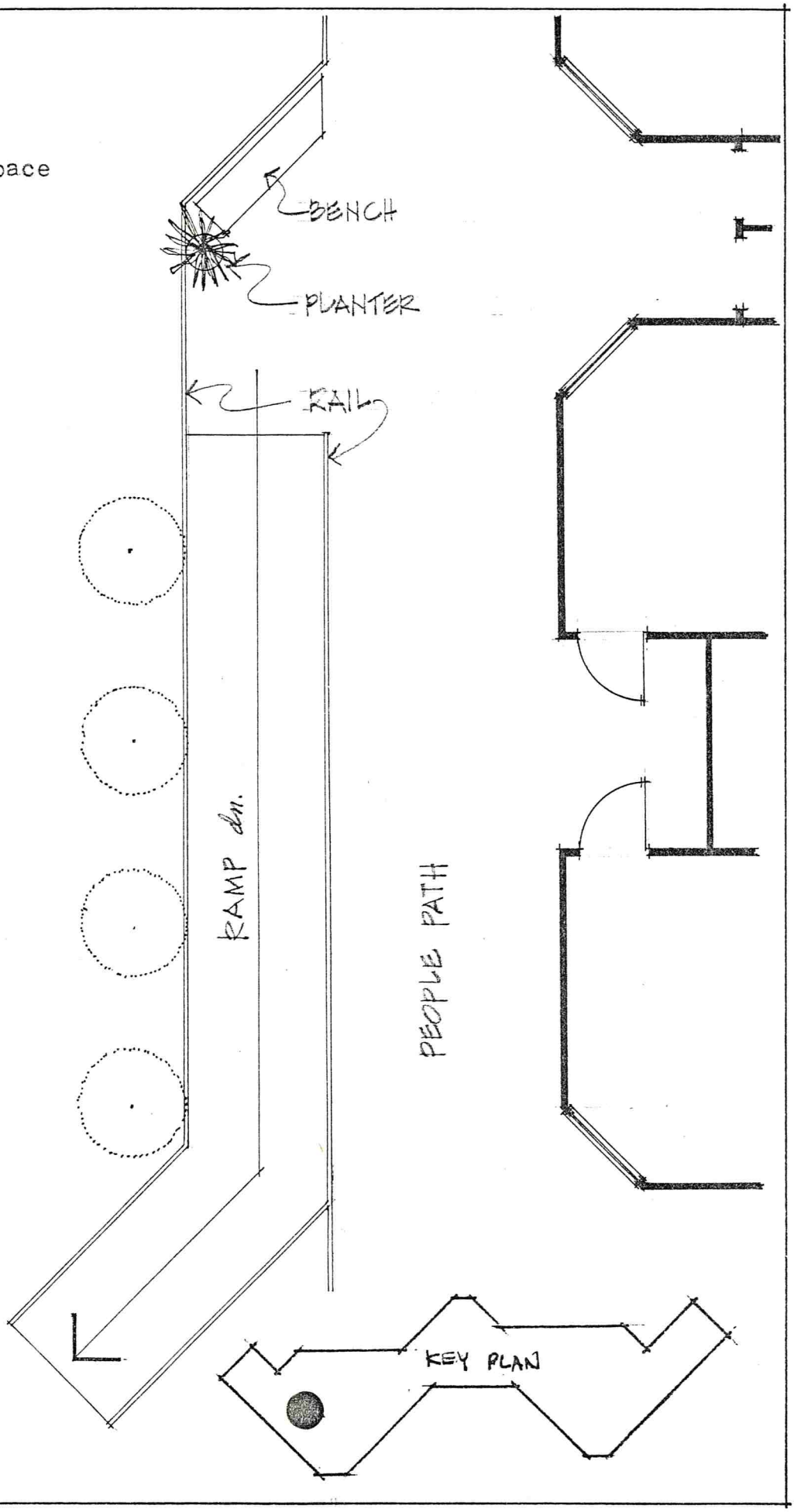
Privacy
Grieving Process
Family Unit
Transitional Space





