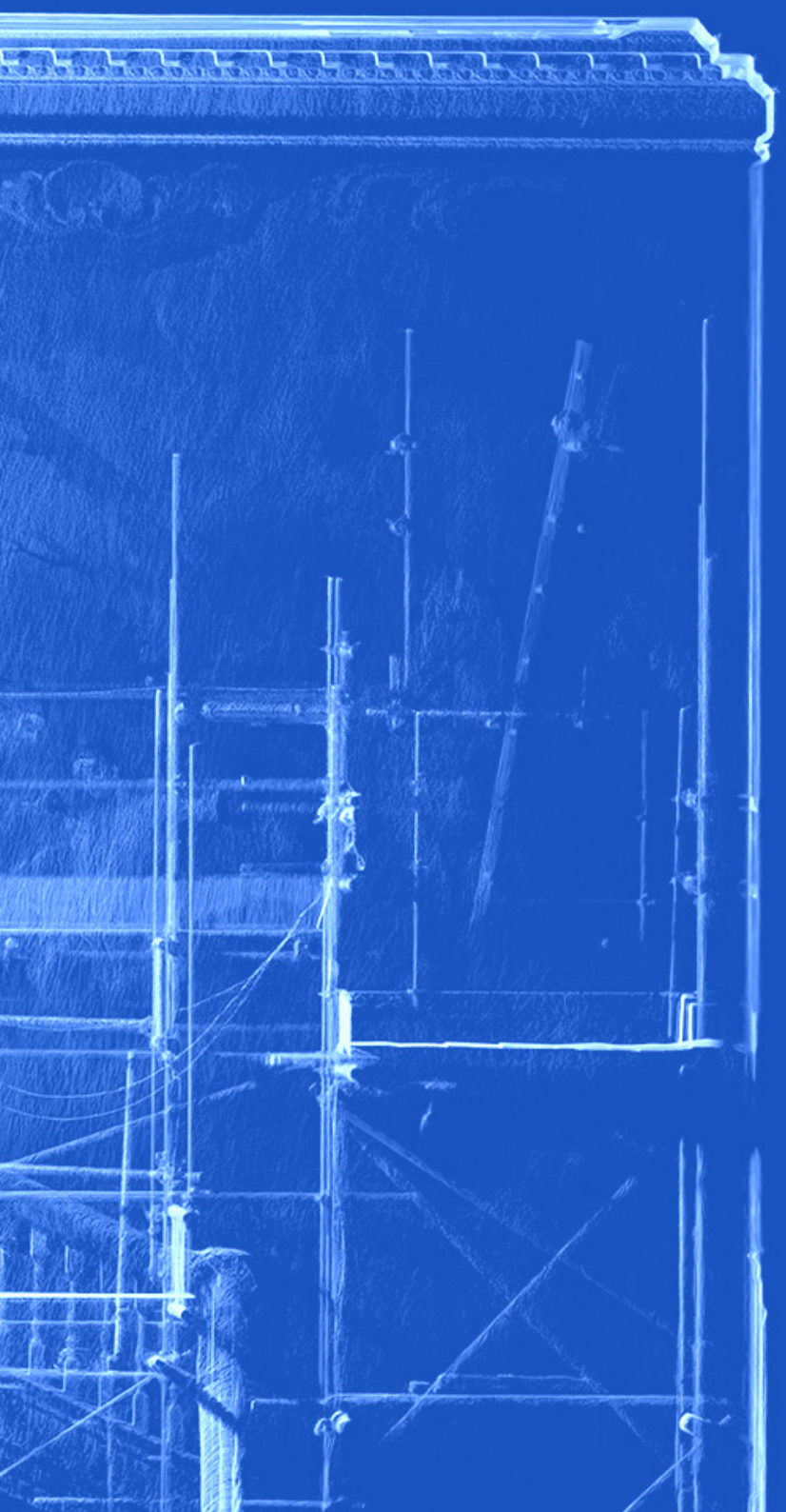

The Third Caregiver

Kaja Hayes

The Third Caregiver

How does Spatial Design Impact Patient and Staff Experiences in Healthcare Settings?

By
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University of Greenwich
MArch Architecture
Year 2024-2025

Cover Image Source:
Captivate Heritage Laboratory,
LiDAR Scan of the Hogarth Stair (2025)

Abstract

This thesis examines the relationship between architecture and healing in medical spaces, challenging contemporary definitions of healing environments. Through comparative analysis of historical and modern healthcare facilities, it investigates how architectural design influences both physiological and emotional responses in patients and staff.

The research begins with semi-structured interviews with medical professionals, focusing on their emotional responses to workplace environments, social dynamics, and observations of patient experiences. These interviews aim to consolidate findings about the significance of patient-centric and holistic design in modern healthcare settings.

The research then explores the Epidaurus Asklepion in Ancient Greece, exploring how these temples integrated nature and architecture to create therapeutic environments. Using Wilson's biophilia framework, the study analyses specific design elements that fostered positive emotional responses and contributed to the healing atmosphere.

The investigation then turns to Maggie's Centres, examining their success in creating calming healthcare environments. Through Caterina Frisone's ethnographic studies and analysis of the Architectural Brief, the research compares their spatial structure to typical institutional medical spaces.

The final chapter examines the North Wing restoration of St Bartholomew's Hospital, exploring its conservation and repurposing for staff respite during the COVID-19 pandemic. This case study shows how institutional healthcare models can provide psychological support to its staff through the innovative repurposing of underused spaces. Through these diverse case studies, the thesis demonstrates the crucial relationship between architectural design and healing outcomes, advocating for more thoughtful integration of biophilic and holistic design principles in modern healthcare facilities.

Contents

Word count: 10899

00 | Are you sitting comfortably? Then I'll Begin.

Space: (noun)

/speɪs/

A continuous

area

or expanse which is free,

available,

or unoccupied.

This definition is not strictly true, however. You and I are occupying space right now; I am writing, and you are reading. That being said, although I am occupying my desk space the kitchen table behind me is unoccupied, as is the sofa which sits next to it. The room I find myself in right now consists of different regions- it is my office, kitchen, dining room, and living room. The overlapping of areas within a space is an important notion I will explore further in this thesis. As I mentioned, I am sat fairly comfortably at the desk in my Greenwich flat. The weather app on my laptop says, 'cold weather now', not that I needed the reminder. I have two blankets wrapped around me and fingerless gloves on, and the wind is blowing the falling leaves harshly against my living room window, which rattle in their frames with each gust. The familiarity of the space I am in brings me great comfort; this is my safe space, my happy place, home. However, I cannot help but question whether the peace I feel here is due to personal memories and subconscious perceptions, or whether the emotional response stems from the design itself. If that is the case how does the spatial design achieve this response? I cannot find the language to answer these questions, the words are unfathomable and just out of reach; left dubiously at the tip of my tongue.

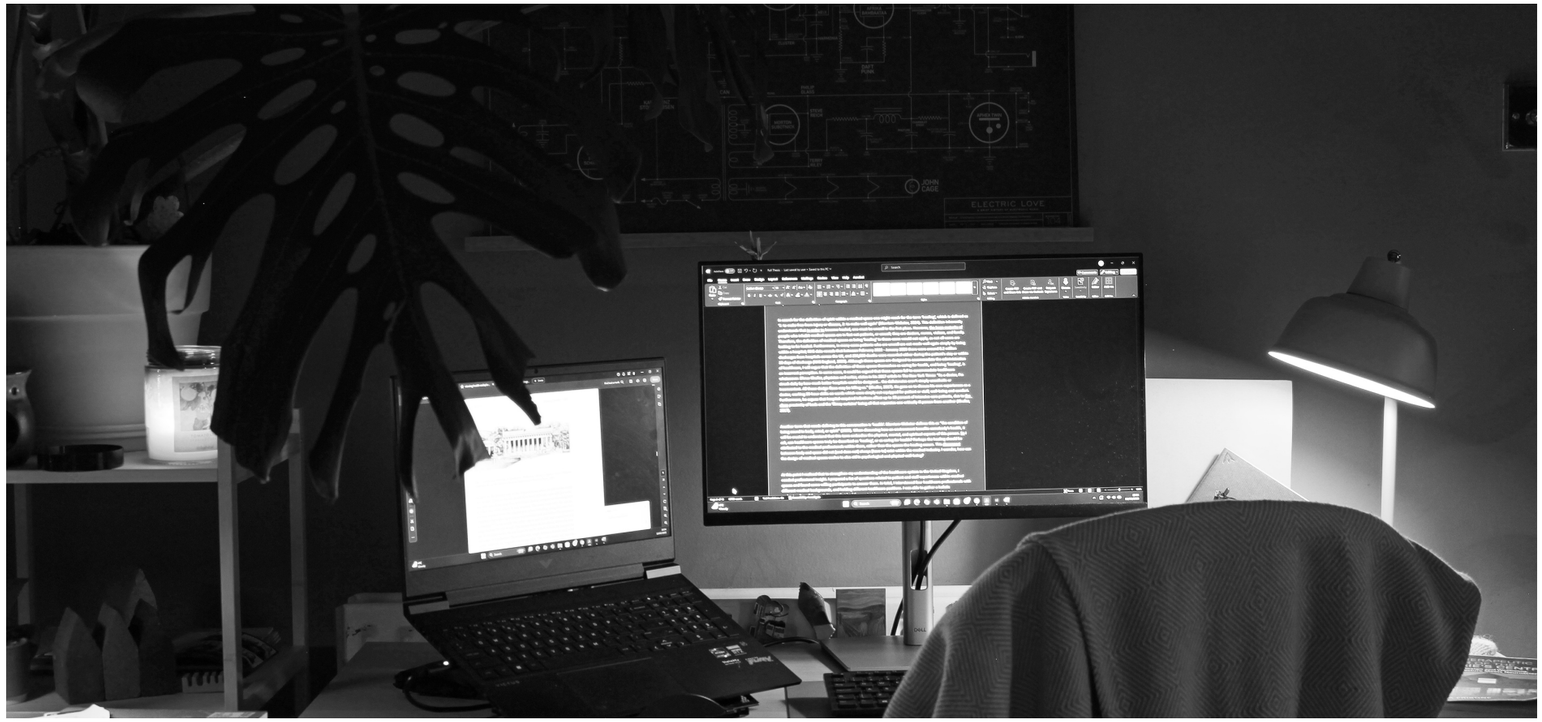

Figure 1
The desk in my Greenwich Flat

The built environment consists of a myriad of spaces, like the room I am in now, they may be enclosed, open, semi-open, the list goes on. Each of these spaces produces a different emotional response within out subconscious. The spatial volumes that shape our daily lives evoke complex and often contradictory emotional responses. Although I enjoy being in my flat, I can say I dislike being on the tube; the walls feel as if they are closing in on me and the thought of being deep underground takes the air out of my lungs. I enjoy being in libraries, hearing the soft turn of the page and the gentle tapping of keyboards. On one such occasion, the 13th of November 2024, I found myself sat in the AA bookshop in Fitzrovia amongst a small group of academics, architects, and supporters of Dr Caterina Frisone, Associate Lecturer in Interior Architecture at Oxford Brookes. We were there for the launch of her seminal book *The Therapeutic Power of the Maggie's centre*. She began:

Figure 2
The AA Bookshop in Fitzrovia, where Catarina Frizone held her book launch

"Subconscious reactions impact judgement when we first enter a space, resulting in an emotional response"
(Frisone, 2024)

I will discuss what I gained from this book launch momentarily; first I must pre-face why I decided to attend this event. When considering universally challenging environments, we may consider healthcare facilities a prominent example. In fact, 10% of the population suffer with an acute phobia of hospitals - this is called Noscomephobia (Fritscher, 2023). Of course, hospitals have negative connotations distinct from the design of the spatial volumes within them; mainly, what we associate with these environments: illness, medical procedures, pain, or sick family members. I am interested in understanding the spirit of medical spaces, this being how these places cause negative emotional responses, why this physiological response happens, and what designers can do to improve patient and staff wellbeing within them.