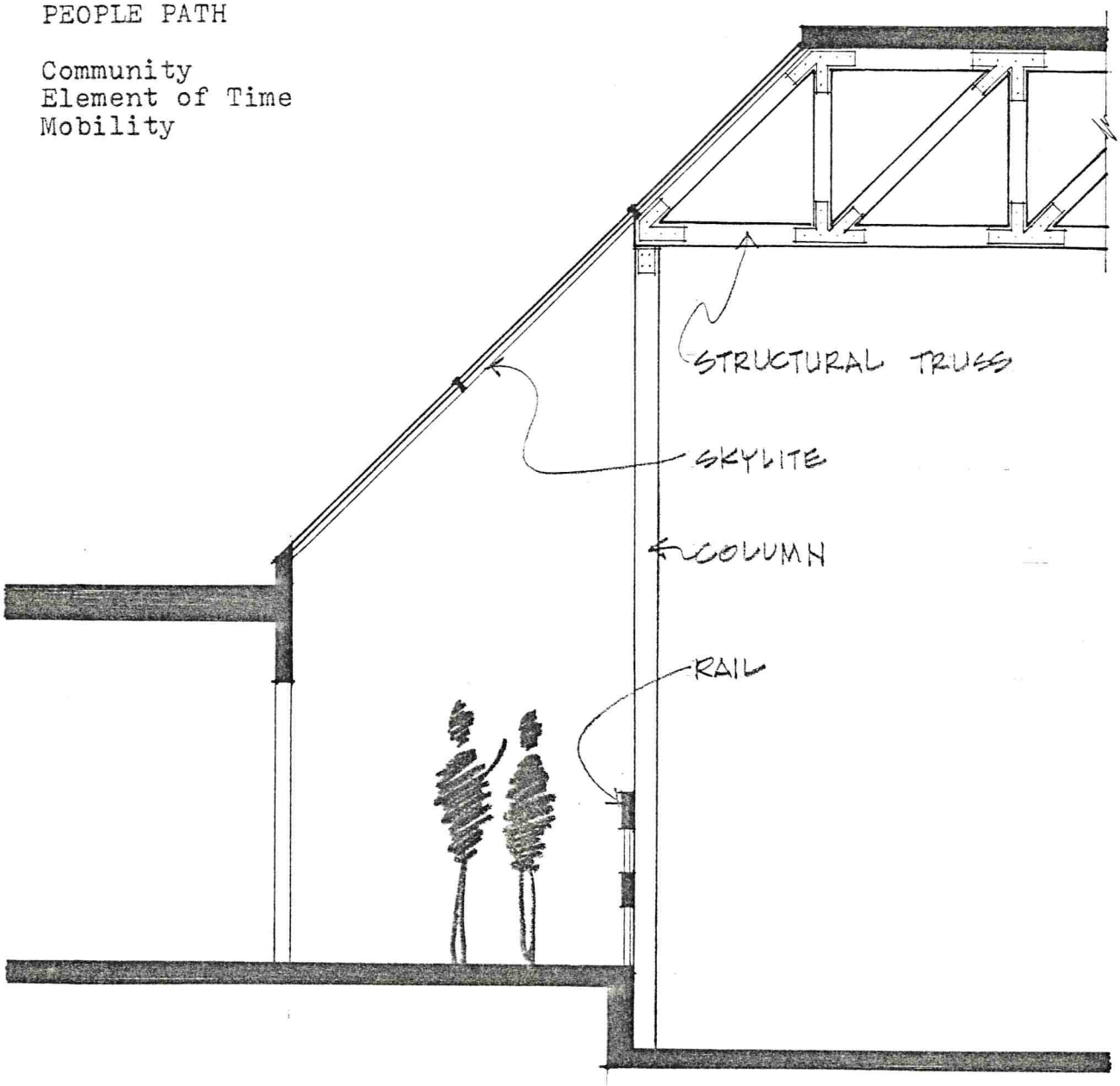
RAMP

Transitional Space
Mobility

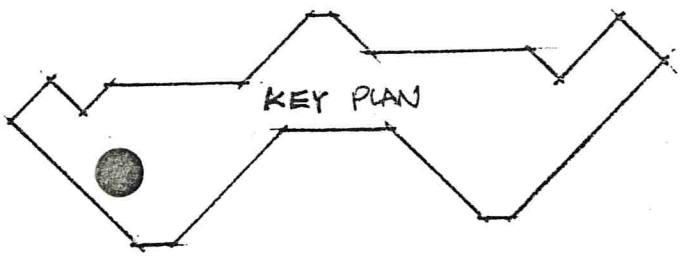


PEOPLE PATH

Community
Element of Time
Mobility

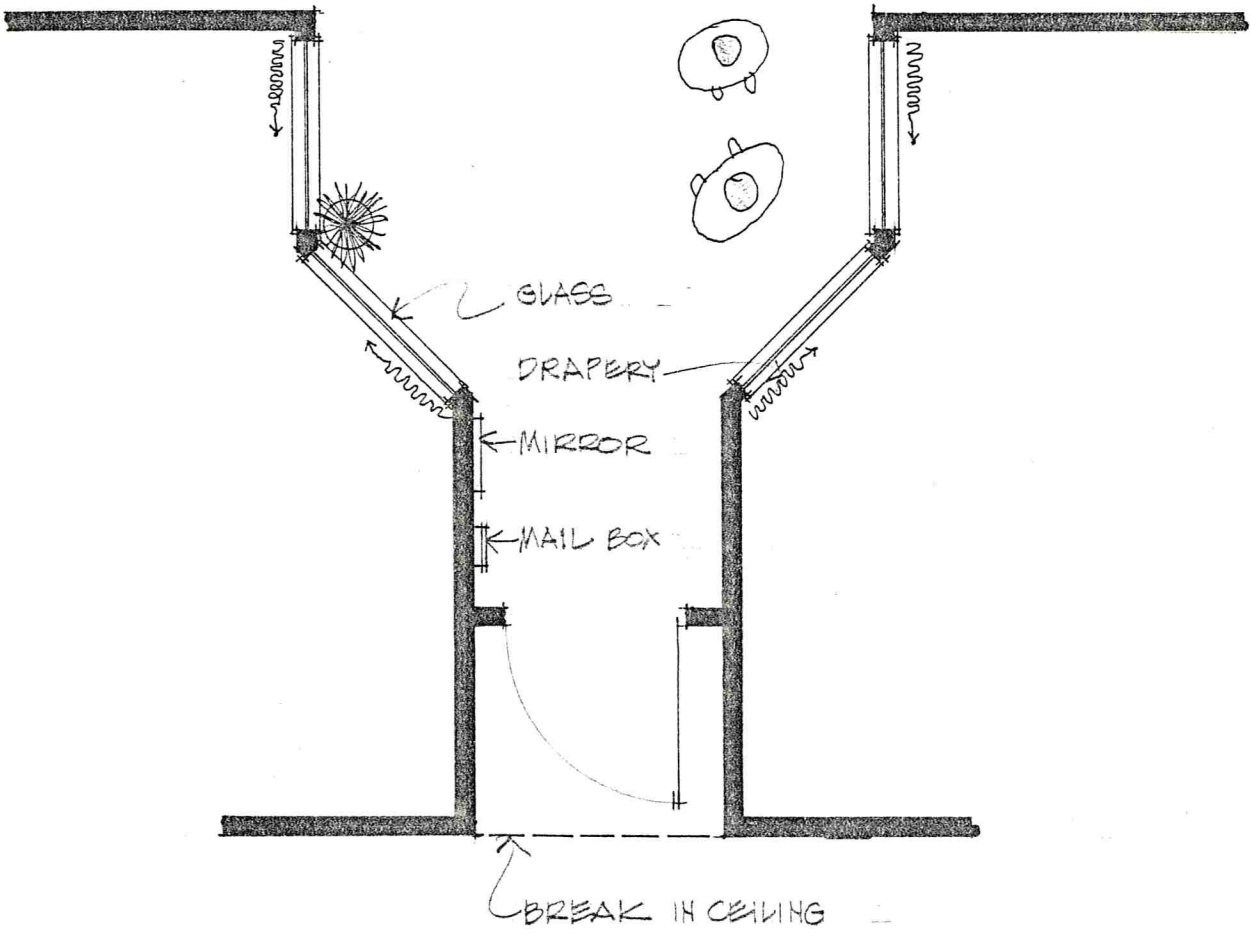


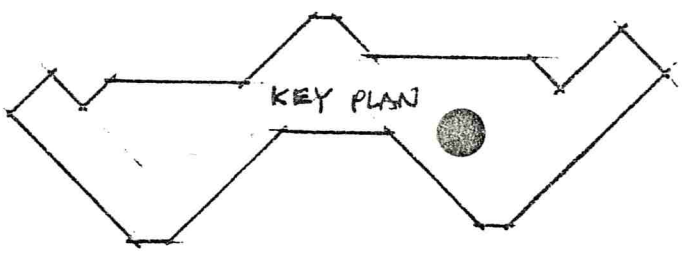
GUEST ROOM PEOPLE PATH INTERIOR COURT



ENTRY TO FAMILY ENCOUNTER ROOM

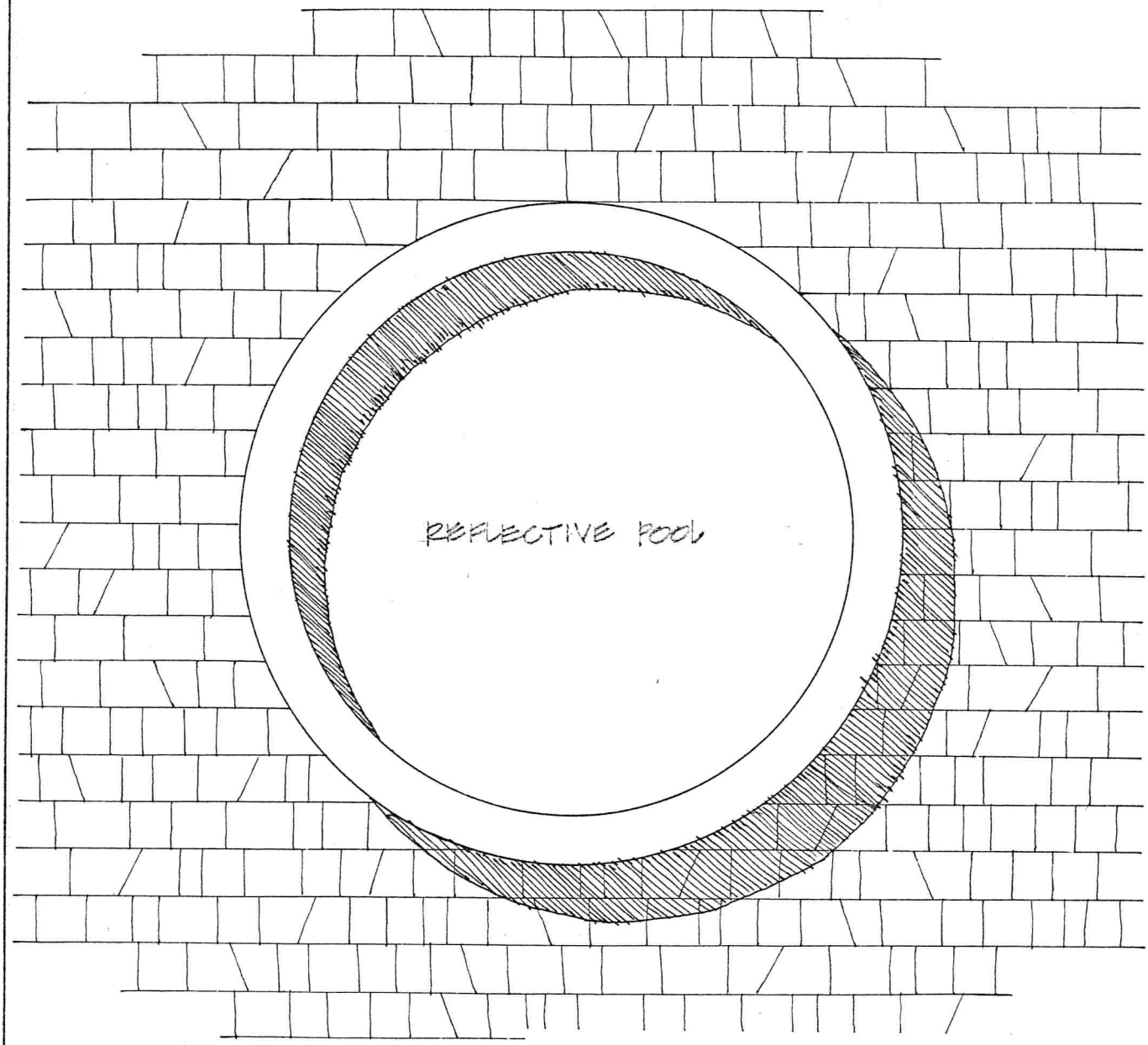
Community
Transitional Space

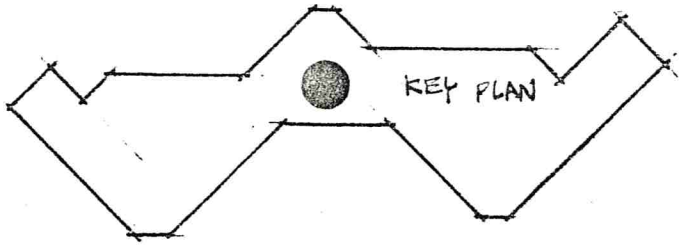




REFLECTIVE POOL

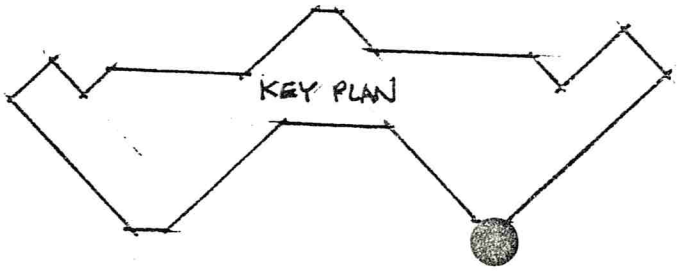
Element of Time
Individual Identity

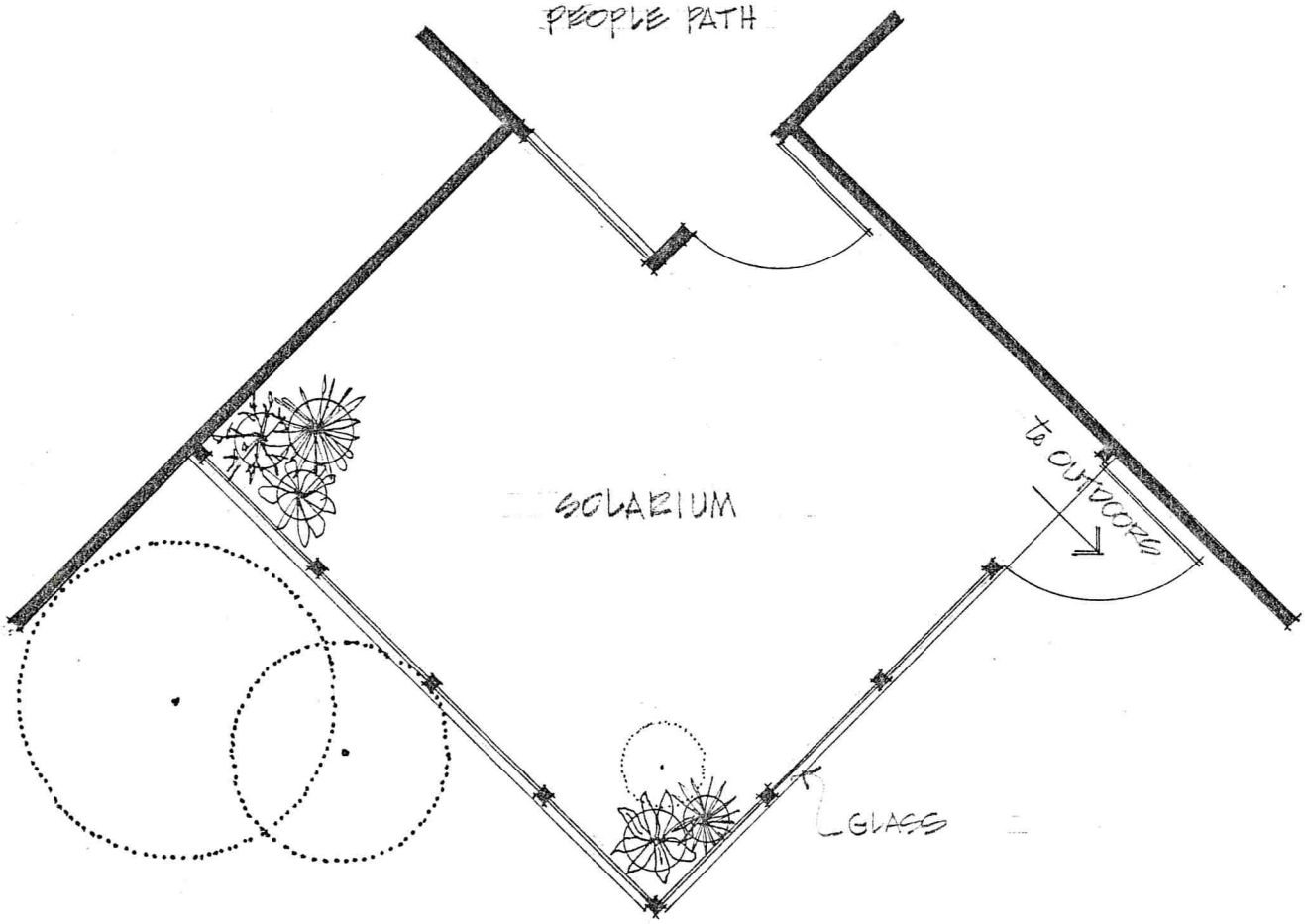


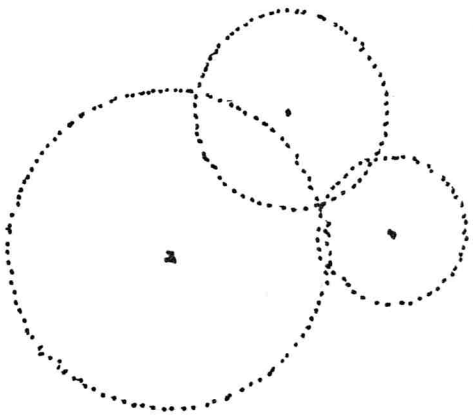


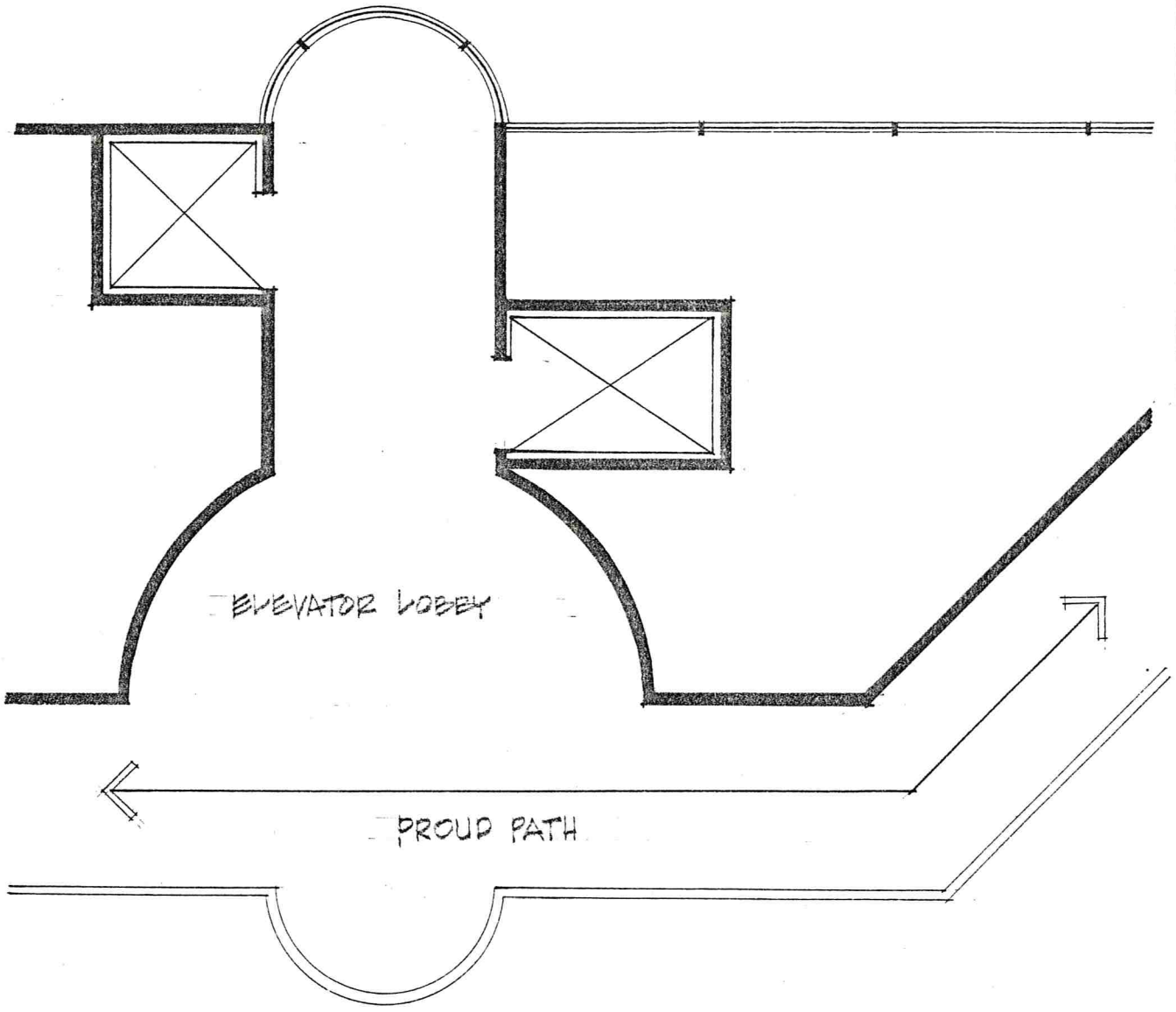
SOLARIUM

Staff Refresher
Community
Freedom of Choice
Element of Time