In search for the language to describe a medical space one might reach for the term 'healing', which is defined as 1: "to make free from injury or disease", and 2: "to make well again" (Merriam-Webster, 2024). This definition inherently suggests that in order to become healed, one must be unwell in the first place. However, many people who inhabit medical spaces are in fact not patients, or unwell; they are doctors, nurses, visitors, and family. Furthermore, in many cases patients who are unwell are not made well again simply by being in a hospital; NHS data reveals that between 2022-2023 there were approximately 8.2 million discharges from hospitals across the UK, and 256,000 deaths were recorded either during the patient's stay or within 30 days of discharge (NHS England, 2023). Although medical spaces are designed to accommodate the administration of healthcare, I will argue that the environments themselves do not necessarily care for health, nor can they be described as 'healing'. Dhruv Khullar, physician and writer, states in his 2017 article in The New York Times: "As a doctor, I'm struck daily by how much better hospitals could be designed... the deficiencies aren't simply unaesthetic or inconvenient. All those design flaws may be killing us." (Khullar, 2017). He goes on to discuss his own experiences as a doctor, working 30-hour shifts on wards which were simply not equipped for patient or staff, wellbeing or comfort. Furthermore, he argues that hospital-acquired infections affect up to 30 percent of intensive care patients, due to the proximity of beds and the 'flimsy curtains' being all that separates one critically ill person from another (Khullar, 2017).

Another term that must be analysed is 'health'. Merriam-Webster defines this as "the condition of being sound in body, mind, or spirit" (2025). When discussing how an environment benefits somebody's health, it will be crucial to understand that this term embodies the

physical, mental, and spiritual attributes of this person. So, I ask, can healthcare spaces truly be described as 'healing', or as caring for health? Perhaps the healing should be attributed to the medical professionals, rather than the institutions the healing occurs? This disconnect between body and space does not have to exist within the medical industry; and may be considered a consequence of medical advancement. I wonder, how can the design of medical spaces evolve to also aid in psychological and physical well-being?

At this point I realised my research would benefit with some insight from medical professionals. I interviewed a sample of four healthcare professionals, asking questions related to the spatial issues that had the greatest impact on them, and their patients, while also discovering the intrinsic limitations within healthcare design. My conversations with healthcare professionals enlightened me on both the negative and positive spatial experiences of the NHS hospital.

In order to look to the future,

we

must

look

to

the

past.

We will visit the 6th century BC, and explore the early practice of healing seen through Asklepieia of Ancient Greece. This analysis will reveal the importance of embodied space in healing; which pertains to "the location where human experience and consciousness takes on material and spatial form" (Low, 2003). These healing sanctuaries, which were dedicated to the physician-demigod in Greek mythology- Asklepios, were built across Ancient Greece, the Eastern Mediterranean area, and the Roman world, forming a 'sacred healthcare network' and the first established public healthcare facilities in the world (Pavli & Maltezou, 2024: 113). Asklepios is depicted as a middle-aged man, holding a rod with a snake wound around it. The rod is known as the 'Rod of Asklepios', and still is the worldwide symbol of physicians today (Ibid.) Figure 3 reveals a statue of Asklepios with his snake rod in The Gkypotek in Copenhagen (Thune, 2012). Asklepieia placed the human experience at the heart of its design and healing philosophies; becoming a pilgrimage location for the chronically ill to immerse themselves in the spirit of healing by strengthening their connection to its God Asklepios (Sternberg, 2010: 220). These sanctuaries were built far from the grime and noise of the city, close to a fresh source of water and with breathtaking views of the surrounding landscapes (Ibid.) The rituals and treatments offered to the patients at Asklepieia are based in understandings of Hippocratic medicine, and spiritual values (Panagiotidou, 2016). While Ancient Greek societies attributed healing at these sanctuaries to divine intervention, modern scientific research validates the therapeutic power of nature in both psychological and physical recovery. I will be focussing my research on the Asklepieion located in Epidaurus, Greece, investigating key structures and treatments which helped establish this example as one of the most notable healing sanctuaries in the ancient world.

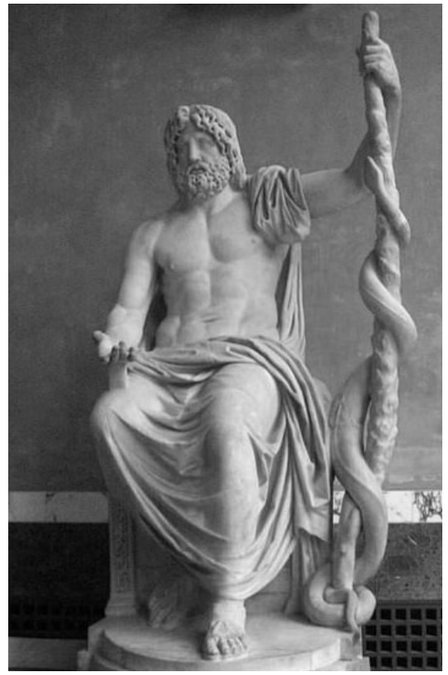

Figure 3
A statue of Asklepios holding his snake rod in the Gkpotek in Copenhagen

Now, we time travel back to the AA bookshop in November 2024, where Frisone had just introduced her book investigating the therapeutic power of the Maggie's centre. In the same way as Asklepieia, Maggie's offer its visitors an experience beyond the typical notions of medicinal 'healing'. Frisone introduces her research with a personal discovery:

> ***"I found myself faced with a major obstacle...due to the possible 'passive' or 'clinical' interpretation of the term, 'therapeutic' was not the right adjective for a Maggie's centre"***
> (Frisone, 2024: 1).

I too was under the impression that Maggie's Centre's were pinnacles of therapeutic design, so if this is the wrong definition, what would be more accurate? My quest moves to St Bart's Maggie's Centre, sited in the grounds of St Bartholomew's Hospital in Smithfields, Central London. In this chapter I reveal the human-centric philosophies and motivations pioneering the organisation, which began with Maggie Keswick Jenck's dehumanising experience with cancer care through the institutional system of the NHS. This chapter also examines how the language of the architectural brief shapes the embodied experience of cancer patients using the centres, while also influencing architects to create varied, unique, proposals that embody Maggie's core principles. An analysis of Barts Maggies demonstrates how successfully its entrance sequence fulfils the experiential qualities outlined in the brief. The theory of 'enabling places', examined by Cameron Duff- professor in Social Change at RMIT University (Duff, 2011)- is used in this critical analysis to explain the centre encourages social dynamism and inspires hope within cancer patients, contributing to its overall therapeutic power. Finally, criticisms are suggested as I analyse how the architects selected to complete most of Maggie's projects potentially taints the impact of the organisation's original motive. Furthermore, the practicality of applying Maggie's Centre design philosophies to institutionalised healthcare buildings is critically examined, using the data obtained in the interviews with healthcare professionals as a guide.

Finally, I discuss St Bartholomew's hospital as a successful model for institutional healthcare. During the Covid-19 pandemic, St Bartholomew's hospital opened its Great Hall in the North Wing as a place of respite for its healthcare staff. Since the pandemic, the organisation has chosen officially to repurpose the whole North Wing for staff respite. I visited the hospital on the 13th of January 2025 for a tour of the refurbishment works taking place in the Great Hall; the link Historic England has within the hospital's strive for staff wellbeing will be examined This chapter will tie together the themes explored earlier in my research and explain how the organisation of St Bartolomew's hospital is a model for institutional healthcare design that bridges the gap between mental and physical wellbeing. This thesis aims to speak for the Third Caregiver in the medical industry – healthcare architecture itself.

Figure 4
Barts Maggie's Centre

01 Conversations with Healthcare Professionals

Between the 24th and 27th of December 2024, I conducted four interviews with healthcare professionals to support my holistic understanding of patient and staff experiences within NHS medical spaces. The methodology and interview questions relating to this research can be found in the Research Methods Statement, and the transcripts can be found in Appendix A.

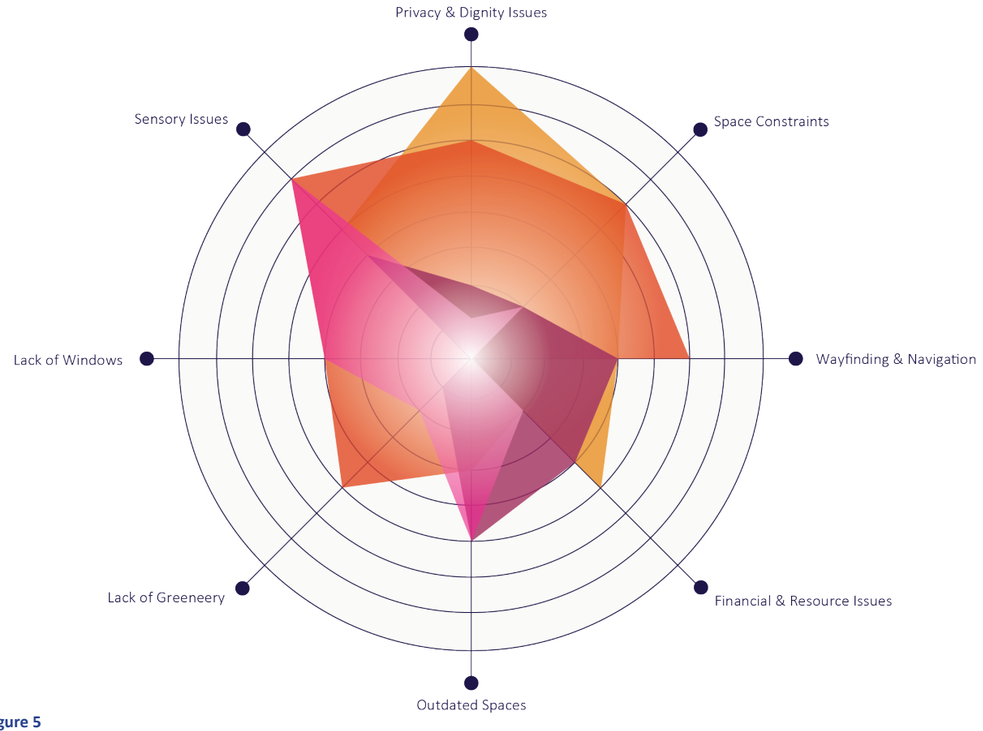

Figure 5
Radar Chart illustrating the negative spatial themes discussed by the interview participants

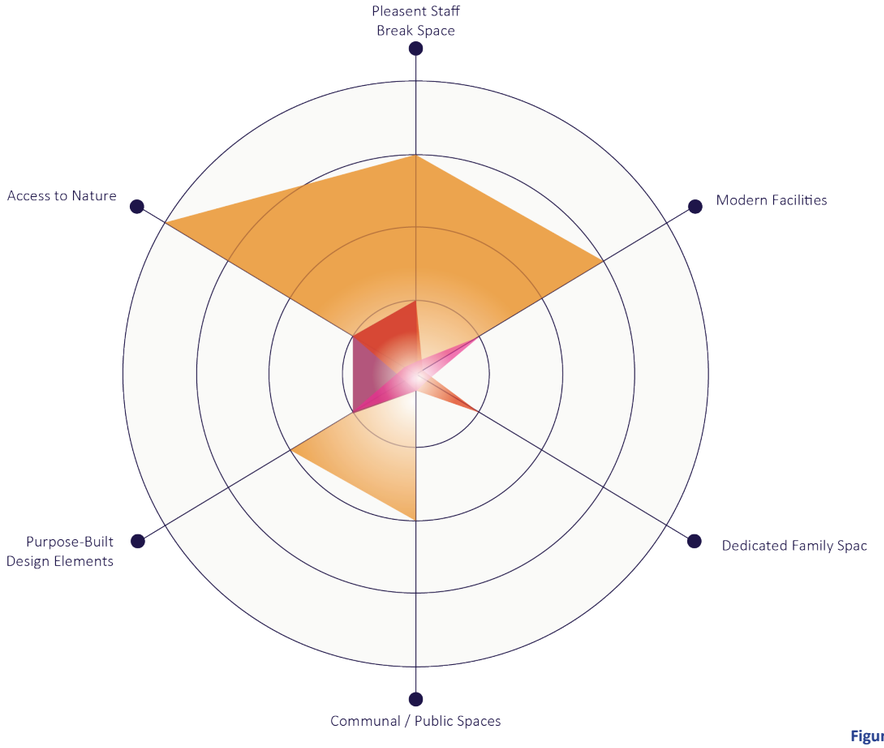

Figure 6
Radar Chart illustrating the positive spatial themes discussed by the interview participants

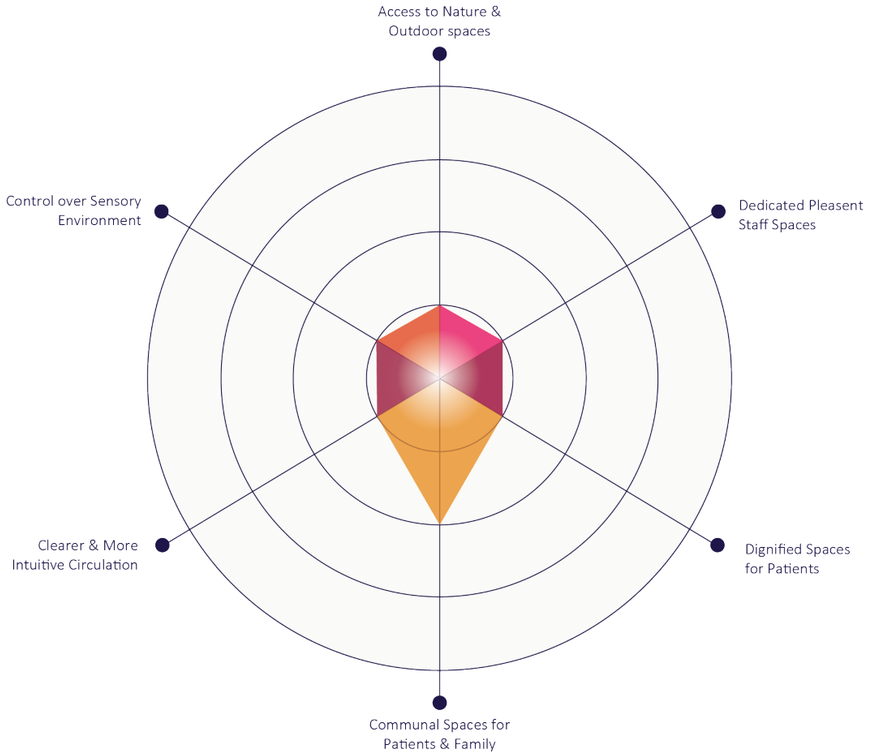

Figure 7
Radar Chart illustrating the desired spatial themes discussed by the interview participants

Where do you go when you need a moment of respite?

The most frequently cited negative theme across all interviews was the lack of adequate privacy for patients and staff. In the typical hospital ward Participant 3 recounts that patient beds are separated by curtains, which are drawn shut when private conversations or medical treatments are carried out.

"If someone is perhaps not well enough to walk… you bring a commode and they have to do what they need to do behind a curtain which isn't always dignified… it might give you the feeling of a false sense of security, that this is private, but I think we all know that it isn't." (Appendix A)

The belief that curtains are an inadequate form of privacy for patients is shared by Participant 2; when asked how the built environment supports or hinders dignified care, they responded:

It's a big misconception that you get privacy behind a curtain

"It's a big misconception that you get privacy behind a curtain. The only thing you get is that people don't see, but they hear everything." (Appendix A)

This sentiment is reinforced by Participant 4 who argues that private conversations had by patients' bedsides were not private, due to the proximity of beds in the ward (Appendix A). Privacy in healthcare spaces, or lack thereof, is a concern felt nationally; the Daily Telegraph cites a survey that stated 58% of people believe their GP's practice lacked privacy (Donnelly, 2019). Specifically, patients felt that due to their practice's thin walls, they were forced to whisper in their consultations with GPs to prevent sensitive information being overheard (Ibid.). This is a serious issue as NHS staff are legally bound to maintain patient confidentiality (Ibid.). Not only are NHS staff exposed to liability, but the patient's dignity is also undermined.

Three out of four participants believed that dedicated and comfortable staff break spaces were scarce in their workplaces. Participant 3 responded to my question regarding where they go for respite with:

"I go to the staff room, which is in the centre of the whole department, with a little sort of kitchen area. Um, no windows and normally someone else in there, so it's not really peace and quiet, but it's just somewhere to go where there's no patients." (Appendix A)

Although Participant 3's workplace provided a staff room, there is little separation between this and the rest of the department. The lack of 'peace and quiet' and windows means that staff are unable to physically and psychologically remove themselves from the clinical setting of the ward. The inadequate design of the break room fails in providing participant 3 with psychological rest from the tensions of their job. In her book Healing Spaces: The Science of Place and Well-Being, Dr Esther Sternberg states that windows allow the body to experience a sense of relief and tranquillity, as we can watch the world outside through a "meditative state" (Sternberg, 2009: 9). The removal of windows from Participant 3's staff room denies this fundamental method of mental rehabilitation and may contribute to feelings of isolation and anxiety. Participant 1 also noted that there were no windows in their staff place of respire, and said it made them feel claustrophobic and isolated as they could not see what was happening outside (Appendix A). Participant 1's description may be more accurate in depicting a prison cell, rather than room intended to provide relief. How does the NHS expect healthcare staff to perform their jobs safely and effectively when they are provided with substandard, anxiety inducing working environments?

Research has demonstrated that natural light is the most influential environmental factor in promotes mental wellbeing in healthcare staff (Zadeh et al., 2014). In one study, access to windows in healthcare spaces revealed higher job satisfaction levels amongst workers, as sunlight and views to nature significantly lowered

occupational stress (Ibid.). The strength and timing of light exposure altars the body's circadian rhythm (Ibid.) which is the physical, mental and behavioural changes experienced by a living organism over 24 hours (Circadian Rhythms, 2023). Exposure to natural light during the day leads to circadian realignment, enabling one to reach peak cognitive performance during the working day (Zadeh et al., 2014). In her book Sternberg references Roger Ulrich's study which discovered that patients positioned next to windows with views to trees recovered faster than those with views of brick walls (Sternberg, 2009: 3). This illustrates the importance of including windows within institutional healthcare spaces not only for the mental rehabilitation of staff, but the physical recovery of patients.

I was curious to know more about the materiality and colour palettes of the participants' staff rooms, and discover whether these factors contributed towards negative perceptions of the spaces. Both Participants 1 and 2 noted that the primary colour palettes were dull and uninteresting; Participant 1 explains that the furniture in the room was beige, and wooden, while the carpet was a blue colour reminiscent of school classrooms (Appendix A). Participant 2 mentions that wall colour was mainly beige, with dully green or blue furniture (Appendix A). Ancient Egyptian societies were known to exercise chromotherapy – the practice of using colour to heal (Cherry, 2024). The theory is still used today, which pictures blue as being associated with soothing illness and healing pain, alongside heightening calmness and stability of the mind (Ibid.). It could be argued that these respite spaces need to be refreshed and updated, and if chromotherapy is to be used it must be used in conjunction with higher quality furniture or placed more strategically. When used subtly, blue helps to balance mood and reduce anxiety (Chong, Heng and Basher, 2023).

The bling, bleep, you know. Lots of stuff, all the time.