Activity
Mobility



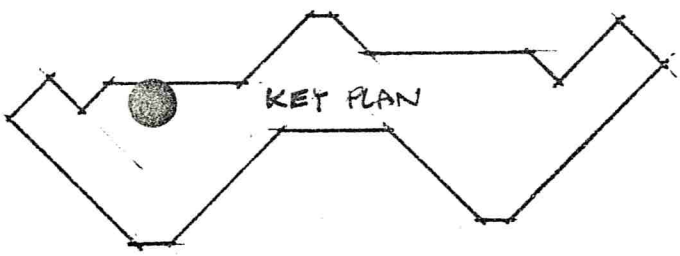


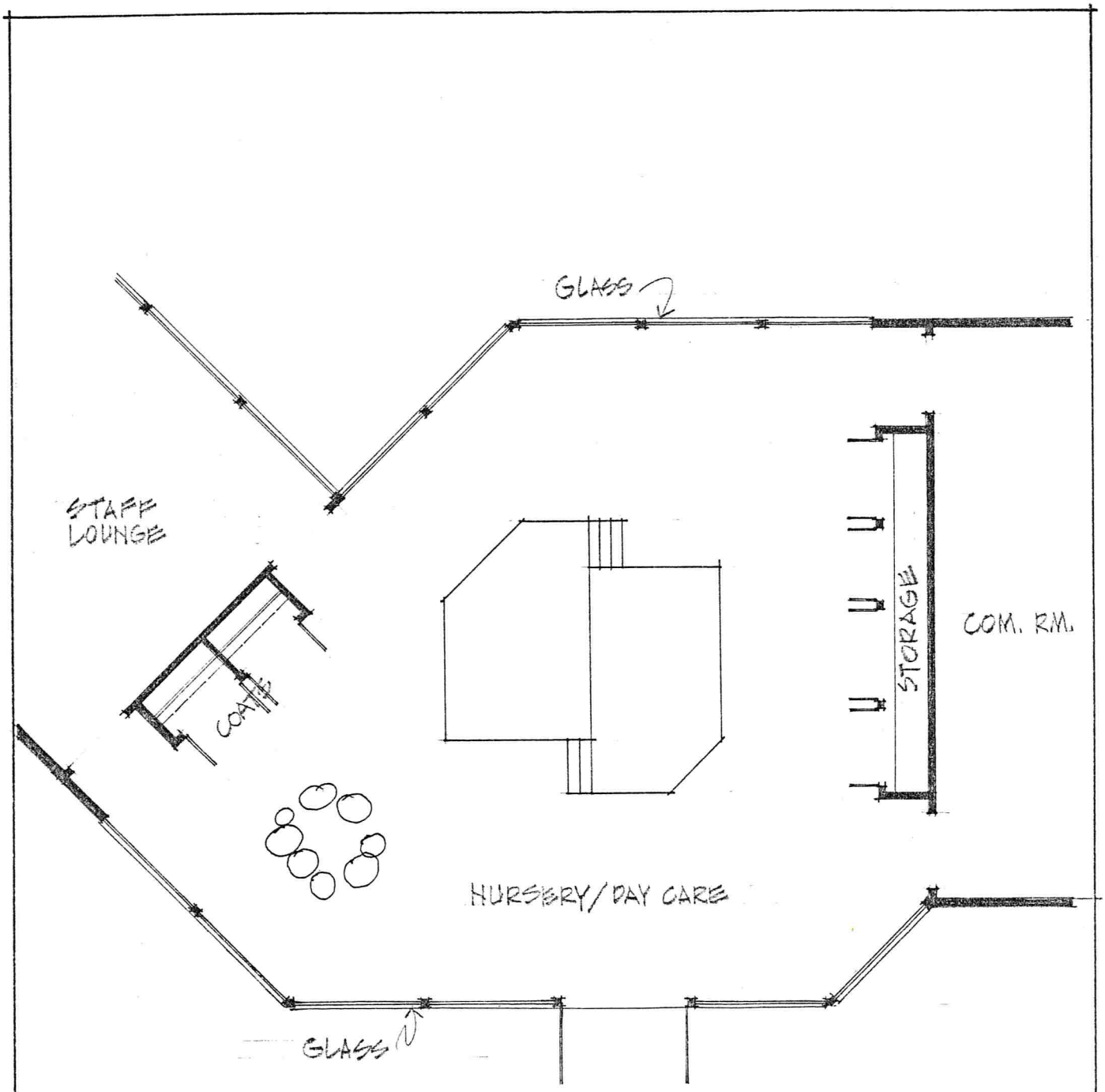




PROUD PATH

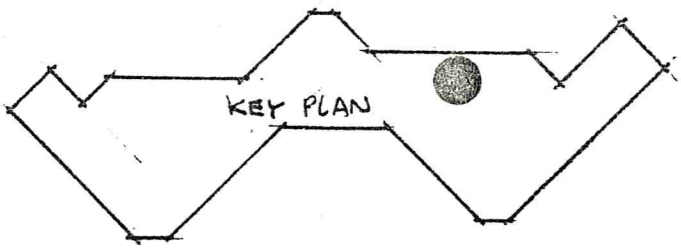
Community
Element of Time
Activity
Mobility





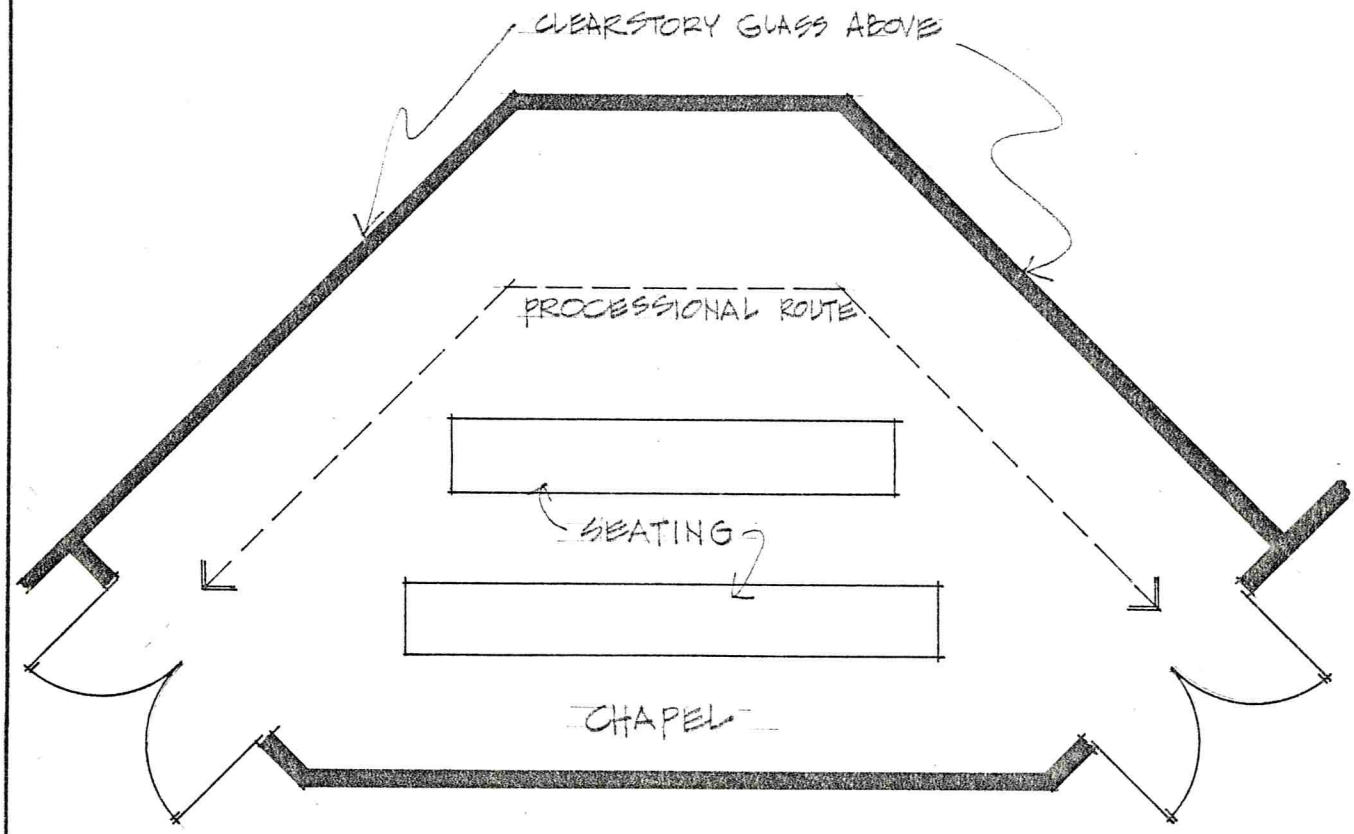
NURSERY

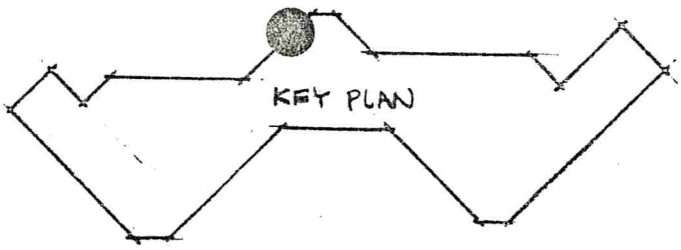
Staff Refresher
Element of Time
Family Unit
Activity
Mobility