Before the interviews I hypothesized that the participants would discuss finding sensory aspects of the hospital environment challenging. However, to my surprise, although the participants recognised that these attributes were difficult at times, they were entirely necessary for the operation of the hospital. When discussing high levels of noise in their emergency department, Participant 3 argues:

"It's always noisy because there are loads of machines all the time. The bling, bleep, you know, lots of stuff all the time. And this is 24/7. It's always noisy because you have to have these machines on to help people"
(Appendix A).

Although they recognise that the constant noise creates a demanding, distracting environment, Participant 3 argues that this is a necessary consequence of keeping patients alive. A 2011 study revealed that noise levels around nurses' stations significantly contributes to staff stress, and coincidently increases the potential for nursing errors (Mahmood et al., 2011: 230). Furthermore, when discussing the lighting conditions Participant 3 states:

"There's very bright light so people can see what they're doing…You have to have these lights. Even at night you can't turn them off because people come in the middle of the night needing care"
(Appendix A).

Nurses in the 2011 study noted that medical errors ranged from missed doses of medication to incorrect dosages or even the wrong medication being administrated (Mahmood et al., 2011: 232). Adequate lighting reduces these risks, which explains why Participant 3 mentioned that the lights are always turned on. However, the loud noises attributed to medical equipment could be considered distracting and stress inducing for both patients and staff- but are not necessarily a feature which can be designed out of the space.

Participants 2,3 and 4 discussed the hospital layout as being a negative aspect of their workplaces. Participant 2 mentioned that in general, the hospital layout was unclear to patients and new staff (Appendix A). This situational confusion is felt amongst many hospital visitors and can greatly affect the psyche of people who are already in pain or anxious due to being in ill health (Confusion in the Hospital, 2016). Hospital environments seem to alienate patients through their complex institutional layouts and unfamiliar medical terminology, creating barriers to understanding and navigation (Ibid.).

Participant 4 revealed that the departments in their workplace are split into gate numbers “like an airport”, explaining that using unfamiliar terminology like “gate 37” instead of standard terms like “ICU” strips patients of their existing medical knowledge, further alienating them in an already complex environment (Ibid.). While they disliked the wayfinding system, Participant 4 spoke highly of the overall hospital layout:

“It’s designed like a flow system… you come in at your worst, go into the wards where you need the most care, and slowly step down as you go down the hospital. It’s designed quite well”
(Appendix A).

It’s designed like a flow system

The analysis of these interviews suggests that organising medical spaces hierarchically based on levels of patient care optimises both spatial efficiency and clinical outcomes, enabling swift patient transfers between stages of care. Additionally, healthcare facilities should implement intuitive, unified wayfinding systems that avoid alienating patients and new staff, as with multiple overlapping coding systems.

Participant 1 discusses utilising transient space within their workplaces from dual perspectives: how they [as staff] experience and utilise these spaces, and how patients perceive these spaces. Participant 1 describes strategically incorporating respite into their workflow by deliberately selecting tasks that require traversing the hospital:

“I would take up a task that needs me to be in a different part of the hospital. Then I can walk through the hospital to get there, which can be quite a nice break during a hectic shift”
(Appendix A).

Participant 1’s use of the transient corridor space for active respite challenges the assumption that institutional respite spaces do not require dedicated areas. In this case, Participant 1 preferred to exercise respite by changing scenery within the hospital, finding value in the journey itself rather than the end destination. The corridor serves multiple purposes, allowing different people to use the space simultaneously in their own distinct ways.

The concept of transient space may also be understood as ‘non-place’, a term coined by French anthropologist Marc Augé (Augé, 1992). In his book Non-places: Introduction to an anthropology of supermodernity, he argues that non-places “surrender themselves to solitary and dividuality”, as places which are “fleeting and ephemeral” (Augé, 1992: 78). His depiction of the non-place as being ephemeral reflects the spaces discussed by the participants; the corridors of the hospital used by Participant 1 to exercise respite rely on movement as the tool of recuperation, rather than the fundamental qualities of the space. Respite is found within and exercised through the transient nature of the corridor.

The concept of the ‘non-place’ was explored by designer and lecturer Adam Griffiths, who showed his project ‘transient_space’- a digital, projected gallery- in Manchester School of Art’s large atrium space. (Ong, 2018). Griffiths commissioned a selection of artists to create 17 second videos based on the concept of disruption, which

were then projected onto the large blank wall of the artium space of the art school (Ibid.). This project draws light to ambiguous places, places where the user may spend a brief preoccupied moment, places with no permanent identity- transient places. By creating a moment of difference and interest, you are invited to reinterpret the position you hold within the space; for a moment you are an observer, a critic, a consumer. Broken is the anonymity of the non-place.

The consideration of transient spaces as non-places, as explored by Griffiths, bring to light creative opportunities in the future of healthcare design. Firstly, that respite can be achieved while traversing through circulation space- as seen by Participant 1- leading to the question of how these spaces can be improved to allow for more therapeutic experiences. Secondly, how the experience of transient spaces within hospitals can be designed to allow for a myriad of functions, and become flexible in nature.

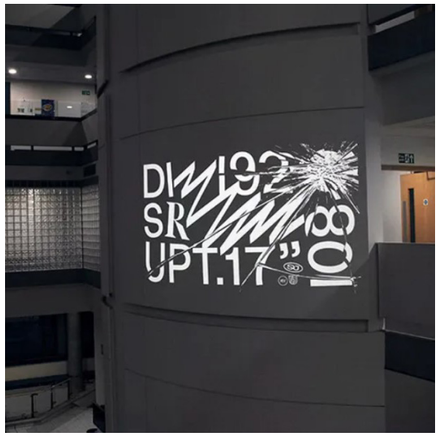

Figure 8
Disrupt The Channel: Studio Jimbo

Figure 9
Disrupt The Channel: Foreign Policy

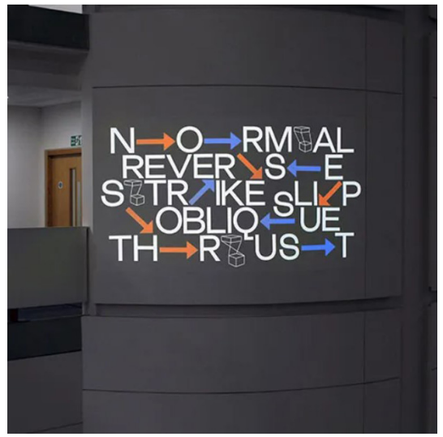

Figure 10
Disrupt The Channel: Republique Studio

Figure 11
Disrupt The Channel: Jonathan Hitchen and Sam Meech

Figure 12
Disrupt The Channel: Playlab Inc

Figure 13
Disrupt The Channel: Ksenia Dubrovskaya

Positive./Variety of Respite Spaces

Participant 4 expressed unique satisfaction with their workplace in comparison to the other participants; their hospital was constructed within the last decade and offers a wide variety of respite spaces for staff and patients. Hearing their perspectives on this hospital's successes and failures was insightful, as it provided me with awareness into the current trajectory of new healthcare design in the UK. Participant 4 noted five different examples in the interview (Appendix A) which were:

1. Break Room
2. Staff Canteen
3. Outdoor balcony
4. Prayer Room
5. Abundance of Green Space between hospital buildings

When describing the break room, Participant 4 noted that it was

"not a very nice environment because it's still on the ward you can still hear all the noise"
(Appendix A).

They followed up by explaining the staff canteen was their preferred respite destination as the short walking distance from the ward provided them with physical separation from their working environment (Ibid.). This sentiment was echoed by Participant 3, who felt their staffroom failed in providing the necessary recuperation due to its location in the centre of the ward (Appendix A). Furthermore, Participant 4 talked extensively about the outdoor balcony provided by their facility, explaining that it was "amazing" in the summertime as the herbs and flowers growing around it gave the sense that you were in a completely different environment (Appendix A). The balcony provides views away from the hospital grounds and enables Participant 4 to separate themselves from the stress and institutional nature of their working environment (Ibid.). It is evident through Participant 4's emotive recount that this relatively small respite space provides a wealth of benefit towards staff wellbeing. The provision of a private, external area, with views to nature allows staff to physically remove themselves from the building, facilitating psychological restoration.

They loved that space.

The therapeutic nature of controlled green space was also discussed by Participant 3, who spoke about a small garden - sponsored by relatives of long-term patients- provided at their former workplace. When asked whether they saw an improvement in patient's mood because of this garden, Participant 3 replied

"Yes, they loved it. They loved that space"
(Appendix A).

As with the balcony, the sponsored garden has clear positive effects on the wellbeing of its users and provides separation from the hospital environment.

02 | Spiritual Foundations

"It is well-known that across history, people painfully confronted with their mortality would often seek out the divine in hopes of ameliorating their ailments."
(Van der Molen, 2019: 1).

Ancient Civilisations Researcher, J.M Van der Molen, argues that through the devastation of war, famine, plagues, or disease, humanity has developed techniques and belief systems which bring light even in the darkest of times. This notion plays a pivotal role in understanding the operation of early examples of healthcare centres, and their significance in the trajectory of medical care across the world. Contemporary medicine owes much of its foundational understandings to the studies of physiology and psychology in ancient Greece (Kleisiaris et al., 2014). These early practices in methodist philosophy sought to find the causes of diseases in the promotion of health status amongst ancient societies; today we acknowledge these philosophies as the groundwork of medical thinking (Ibid.). The societal striving to understand illness was guided by Hippocratic medicine; physicians offered the sick practical, science-based treatments, therapeutic herbs, and other medicinal remedies (Leonard, 2019). However, when local physicians proved ineffective in providing a cure, many chronically sick people turned to the faith-based holistic practices provided at healing sanctuaries - Asklepieia (Ibid.).

Patients at Asklepieia were provided with a healthy diet, fresh water, music, and sleep (Sternberg, 2009: 220). Alongside this, they were treated with ceremonial respect; their wholes being understood as the sum of their spiritual, psychological, moral and natural characteristics (Papageorgiou et al., 2022: 2). The holistic, patient-centric practices at Asklepieia revealed how ancient civilisations' perceived health as embodying the realms of both mythology and philosophy (Ibid.).

The Epidaurus Asklepieion serves as an ideal case study for critical analysis, as it intersects meaningfully with my broader research themes. Catarina Frisone discusses how the therapeutic qualities of this healing sanctuary inspired both Maggie and Charles Jencks during a trip they took in the 1970's; therefore, relating directly to my analysis of the Maggie's Centres and their conceptual foundations (Ibid.). Furthermore, this thesis will draw parallels between the programme at Epidaurus Asklepieion and that of St Bartholomew's Hospital, investigating how the approaches contributed to their endured success. The investigation will focus on the therapeutic attributes provided at the sanctuary: its connection to landscape, the ritual of sleep therapy in the abaton, the role of music in the theatre, and patient respite in the katagogion.

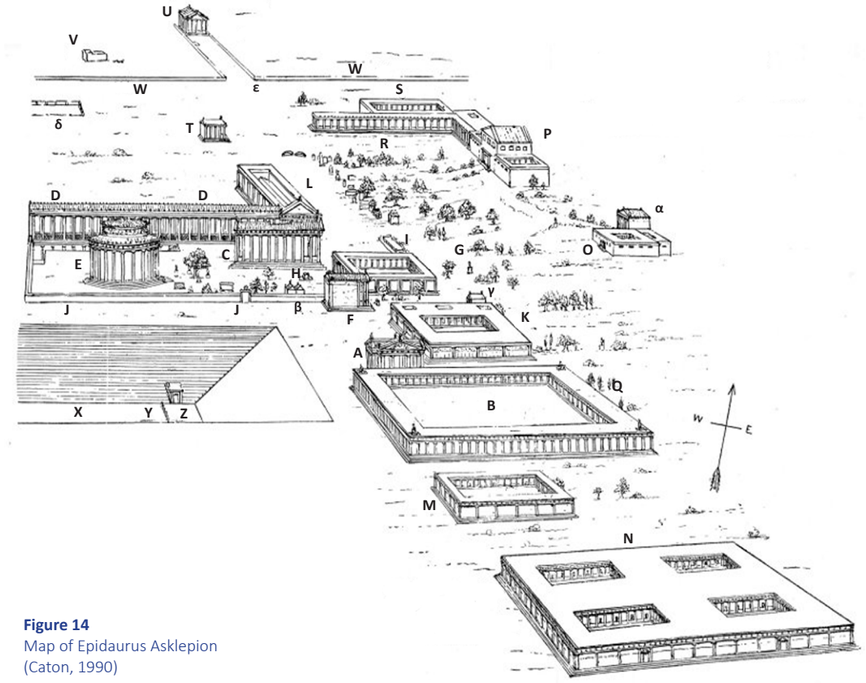

Figure 14
Map of Epidaurus Asklepion
(Caton, 1990)

A South Propylæa
B Hestiatorion "Gymnasium"
C Temple of Asklepius
D East and west Abaton
E The Tholos
F Temple of Artemis
G The Grove
H Altar of Apollo
I Altar of Asclepius
J South boundary of sacred precinct
K The 'Square building.'
L The baths of Asklepios
M Bath House
N Katagogion
O Roman Building
P Baths
Q Supposed portico of Kotys
R North-Eastern Colonnade
S Stoa
T Temple of Aphrodite
U Northern Propylæa
V Roman Building
W Northern Boundary
X Stadium
Y Goal, or perhaps starting place
Z Mouth of subterranean Passage
α Temple of Asklepios and Apollo
β Supposed Temple of the bountiful gods
γ Temple of Themis
δ Reservoir or bath
ε Position of Ancient Cemetery

The Asklepieion of Epidaurus, founded in the sixth century B.C (Hart, 1965: 234), is situated on the Greek mainland, where the mild climate and abundant freshwater springs make it one of the most significant therapeutic centres in both Greece and Rome (Papageorgiou et al., 2022). The sanctuary was built outside of the city, nestled within the rolling hills and greenery of the countryside (Frisone, 2024: 6). During the Greco-Roman era, a pivotal Hippocratic medical text, On Airs, Waters, and Places, provided guidelines for healthy placements of new settlements by discussing how environmental qualities effected the four humours of the body (Hippocrates & Jones, 1923). The humoral theory was a medical system most likely developed by the ancient Egyptians and was widely adopted by ancient Greek and Roman physicians (Van Sertima, 1992: 17). This theory systemised the operation of bodily functions based upon the production of four bodily fluids: blood, phlegm, yellow bile, and black bile (Hippocrates et al., 2016) Hippocrates, Greek physician and philosopher, believed that these four fluids must be kept in balance, and when they are unbalanced the body experiences pain and ill health (Mann et al., 1983).

In On Airs, Waters, and Places, Hippocrates instructed how new settlements should be located near high water sources, particularly those which flow east towards the rising sun (Hippocrates & Jones, 1923: 87). This was reflected in the Asklepieian ideal- the majority of healing sanctuaries, including Epidaurus, which were typically built upon higher topographies such as hillsides, to access cleaner air sources and fresh water (Baker, 2017: 148). Furthermore, this suggestion is echoed by Roman writer Vitruvius, who states that water arising from healthy [fresh] springs is able to cure disease and heal the body faster (Ibid.). One source, investigating the truth behind legends of waters' healing powers, claims that "natural spring waters often have high mineral content that do provide therapeutic value" (Zimet, 2024). The source also explains that naturally occurring salts found in the spring water even have the potential to ease arthritis pain, sulphates and bicarbonates can relieve gastrointestinal issues and calcium strengthens bones and teeth (Ibid.).

The ancient Greeks believed in a strong connection between Asklepios, his healing powers, and the natural world. Patricia Baker, head of Classical and Archaeological Studies at the University of Kent (Baker, 2014), explains that ancient Greeks believed that the sun was the deity Apollo, while the fresh air sweeping through the sanctuary was Asklepios; bringing health to mortals (Baker, 2017: 158). Baker says that it is this visual communication between God and the mortal, that translates the Ancient Greek belief that healthiness and the natural world are connected (Ibid.). In his manuscript On Architecture, Vitruvius argues that the space between colonnades, which are open to the sky, should provide views out to green plots of land [green pertaining to foliage in natural landscapes]. He proposed that this was healthy for vision, as it cleared the thick humours from the eyes (Granger, 1970).

Vitruvius's distinctive emphasis on the therapeutic power of natural vistas found concrete expression in the architectural design of Asklepieia, where carefully framed views of nature were integral to the healing experience. (Ibid.). An example of this can be seen at Epidaurus; to the south of the site the valley opens up to create a V-shaped opening in the horizon, and the curved ridgelines of the landscape stretch to enclose the remaining perimeter (Baker, 2017: 153). Once inside the site, which sits in a low-lying landscape, visitors would be able to look out onto panoramic views of the surrounding hills (Ibid.). The temple of Asklepios faces eastward towards the mountain of Tithion, and an existing groove in the site assumes that visitors would be able to look out onto a sea of greenery in the landscape between the encapsulating mountains (Ibid.).

Hippocrates believed that humans are bound to a relationship with the environment, even possessing the power to adapt and control it (Baker, 2017). While the ancient Greeks attributed nature's healing powers to spiritual forces, modern science recognises these therapeutic effects as biophilic responses. Edward Osborne Wilson, American biologist and naturalist, coined the theory of Biophilia as "...the innately emotional affiliation of human beings to other living organism. Innate means hereditary and hence part of ultimate human nature" (Wilson, 1984: 31). He argues that humans' intrinsic connection to the natural world was forged through the evolution of mankind alongside the organic wonders and mysteries of the natural world (Ibid.: 10). The theory of biophilia is comparable to Hippocrates theory of the binding relationship between humans and nature. Biologically, natural environments promote ones' ability

to recover from mental and physical fatigue, lower stress levels, and may be referred to as 'restorative' (Gillis & Gatersleben, 2015). The vistas provided towards natural landscape surrounding the Asklepeion provide visitors with an immersive experience that fosters active engagement with nature, deepening their understanding and appreciation of natural processes beyond mere visual observation (Kellert, 2018: 14). It can be believed that this visual connection people had with this environment greatly enhances their mental and physical wellbeing (Baker, 2017: 145).

The Abaton

Sleep therapy was a fundamental, spiritual, treatment offered to patients at the Epidaurus Asklepeion. Patients were led to the Abaton - or dream room - located in the temple of Asklepios. (Hart, 1965: 234). At Epidurus, the Abaton is noted on the map as building 'D'. In this space, patients slept underneath a large ornate statue of Asklepios, and with prior preparation and treatments, they allegedly experienced dreams in which the God visited them and revealed the cure for their illness. This meeting was called the 'enkoimesis', or incubation ("Ancient Healing at the Sanctury of Asklepios", 2023). Ancient Greeks believed that this mystical dream symbolised the death of one's ill self as part of the journey toward healing (Ibid.). It was known that a common preparation to sleep therapy in the Abaton involved the administration of psychedelic herbs, which heightened the dream sensations and brought the pilgrim closer to God (Pavil & Maltezou, 2024).

According to historians, feelings of 'hope' were facilitated through the stone carvings that adorned temple walls that depicted Asklepios healing chronically ill patients; this promise of divine cure drew countless seekers to Asklepieia across Greece (Hart, 1965: 234). Figure 1 depicts one such carving, Asklepios is seen healing a patient while she sleeps in the Abaton.

The Theatre

A large part of the traditional healing process seen at the Epidaurus was facilitated by the Theatre, located on the southernmost point in the site (Thomlinson, 1983: 85). This structure is the most notable of the sanctuary due to how well preserved it is, and its beautiful symmetry and panoramic views across the landscape (Ibid.). The enormous stone amphitheatre still provides excellent acoustics to this day and is built in the slope of Mount Kynortion ("Theatre of the asklepieion", n.d.). Here, patients and pilgrims experienced music and theatrical performances, hymns, and paeans, which were believed to speed healing of bodily ailments, aid in mentally rehabilitation (Kleisiaris, Sfakianakis and Papathanasiou, 2014). The Ancient Greek philosopher Pythagoras developed a theory of purification of the human soul through music, further exemplifying the Ancient Greek's belief in the therapeutic value of music (Pavli and Maltezou, 2024: 114).

The provision of entertainment for the patients and pilgrims of the Asklepieion revealed Greek understandings that 'healing' engaged the mind, body, and soul, rather than being purely diagnostic- as seen today. Healthcare buildings today are often devoid of recreational activities for patients; Participant 1's argued that patients do not have the luxury of changing locations in the ward, as they are required to remain in their bed as medical staff are required to monitor their whereabouts (Appendix A). Although patient monitoring requirements within NHS hospitals have contributed to the reduction of communal and entertainment spaces, this regulatory framework should not prevent the thoughtful integration of supervised gathering areas where patients can find respite from clinical settings.