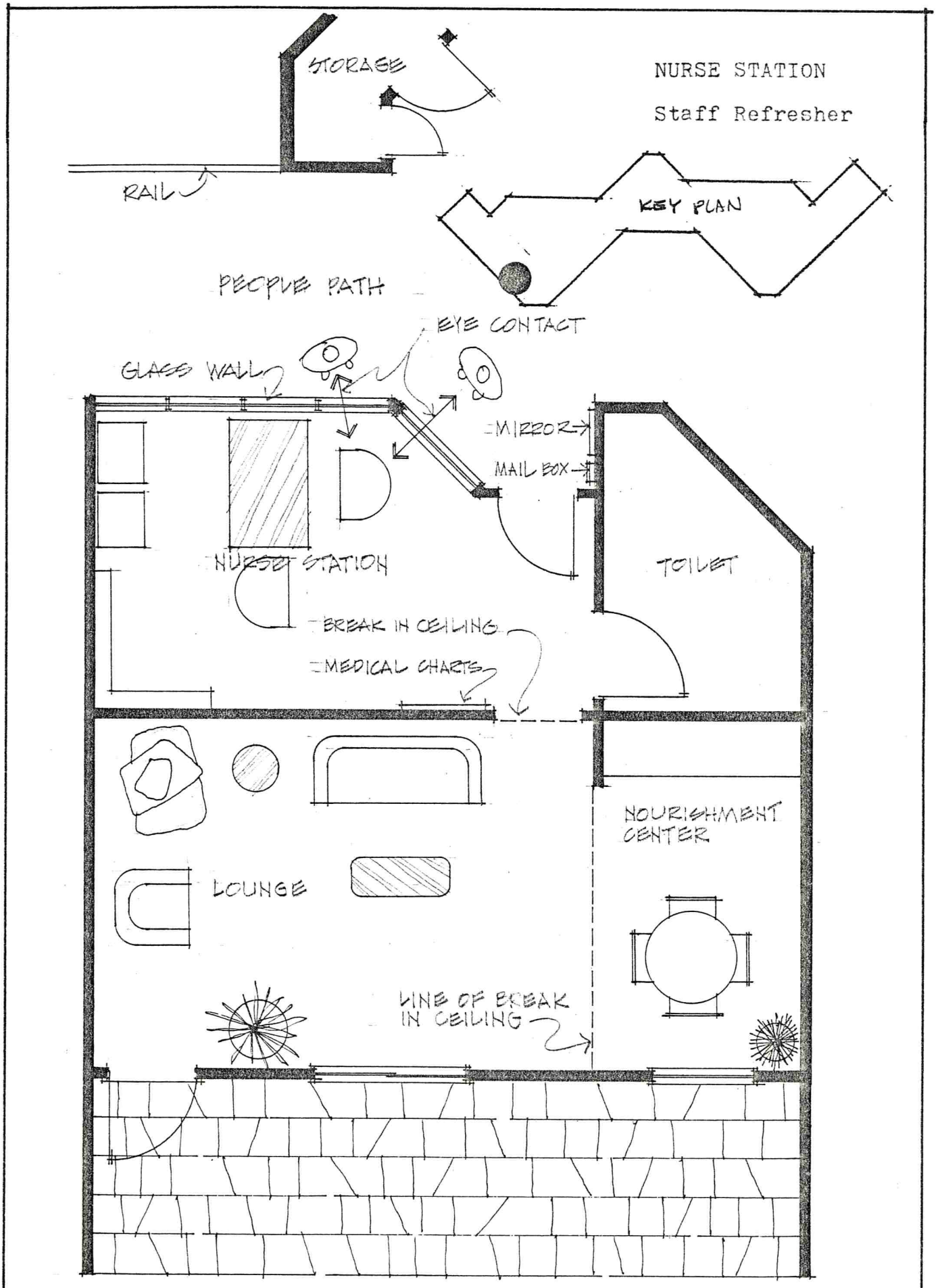


CHAPEL

Staff Refresher
Privacy
Grieving Process
Individual Identity

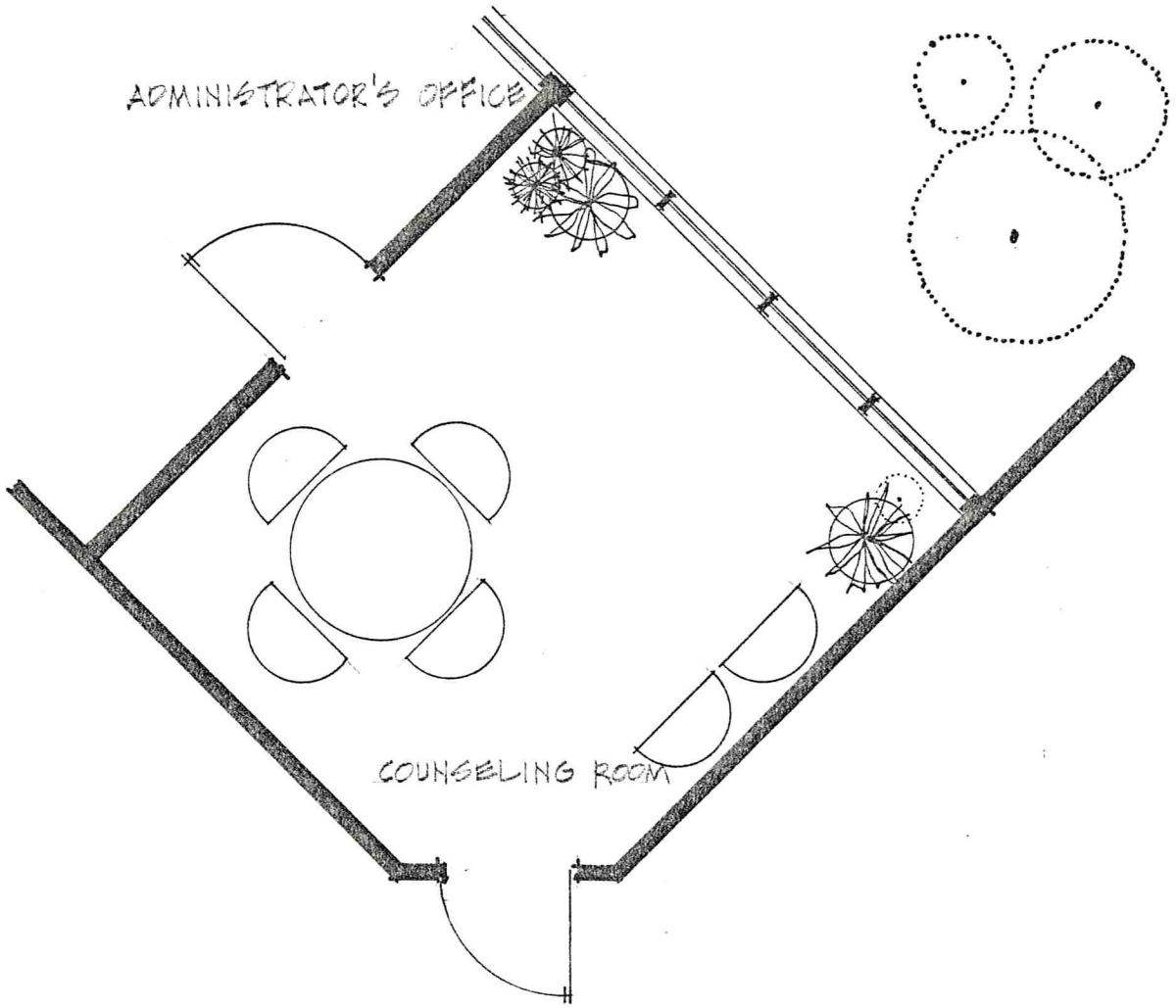


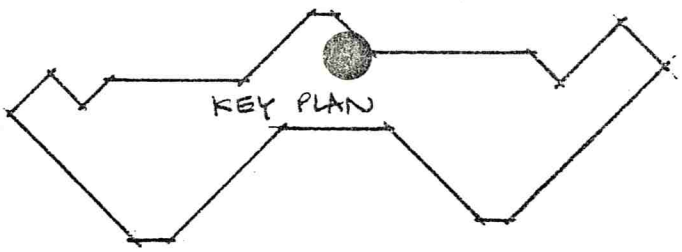



NURSE STATION
Staff Refresher
STORAGE
RAIL
KEY PLAN
PEOPLE PATH
EYE CONTACT
GLASS WALL
MIRROR
MAIL BOX
NURSES STATION
TOILET
BREAK IN CEILING
MEDICAL CHARTS
NOURISHMENT CENTER
LOUNGE
LINE OF BREAK IN CEILING