Figure 15
Stone carving found in the Abaton at Epidaurus, depicting Asklepion healing a chronically ill patient

Figure 16
The Theatre at Epidaurus

03 | Maggie's Power

This chapter examines how the Maggie's Centre architectural brief shapes the creation of therapeutic environments by critical analysis of the language used in the document. Focus will be on the centre on the site of St Bartholomew's Hospital, colloquially known as 'Barts'. The centre, designed by Steven Holl Architects was completed in 2017 and replaces a disused brick structure which sat adjacent to the North Wing, designed by James Gibbs in the 18th Century. This historically changed building faces the large courtyard of the hospital in London (Maggie's centre barts, 2024). I believe that St Bartholomew's Hospital exemplifies excellence in healthcare through its provision of therapeutic environments to both patients and staff. This is not only achieved through the Holl's Maggie's Centre, but also through the repurposing the Great Hall [located in the hospital's North Wing] to support the hospital staffs' respite and wellbeing. Furthermore, the programmatic organisation of St Bartholomew's hospital is reflective of the Epidaurus Asclepieon. The Great Hall, and programme at St Bartholomew's Hospital will be discussed in the conclusion.

Firstly, it is important to note that these centres are not an alternative to clinical cancer treatments. Instead, they offer a supplementary support system to people undergoing cancer treatment, people who are in cancer remission, or people who are struggling with the loss of a loved one due to cancer (Martin et al., 2019: 1). Maggie's is a charity which operates independently from state healthcare systems, but its centres are located on the grounds of major hospitals that have oncology units (Ibid.). Staff at Maggie's Centres come from healthcare backgrounds, which enables them to offer services such as counselling, wellbeing support, and advice surrounding nutrition and physical health (Ibid.).

Figure 17 Maggie Keswick Jencks

Maggie Keswick Jencks (1941-1995) was a writer, designer, and landscape gardener (Our Founders, n.d). Maggie was diagnosed with breast cancer aged 47, and after some successful rounds of treatment she reflected "I had put cancer so far behind me I didn't recognise it." (Jencks M.K, 2007: 10). However, in 1993 she was found herself in a windowless hospital corridor processing the news that her cancer had aggressively returned, and she had three months left to live (Ibid: 20). Deeply affected by the impersonal nature of her cancer diagnosis, and the glaring absence of emotional support in the aftermath of her prognosis, Maggie resolved to revolutionise the system. By May 1995, she had written a 'Blueprint' for the cancer care centre she so desperately wished could be made available to her (Blakenham, M, 2007: 3). Edinburgh based architect Richard Murphy agreed to bring the plan to life, converting a small stable building on the hospital grounds of Western General Hospital into the flexible, comforting space Maggie spoke of (Ibid.). Sadly, she passed away on July 8th 1995, and was never able to see the completion of Edinburgh's Maggie's Centre- her visionary project- in November 1996 (Ibid: 4). This centre, which transcends institutional and clinical boundaries by prioritising patient comfort and psychological wellbeing, was the first of what would eventually become 24 [and counting] cancer care facilities across the UK (Maggie's 2022 Key Facts, 2022).

In the last year of her life, Maggie wrote A View from the Front Line, where she in a somewhat light-hearted voice, narrates her life after receiving a death-sentence prognosis. The overarching message of this moving book is how to navigate the turmoil of a cancer diagnosis without losing hope, or one's sense of self. Furthermore, she uses her negative experience with the institutional method of cancer care as a springboard to project her aspirations for compassionate cancer care in the future. In her memory, Maggie's Centres uphold her wishes and have become a template for person-centric design that inspires hope and brings joy to those affected by cancer.

"What matters most is not to lose the joy of living in the fear of dying."
(Jencks, M.K, 2007)

The primary functions of NHS hospitals are diagnosis and treatment, often neglecting the psychological impact of clinical environments on patient wellbeing. Maggie's Centres acknowledge this failing, aiming to bring some of the psychological comforts of home to healthcare environments. The centres, and the charity behind them, strive to create a synergy between practical and psychological support that enables people with cancer to face their diagnosis surrounded by a supportive community (Frisone, 2024). The Maggie's Centres architectural brief, written by the charity and based upon Maggie Jenck's aspirations in A View from the Front Line, helps achieve this ambition. The architectural brief is given to each designer of a centre, alongside a copy of A View from the Front Line, and a medical brief which outlines evidence-based design principles for cancer support. These documents can easily be found on their website and made available to the public for full transparency (Publications, n.d). To ascertain how psychological wellbeing is supported in Barts, I will be critically analysing the language used in the architectural brief for how it influenced the design. The document precisely articulates the intended emotional impact of the design, while also remaining flexible on the aesthetic implementation. The intention of this strategy is to allow each architect to interpret the brief uniquely, and to prevent homogeneity in centre designs.

The introduction employs abstract and emotional language, directing designers to "acknowledge what people are going through" and create "beautiful" spaces while emphasising the importance of "feelings" in the design process. Exactly how the architecture should recognise hardship is not specified, neither what Maggie's deems to be beautiful design; therefore, trust is placed in architects to tell Maggie's story as she would have wanted. The following discourse will walk you through the Barts centre as depicted by the architectural brief.

"More than anything else this brief is about the feelings we need the design of these places to convey to the people who will be visiting them… These places should look as if they are acknowledging what people are going through, saluting the magnitude of the challenge they are facing and themselves rising to the challenge of trying to help. They should be beautiful."
(Maggie's Centres, 2015: 2)

The Maggie's design brief states emphasises that the entrance should be domestic and welcoming, and thought of as a 'pause' space (Maggie's Centres, 2015: 8). This architectural pause acknowledges that newcomers may require multiple visits before stepping inside, as they process the reality of their diagnosis (Frisone, 2024: 67). Frisone explains that the door is historically understood as a passage between two worlds - in this context, a world before a cancer diagnosis, and a world after. (Ibid.: 69). The entrance therefore serves as a physical and psychological threshold, reflecting the profound transition in accepting help for one's diagnosis. The design philosophy of the domestic entrance acknowledges how cancer diagnoses often leave patients feeling stripped of choice and power, recognising that the self-directed decision to come to a Maggie's has the capacity to restore their sense of agency.

The entrance transition Barts exemplifies an 'enabling place', as the strategically designed progression of architectural spatial sequences contribute to an overall therapeutic environment. Cameron Duff, professor in Social Change at RMIT University, argues that 'enabling places' are "composed in diverse actor-networks, facilitating access to assorted resources and supporting the development of novel agencies and capabilities" (Duff, 2011: 150). This means that for a place to be considered as enabling, the various interconnected elements [staff, visitors, architecture], enable users of the space to access support [community, equipment, comfort], to develop new strengths and abilities [ways of coping or adapting]. In his work, Duff explores the relationship between health and place, claiming that enabling places are healthy places as they create a series of enabling encounters amongst the users of the space, and these encounters generate resources or benefits that promote health (Ibid.). What makes the entrance at Barts so successful is the power of choice it gives back to first-time visitors, a complete contrast to this lost experience following a cancer diagnosis.

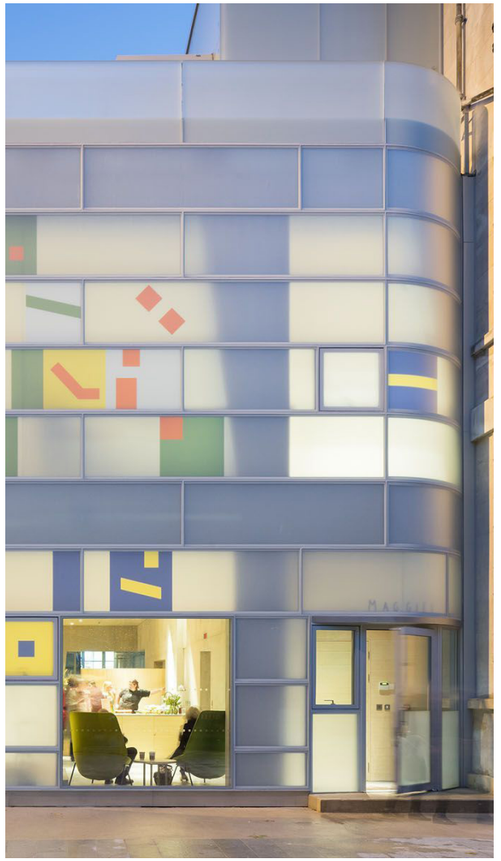

Figure 18
Barts Maggie's Entrance

The Kitchen

Once a visitor has passed through the first and second entry spaces, they enter the kitchen. Conventionally the kitchen is seen as a domestic space; their inclusion in Maggie's Centres sets them apart from institutional healthcare buildings which typically do offer these facilities to patients. As described in the brief, "the layout of the kitchen should encourage people to help themselves to tea and coffee" (Maggie's Centres, 2015: 8). When I attended Frisone's book launch in November, she explained how the simple act of holding a warm cup of tea and having a conversation with another person serves as a ritual. By holding the cup between your two hands it gives you agency and control, over your diagnosis, life, and future (Frisone, Book Launch, 2024). This analogy extends beyond the cup of tea, reflecting the intention of Maggie's Centres as a whole.

The brief specifies the kitchen should resemble a 'country' style, where visitors can gather around a large kitchen table that seats at least 12 people (Frisone, 2024: 72). The kitchen at Barts features bamboo clad counters, a fridge, a hob, and a large kitchen table that can be moved to allow for flexibility on the ground floor. Feedback from Maggie's users revealed the kitchen table as the valued space in their centre (Martin & Roe, 2022: 4). Duff demonstrates that the atmospheric qualities of enabling spaces directly shape the social interactions and activities that unfold within them, one of these qualities being the material resources of a space. He suggests these are specifically revealed in healthcare buildings and come in the form of the physical environment which take on 'enabling functions' for the user (Duff, 2011: 154). For instance, objects such as handrails aid people who struggle with mobility in accessing the site (Martin & Roe, 2022: 2). In the case of Barts, the kitchen table acts as the material resource for facilitating community and conversation between strangers. This social casual, domestic atmosphere seen around Barts kitchen table contrasts the institutional healthcare environments of traditional hospitals, as described by the interview participants. When discussing spatial elements that triggered patient anxiety and stress, Participant 2 said:

> ***"I think often an overly clinical feel is the first thing, it's very alien to them because it's not homely. It's not friendly generally speaking and out-patient is quite a sterile and bland."*** (Appendix A).

The Maggie's architectural brief further distances itself from traditional healthcare environments by specifying the absence of institutional signifiers such as corridors, lifts, rows of toilet cubicles, and all signage [like indicators of direction, fire exists, and room names] (Frisone, 2024: 40) The resulting environment aims to make the centres feel like home rather than a hospital, reminding the visitor they are a person in this space, rather than a patient (Ibid.). However, the absence of some signifiers, such as lifts, creates a conflict between function and aesthetics which excludes those most in need of therapeutic support- specifically patients weakened by cancer treatment. Barts Centre addresses this challenge by strategically placing the lift discreetly at the rear of the floor plan, preserving the non-clinical atmosphere while ensuring accessibility for all users to engage with the supportive environment.

Figure 19
Barts Maggie's Kitchen viewed from the spiral staircase

Open and Semi-Open Spaces

Open and semi-open areas in Barts promotes spontaneous social interactions and dynamic movement, helping users find the agency to reclaim their lives and spirits. One way it achieves this is through an enfilade sequence of rooms, in favour of "spatial interaction rather than walls", as quoted from the design brief (Frisone, 2024: 66). Implementing open plan strategies across all Maggie's enables them to be immediately understood upon entering due to the architecture's transparent layout (Ibid.) To ensure visitor comfort and privacy, a spatial hierarchy of volumes is seen within Barts; smaller intimate spaces are positioned off larger central spaces, ensuring there are environments to tailor for a range of needs and emotional reactions (Ibid.). The brief states that "the interior shouldn't be so open that people feel watched or unprotected" (Maggie's Centres, 2015: 9).

Barts open-plan design encourages the users' freedom of movement, echoing the ancient Greek practice of using dance as therapeutic release - a tradition that recognised movement had the ability to alleviate pain and anxiety (Frisone, 2024: 27). When moving through the open plan at Barts the mind 'mutates', releasing thoughts and stresses previously trapped in the body. This mutation allows the brain to evolve and become more present and receptive, thereby entering a state of flexibility (Ibid.). Curiously, this may be compared to the inherent flexibility of neural circuits of the brain, which are able to rapidly reconfigure in response to environmental stimuli, allowing an improvement in dynamic brain function (Ovsepian, 2019).

The naturally bright open plan format of Barts contrasts many hospital buildings; where layouts often consist of labyrinths of corridors that leave patients feeling lost and alienated (Glover, 2024). Participant 2 discussed how a "lack of clear direction" is felt by new patients and staff to the hospital (2024). They argued that for the large size of the building, and number of departments within it, there was inadequate signage or visual direction which new people could easily follow (Ibid.). Perhaps implementing open plan spaces on arrival to these institutions would prevent patients from feeling immediately confronted by the hospital's architecture, but rather, welcomed into it.

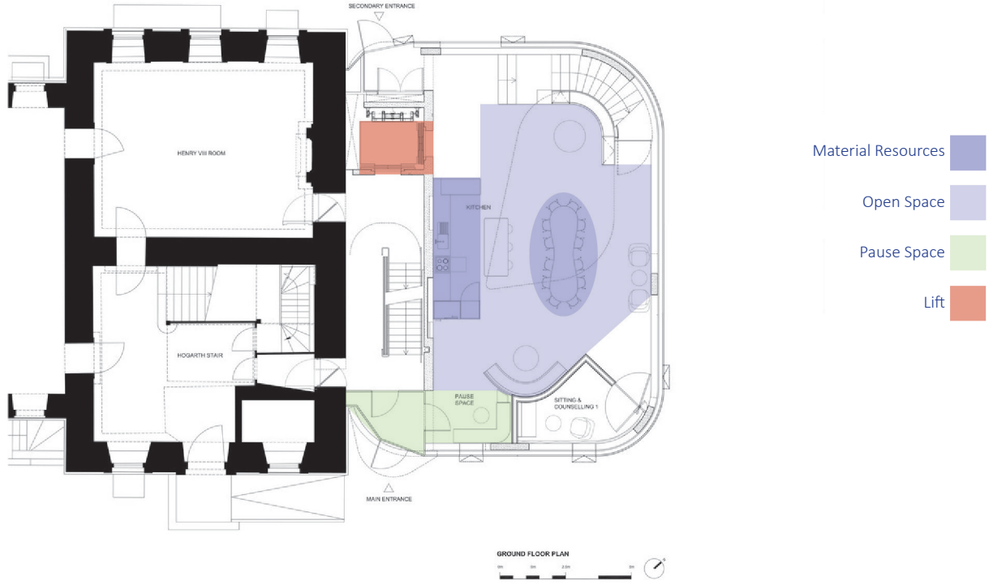

Figure 20
Ground floor plan of Barts Maggie's Centre, revealing the overlaping of zones within the open plan format, coloured diagrams are my own

Merriam Webster defines hope as "to cherish a desire with anticipation: to want something to happen or be true" (Merriam-Webster, 2025), while Duff describes feeling hopeful as being "more capable of the agency necessary to realise [a] sentiment" (Duff, 2011: 154). Steven Holl explores how visitors of Barts experience feelings of hope through the strategic design of the building's envelope, and how it allows light into the building. The three-storey building at is dressed in matt white glass, speckled with coloured glass fragments recalling 'neume notation' – neume originating from the Greek word pnevma meaning 'vital force', or 'breath of life' (Maggie's centre barts, 2024). This translucent glass case transforms into a 'lantern', illuminating people's paths in the dark (Frisone, 2024: 10). Once inside, the envelope filters daylight into the interior, creating dynamic coloured patterns that shift with daily and seasonal rhythms, subtly manifesting hope through this ever-changing play of light (Ibid.). This vibrant shifting light draws visitors towards the heart of the building: the kitchen table. Beyond the table, a sweeping staircase ascends through an open interior, leading to a verdant rooftop garden where activity classes and visitor gatherings occur (Ibid.).

The creative use of light at Barts - which creates an architecture erased of shadows- contrasts the hospitals discussed by my interview participants. Participant 3 commented on the use of frosted window film over the few windows available in one area of their workplace, and how this prevented views outside but still filtered natural light into the space (Appendix A). The use of 'matt white glass' at Barts creates a similar effect to frosted window screens - although at Barts this strategy made the interior space feel larger and brighter. It may be suggested that the window film is used in Participant 3's workplace is used negatively, whereas as Holl uses it positively to allow the building to glow like a lantern in the dark. While Barts deliberately employs frosted windows to enhance its therapeutic environment, Participant 3's example creates barriers between interior spaces and the external world.

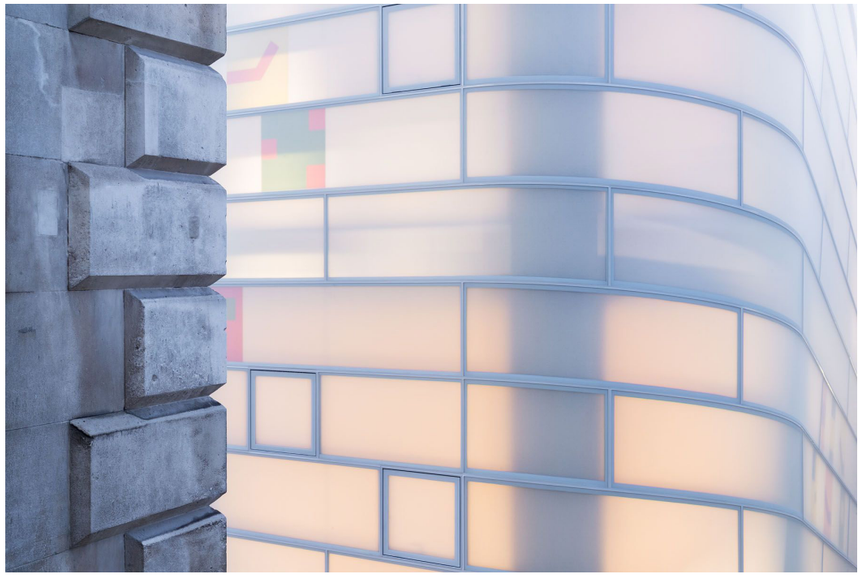

Figure 21
The matt white glass envelope of Barts Maggie's Centre illuminates from within

Figure 22
Barts Maggie's Centre acts as a guiding light in the dark, illuminating the path for potential visitors

Criticisms

The term 'Starchitect' originated in 1987 to describe "a famous architect, esp. (disparaging) one whose designs are considered extravagant, outlandish, or incompatible with their existing surroundings" ('Starchitect', 2024). Starchitects are synonymous with grand gestures, often subject to ridicule; a New York Times article suggests that the term is used to mock architects whose 'increasingly flamboyant' designs are more concerned with style and money, rather than functionality (Ouroussoff, 2007). Architects of Maggie's Centres are widely referred to as "starchitects" in public discourse which is exemplified through media headlines: "'Maggie's Centre's' to exhibit starchitect cancer-care centre design in New York" (Bustler, 2014) and "From Frank Gehry to Amanda Levete, starchitects are designing the highest-standard facilities for cancer support at Maggie's Centres" (Stathaki, 2020). Steve Rose questions "why the starchitects?" in his 2010 Guardian article (Rose, 2014). He asks whether Maggie's Centres architects consider these projects as personal status symbols rather than buildings offering healthcare, stating they "are a free pass for virtuoso architects to get something built" (Ibid.).

The selection of high-profile 'starchitects' for Maggie's Centres raises concerns that these projects have become prestigious architectural showcases, potentially overshadowing Maggie Jencks' original vision of creating nurturing spaces dedicated to holistic cancer care. This is explicitly seen in reviews from users of Daniel Libeskind's Maggie's Centre in Hampstead, London. Architecture critic Rowan Moore discusses how the reviews mentioned experiencing trouble with noise bouncing around the open interior space, and that the awkward nonrectangular rooms made it difficult to carry out yoga classes and group activities (Moore, 2024). However, Liebskind argued that the point of the building was not to be purely functional, and that you could never have a dull thought when inhabiting it (Ibid.). Perhaps Liebskind's statement suggests that 'starchitects' truly prioritise aesthetic design over building function.

While not a critique of Maggie's Centres in themselves, this thesis must address the complexities in translating their architectural philosophies to institutional healthcare environments. Whilst the architecture of Maggie's Centres are designed to create calming atmospheres which support emotional wellbeing in a smaller demographic of visitors, hospitals are more concerned with the architecture's ability to facilitate immediate medical care to high volumes of patients. Furthermore, Maggie's Centres are not required to provide the same sterile, clinical environments as seen in hospitals. This was highlighted in my interviews with healthcare professionals; when asked what sensory aspects of their workplace were the most challenging, Participant 1 answered:

"Hospitals can just smell very sterile, but that's because it has to be"
(Appendix A).

This sentiment is backed up by Participant 2 who argues

"with patients you have to be so clean and clinical and sterile… you can't introduce any potential allergens or anything that might upset people… which is why everything is very bland."
(Appendix A).

They argue that there is a pragmatic necessity to the clinical sterility, which is inherent in all medical environments. This clinical nature presents itself through not only smell, but also lighting, colours, and noises. Where Maggie's Centres can eliminate institutional and clinical features from their designs; hospitals and other healthcare settings simply do not have that choice. Healthcare and sterility are fundamentally linked.