COUNSELING ROOM

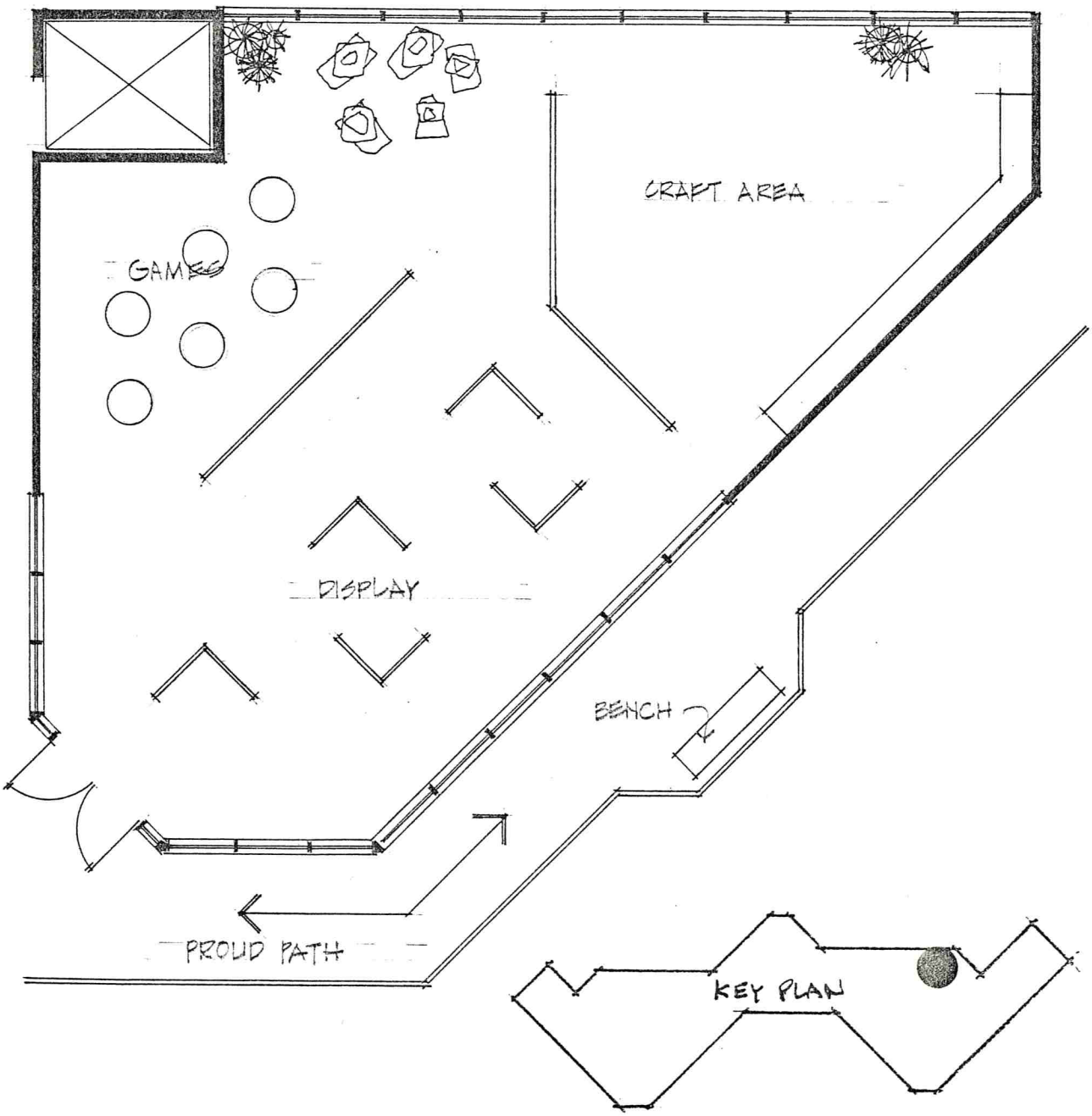
Privacy
Grieving Process
Family Unit

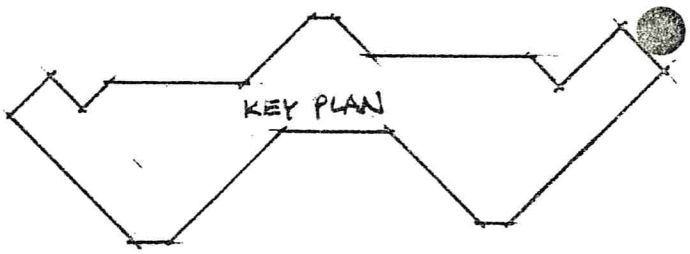




COMMUNITY ROOM

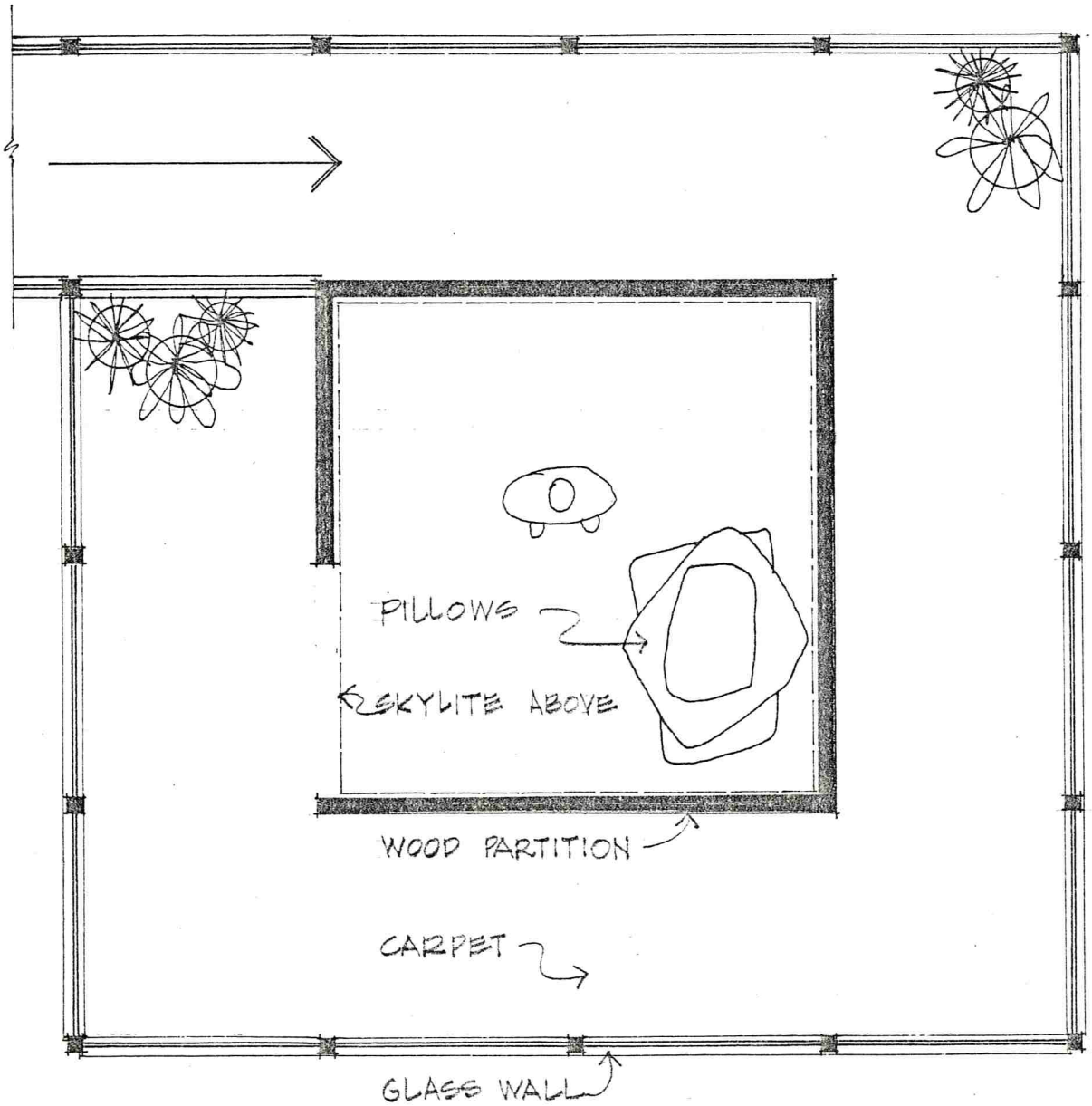
Staff Refresher
Community
Freedom of Choice
Element of Time
Activity
Mobility





HIDING PLACE

Privacy
Freedom of Choice
Grieving Process
Element of Time
Individual Identity



STAFF
REFRESHER

Rejuvination areas are necessary in order to provide a place where the caring staff can emotionally dwell on something other than the problems they face in dealing with terminally ill patients. Physically, these areas help replenish the energy expended by the staff as a result of constantly dealing with dying.

For example:

1. Nursery- Symbolizes youth and vitality, the living process.
2. Island- Provides a physical separation from their duties.
3. Noise Room- An area to vent frustrations and grief.
4. Hiding Place- A place to focus on oneself to reorient their own thoughts.

With the help of these refreshers, the staff is better able to cope and start anew.

COMMUNITY

The idea of Community implies participation..... A forum in which people with common interests, characteristics, etc. may lend peer support to each other. The inherent value of not allowing oneself to be "an island", in this context of community, is that one can see that his problems are shared and understood by others.

The interaction of the outside community with the facility community allows for the patients' need to be included and accepted in society and for society's need to learn and understand the dying process.

PRIVACY

As Kubler-Ross states, "What we often tend to forget is the preparatory grief that the terminally ill patient has to undergo in order to prepare himself for his final separation from this world." In some cases, this is done in complete privacy.

As relates to separation, the idea of privacy as part of the 'Denial' stage is perfectly normal. If a person wants to hide from himself and others, by seeking out this 'Hiding Place' of 'Privacy' he is in effect given the chance to physically act out his emotions.

FREEDOM OF CHOICE AND ALTERNATIVES

Architecturally, the facility provides for a variety of elements to allow the user to have control over his environment. Alternatives exist to allow for his specific and changing emotional needs.

The most important choice is his use of private or public spaces. For example: A person may choose to have dinner in the privacy of his own room or to socialize in the Dining Room.

Also, the user has a choice as to which space he will use to perform a specific activity. The patient who wishes to read a book can do so in the Solarium, Community Room, on the Island, etc.

GRIEVING PROCESS

The grieving process may be acted out more comfortably in the 'Family Encounter' room, in familar surroundings, similar to those at home. This environment would encourage the sharing of grief and guilt, if any, and would help strengthen the bond of unity among those involved. However, in some cases, individual grief may best be resolved or acted out while alone. For these individuals the 'Hiding Places' or 'Noise Room' are provided to to help them move through this experience.

The Chapel allows for the spiritual needs of the individual or group as they act out the grieving process.

ELEMENT OF TIME

Many areas in the facility have been designed to allow the patient to become aware of the passage of time as relates to positive therapeutic experiences.

For example:

1. Planting a seed in the garden and watching it grow.
2. Developing an activity in the Community Room, such as a painting, and seeing it progress on a daily or weekly basis. (sense of permanancy)
3. Looking at oneself in a mirror helps give a sense of immediate being. (I'm still alive)

By focusing their awareness on the passage of time, the emphasis is placed on the living process rather than the dying process.

INDIVIDUAL IDENTITY

It is extremely important for the dying person to maintain control over himself and those things he wishes to do and say.

For that person to perceive himself as capable of making meaningful decisions as they apply to the time he has remaining is critical, as Kubler-Ross states, in allowing that person "To live to the end with dignity".

Once the dying person can perceive and control his own needs, with the help and encouragement of family and staff, his image of himself will become more positive and help to promote the 'Circle of Peace'.

FAMILY UNIT

Kubler-Ross states, "We cannot help the terminally ill patient in a really meaningful way if we do not include his family." Also, the "family's needs will change from the onset of the illness and continue in many forms until long after death has occured." The family will experience very nearly the same emotional reactions. "If members of a family can share these emotions together, they will gradually face the reality of impending separation and come to an acceptance of it together."

The essence of this thesis then is to allow for the 'Circle of Peace' to be lived out by providing a sympathetically designed facility.

note: See definition of 'Family Unit' starting on page 23.

ACTIVITY

Whenever possible, the patient should be encouraged to 'use' as much of the facility as he can. For example, he could use the Dining Room facility instead of eating in his room, he could participate or observe activities in the Community Room which is designed to accomodate a mix of outside social community with the facility's social community. Perhaps he could show someone around the facility by taking a walk around the Proud Path, or visit the Solarium to talk with friends.

These example spaces are intended to provide a variety of 'activity-oriented' participation.

TRANSITIONAL SPACES

The introduction of transitional spaces is intended to provide a specific awareness of the state of passing from one place, condition or action to another. These architectural transition spaces are related to the psychological and emotional transitions from one stage of dying*to another. At times, the same transition space will have the effect of acting as a multi-functional therapeutic design tool aimed at complex and changing problems of patient/family/staff. (The degree of this effect depends on the individual and his awareness of his place in space and time.) Also, each of the group, (i.e., patient/family/staff) will find a different meaning to these spaces based on their own individual value judgements and on whatever feelings or security is needed.

These planned spaces act as a threshold between anticipation and realization.

*Kubler-Ross, 1. denial and isolation, 2. anger, 3. bargaining, 4. depression, 5. acceptance.

MOBILITY

Whenever possible the patient should be allowed and encouraged to move about his environment. I believe this has a positive emotional effect on his sense of being. It will demonstrate to him that he is still very much alive, and that even if he requires the assistance of others, he will be exposed to some positive experiences as he moves through the various spaces. His sense of accomplishment will be heightened as well as the obvious benefits of the social exchange as he sees, visits, talks with and listens to others.

DESIGN CONSIDERATIONS

The following information is structured to provide a checklist guide for design consideration elements including;

1. Site Considerations.
2. Building Considerations.
3. Design Element Considerations.

The intent here is to make all statements directive in nature and to provide thought stimuli to the Architect or Designer.

SITE CONSIDERATIONS:

1. Rural or Suburban (solution presented)
   A. Pastoral setting
2. Urban
   A. Need for landscape courtyards
   B. Circulation problems
   C. Noise problems
   D. Proximity of services

BUILDING CONSIDERATIONS:

1. Highrise
   A. Poor circulation
   B. Psychological mobility impeded
2. Courtyard
   A. Possibility depending on ratio
3. Individual living unit detached
   A. Psychological advantage in individuality
   B. Perpetuates family unit
   C. Poor tie to main facility and services
   D. Large site required
4. Spinal Circulation(solution presented)
   A. Allows for variety of spaces

B. Best circulation- helps create an emotional map
C. Offers many vistas
D. Strong node activity
E. Separate zoning qualities i.e., either side of spine
F. Termination of axial procession with special event

DESIGN ELEMENT CONSIDERATIONS:

1. Sound- or lack of it to help create a mood.

2. Motion- could be suggested by a hanging mobile or banner.

3. Color- bright colors for public spaces, subdued colors for more intimate spaces.

4. Texture- To help give some recognizability and familiarity of materials.

5. Materials- could be smooth and hard, or soft and absorbant to help deliniate the intended activity of a space.

6. Graphics- loud and colorful, or sedate and directive may act as an accessory to a space or can dominate it.

7. Light- natural or artificial, implies or symbolizes the passage of time, also act as mood setter.

8. Space Vitality- assimilation of several design elements to create a certain feeling of emotional identification with that space.

9. Building Mass- Unity of emotions through scale, mass and entry.

10. Variety of Spaces- need for completely private or public spaces and some in-between.

11. Glass- indicates transparancy, symbolizes reflectiveness.

12. Ramps and Stairs--suggest mobility.

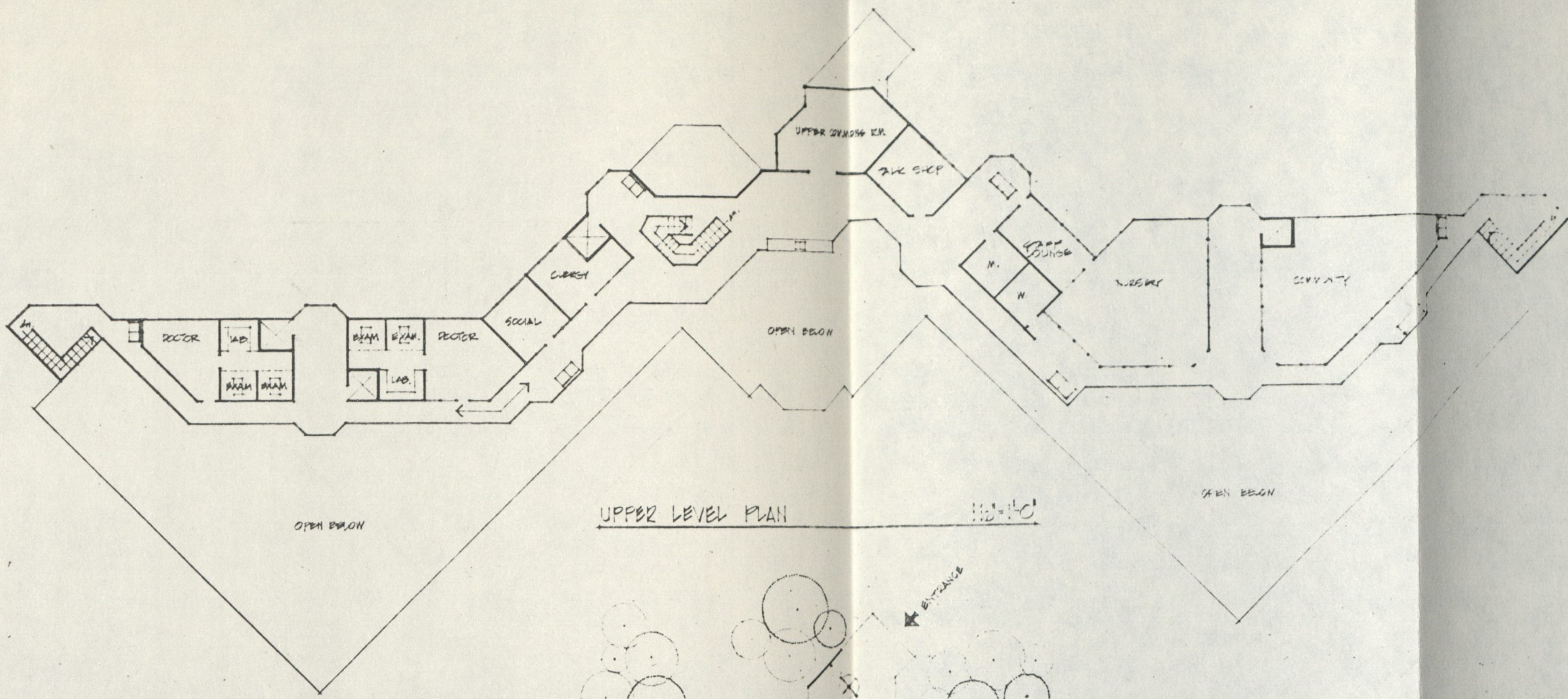
13. Plants- symbolize the living process.

14. Furniture- should be designed to suit everyone.

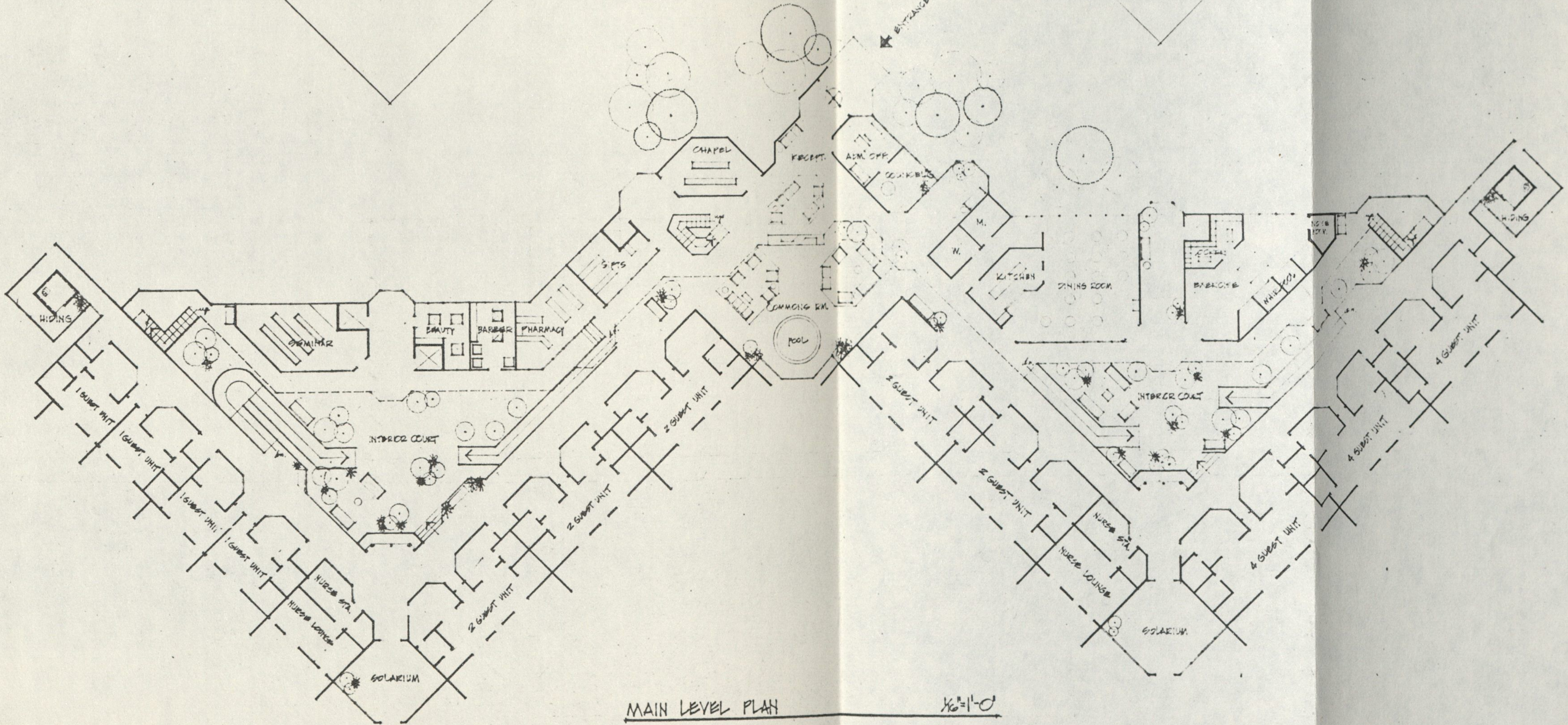
15. Clocks- Symbolize the passage of time.

16. Fireplace- Provides real, visual and symbolic warmth.

17. Soundproofing- critically important to protect individual and group privacy.

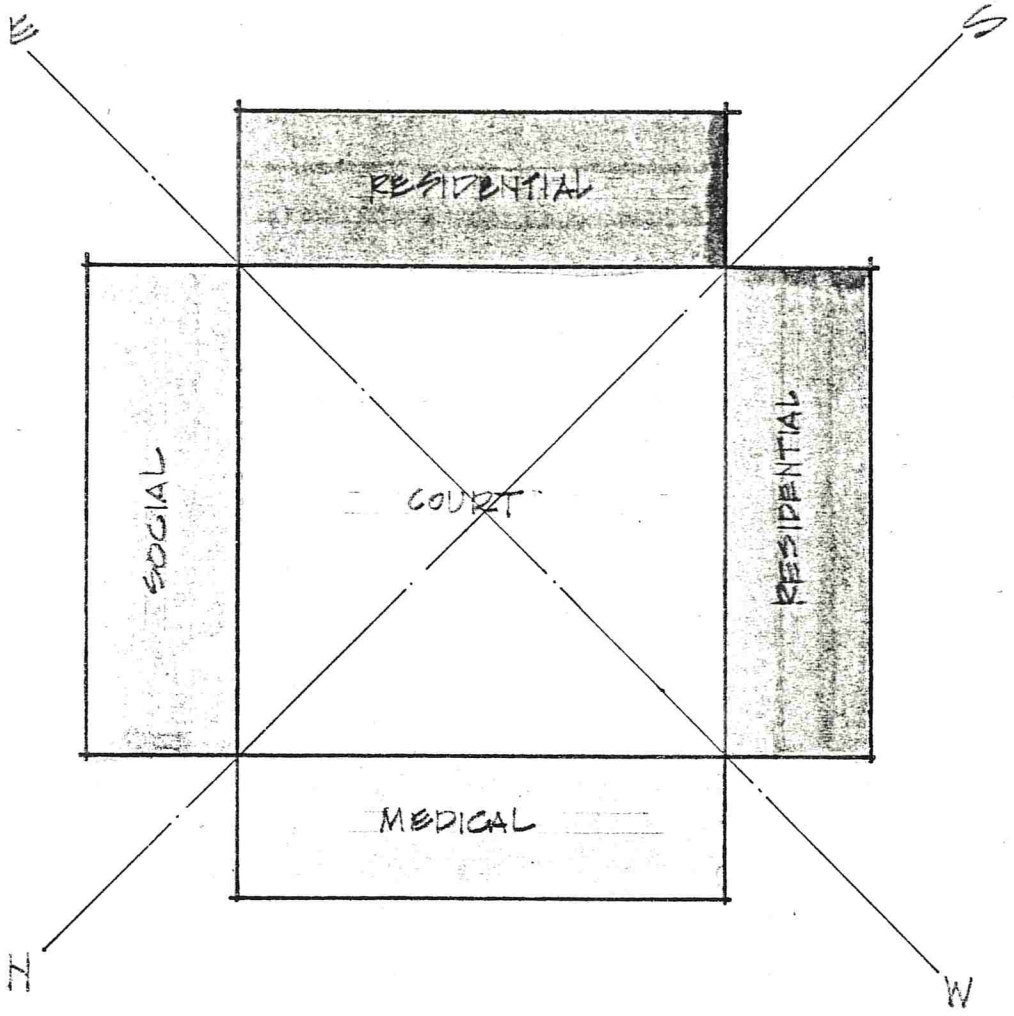


UPPER LEVEL PLAN 1/16"=1'-0"

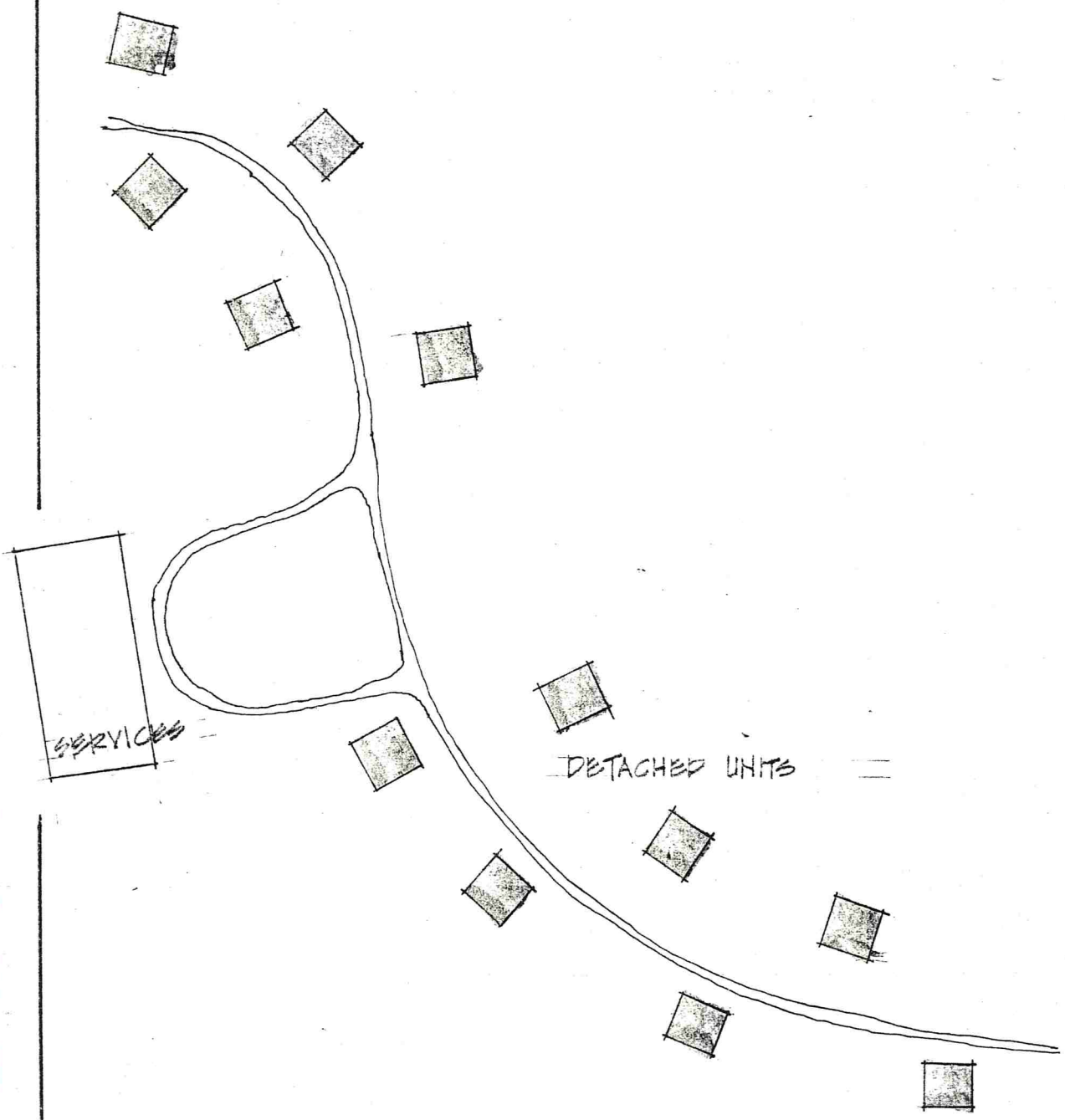


MAIN LEVEL PLAN 1/16"=1'-0"

TYPOLOGY- COURTYARD



TYPOLOGY- DETACHED UNITS



SUMMARY OF FINAL SUBMISSION

The Final Presentation was presented in two parts.

1. Review of the new Presentation material, i.e., development of building plans discussed at the Intermediate Submission.
2. Discussion of the Workbook material.

Several new programming requirements as determined after the Intermediate Submission were discussed, such as, Nurses' Station, Medical Offices, Exercise and Whirlpool Room, Pharmacy and Chapel. Those issued discussed included the use of appropriate materials, textures and colors in an effort to heighten the awareness of the user. It was agreed that the concept was based on the user needs which responds to the real issues at hand. Proper consideration of the appropriate elements could provide the necessary solutions to these issues. Through the use of proper materials, textures and colors, a variety of spaces attuned to these user needs can be successfully implemented. Also a unity of emotions can be established through the sensitivity of the Architect as relates to height, scale, modulation, juxtaposition and manageability.

As for the specifics of the plan, some minor additional documentation revisions would help the future user of the Workbook. These revisions include; A resolution of the termination of the Proud Path, addition of an Upper Commons Room, and the labeling of some room names for clarity.

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SEGMENT III REVIEW PANEL REPORT

(~~PRELIMINARY/INTERMEDIATE~~/FINAL)

STUDENT NAME: Ron Albert DATE: 6/1/77

SEGMENT III REP. B McQueen * GRADE: Pass

ADVISOR: R. Entin * GRADE: Commend

EXPERTS: William Redpath * GRADE: Pass

Pat Slattery * GRADE: Pass

* OVERALL GRADE: Pass

The Faculty Advisor, as Chairman of the Review Panel, will record a concensus of the Review Panel on the following items and submit this form to the Segment III Committee:

1. Description of project and areas of strengths in work thus far:
   Dying: A Final Life Process
   Ron's premise of producing a workbook dealing with hard emotional, and personal feelings and documenting the process of transmitting those ideas to others as a guide were achieved and successfully presented at this final review meeting.
2. Areas in need of further investigation:
   Some minor additional documentation dealing with appropriate materials, textures, color & interior and exterior scale will be valuable tools to include relating to Ron's personal feelings of use-appropriateness or inappropriateness.
3. Items to be completed prior to next review:
   Thesis Abstract
4. General Comments:
   Ron has accomplished those goals relating to thesis he set out to investigate. The subject matter to be sure was well covered and documented, but just as important was his setting of his own limitations as an architect and designer and working unstintingly for himself with his advisor to reach an understanding of the complex emotional & environmental nature, always keeping the dignity of the end user in the forefront, of his investigations & concepts.

* Grades are to be either PASS, FAIL, OR COMMEND.

PV/MS

Rev. 8/3/76

THESIS
CONCLUSIONS

In order to design a facility for the terminally ill, the Architect must first recognize the need for extensive research into psychological/emotional aspects of the end users. This research will enable the Architect to design a more sensitive and sympathetic facility, attuned to the very special needs of the terminally ill person.

It became clear to me that certain fundemental areas would have to be stressed in order to allow for these needs, namely patient, family, staff. In my opinion the intregrity of the family unit is the most important consideration to strive for in shaping the architectural environments in which the final life process is to be acted out. The Architect should also recognize the importance of the staff's role in this type of facility and do all that he can to help sustain them as they help others to move through these psychological/emotional and environmental stages.

As the Architect becomes more aware of the importance of these patient, family and staff needs, as well as the definition of

the stages of dying, (see page 12) he then will be capable , I believe, to address such a difficult design solution.

It is my belief that the contents of this thesis in acting as a valuable design aid and guide to the future Architect will have accomplished that which it set out to do.

Finally, I know of no other process of learning that has proven as valuable to me in persuit of educating myself as an Architect, as my involvement with this Thesis project.

BIBLIOGRAPHY

Colen, B.D., Dying in the Age of Eternal Life, New York, Nash Publishing, 1976.

Demsey, David, The Way We Die, New York, Macmillan Publishing Co., Inc., 1975.

Glaser, Barney G., Strauss, Anslem, Awareness of Dying, Chicago, Aldine Publishing Co., 1965.

Grollman, Rabbi Earl, Concerning Death, Boston, Beacon Press, 1974.

Grollman, Rabbi Earl, Explaining Death to Children, Boston, Beacon Press, 1967.

Keleman, Stanley, Living Your Dying, New York, Random House, 1975.

Krant, Melvin J., Dying and Dignity, Springfield, Ill., C.C.Thomas, 1974.

Kubler-Ross, Elisabeth, On Death and Dying, New York, Macmillan Publishing Co., Inc., 1976.

Kubler-Ross, Elisabeth, Questions and Answers on Death and Dying, New York, Macmillan Publishing Co., Inc., 1976.

Shepard, Martin, Someone You Love is Dying, New York, Harmony, 1975.

Thompson, John D., Goldin, Grace, The Hospital: A Social and Architectural History, New Haven and London, Yale University Press, 1975.

Weisman, Avery D., On Dying and Denying, New York, Behavioral Publications, 1972.