04 Innovation at St Bartholomew's Hospital

St Bartholomew's Hospital [Barts], founded in 1123 by Henry I's former courtier Rahere in Smithfield, London, stands as England's longest-running hospital providing continuous care at the same location (Barts Health, n.d). Most of its medieval structures were replaced during an 18th-century renovation by Scottish architect James Gibbs, [except for the tower of St Bartholomew the Less Church] (Ibid.). During this rebuild Gibbs designed the North Wing, which was completed in 1732 with the original purpose being for ceremonial and administrative activities (Donald Insall Associates, 2025). The 18th Century interiors are Grade I listed and include the Hogarth Stair [featuring two beautiful murals by artist and engraver William Hogarth], alongside the monumental Great Hall (Greasley, 2020). The North Wing is currently undergoing restoration by Barts Heritage, which I was lucky enough to tour at the beginning of this year as part of the institutions strive to reconnect the public to St Barts Hospital and heritage (Barts Health, n.d).

St Bartholomew's Hospital has powerfully stood the test of time; surviving Henry VIII's reformation, the Great Fire of London, and even the bombings of World War II (Ford, 2025). A brief timeline of pivotal moments in its history are depicted in figure 23. Today, the hospital functions as a specialised cardiac and cancer care centre; recently celebrating its 900th anniversary in 2023 (Greasley, 2023). This chapter will explore the significance of the North Wing restoration project, and how it demonstrates a harmonious balance of rich medical heritage and pioneering therapeutic innovation - setting the standard for the future of healthcare in the UK.

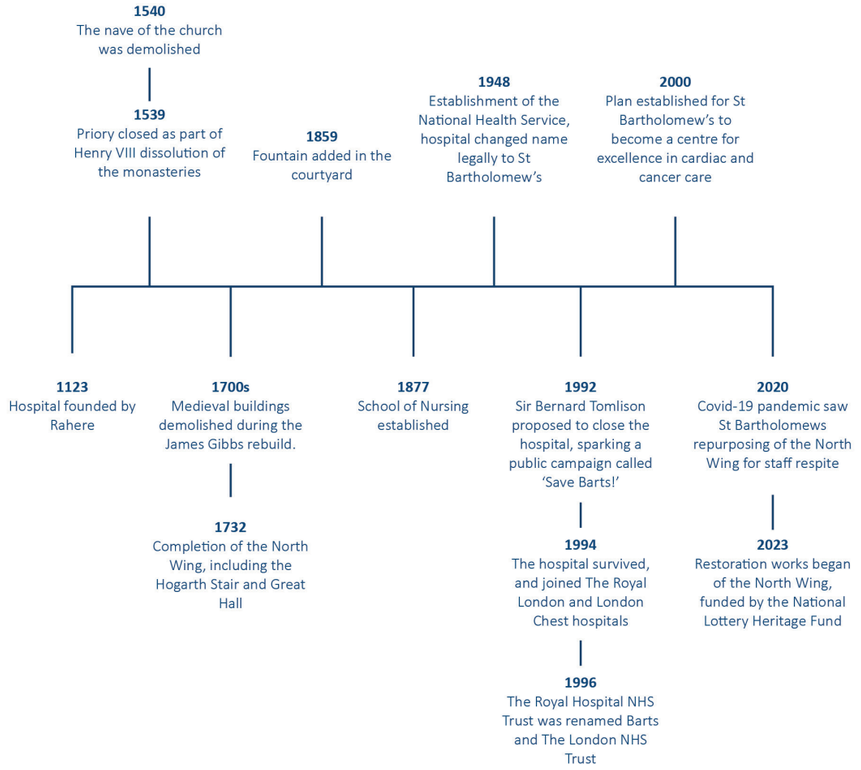

Figure 23
A timeline depicting key historical moments in St Bartholomew's Hospital history
[Information gathered from (Greasley, 2023)]

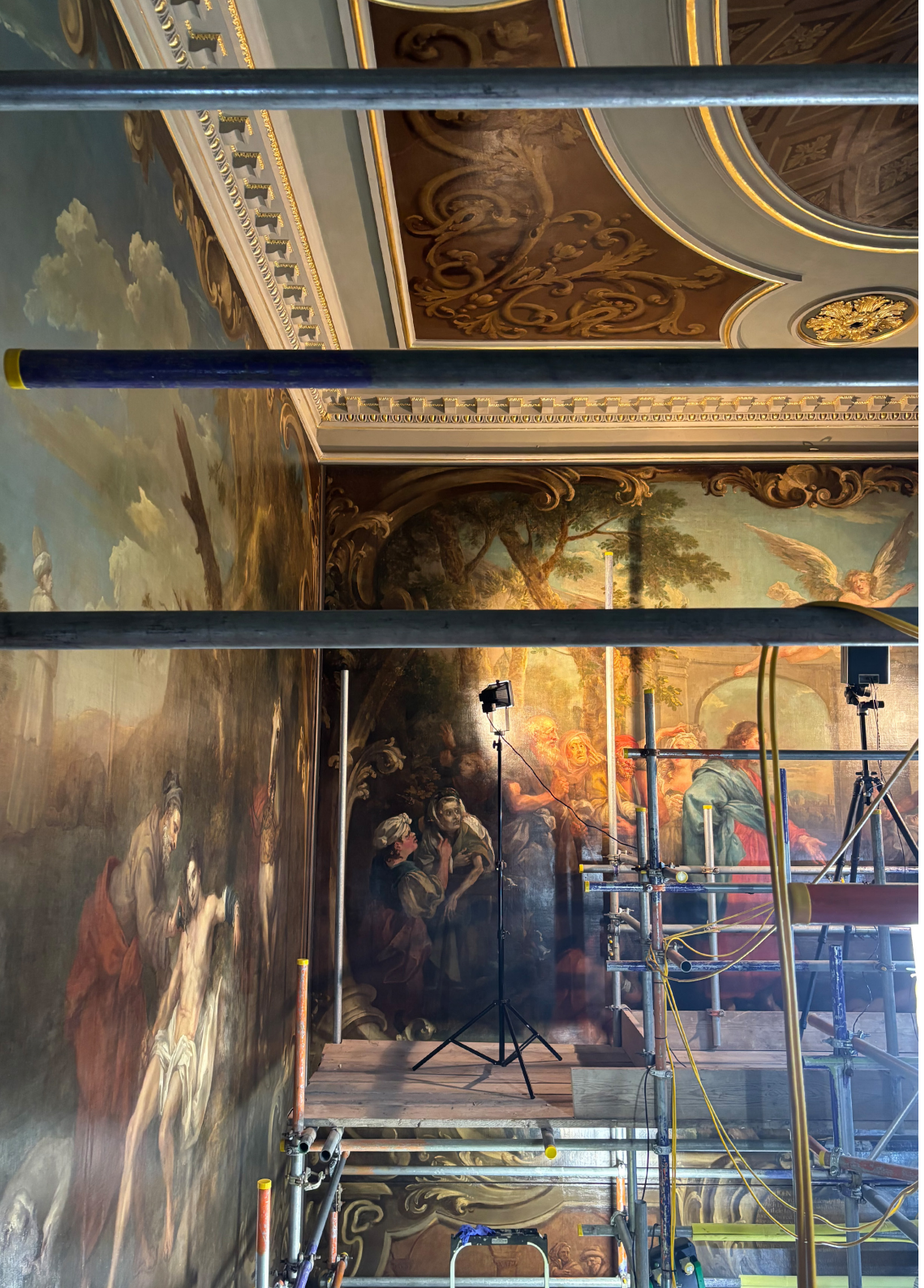

Figure 24
Restoration works in the Hogarth Stair at St Barts
(Hayes, 2025)

The staircase was commissioned by the hospital governors to be a striking arrival sequence for the Great Hall (Donald Insall Associates, 2025). This commission originally went to an Italian painter, but Hogarth - being born nearly 50 meters away in Bartholomew Close - volunteered his talents for free, in the name of local pride (Brown, 2023). The two completed paintings include 'The Good Samaritan' and 'The Pool of Bethesda', which depict stories from the bible and are hung from the walls of the stairwell (Hogarth Paintings, 2025).

The Pool of Bethesda illustrates a scene from The Gospel According to John, where a man who was unable to walk is miraculously healed by Jesus (Barts Heritage, n.d). In the background we can see sickly looking people with pale faces and pained expressions; it is thought that these figures played an educational role, as their ailments are said to be based on real patients of the hospital (Brown, 2023). The Good Samaritan communicates themes of compassion and charity, portraying a scene from the Biblical parable of the Good Samaritan, where a Samaritan man helps an injured traveller and his dog (The good Samaritan (1737) by William Hogarth, 2024). The artistic, spiritual, narratives conveyed through Hogarth's work can be likened to the stone carvings found at Epidaurus, which were discussed in the second chapter. Both Hogarth and the Asklepion use art to convey the divine healing of the Gods; spreading a message hope to those who view it.

As part of the North Wing restoration works, the Hogarth Stair murals are being cleaned to restore them to their former glory; during my tour scaffolding filled the stairwell to allow art restorers full access to the highest points of the work. Regular public access will be made available to the Hogarth Stair, allowing the artwork to be speculated and interpreted by locals and strengthening the connection between St Bartholomew's Hospital, its heritage, and its local community (Harris, 2023).

Figure 25
A 3D LiDAR scan with Leica BLK2GO depicting the Hogarth Stair at St Bartholomew's North Wing (Captivate Heritage Laboratory, 2025)

During the Covid-19 Pandemic, the Great Hall was repurposed as a place of respite for St Barts hospital staff, revealing the hospital's recognition that the increased pressures and stress would have a negative impact on the mental wellbeing of its 2500 hospital staff (Greasley, 2020). The hospital aspired to have:

"somewhere staff would escape the clinical environment and enjoy a range of activities, aided by the soothing power of art and architecture"
(Greasley, 2020).

The restoration project, which is being carried out with support from the National Lottery Heritage Fund, is described as a "catalyst to unite heritage, health and wellbeing" (Potter, 2022). Barts are planning to convert currently under-used spaces in the North Wing's West Pavillion into a wellbeing hub, where they will host programmes which support the psychological recovery of its staff (Health & Wellbeing / Sharing Historic barts, 2024). The aspirational wellbeing hub will provide a non-clinical setting which allows "rest and reflection, inspiration and team-working" (Ibid.). Similarly to Barts Maggie's, the staff wellbeing hub will offer a combination of smaller private rooms for more intimate moments of respite, and large open spaces for group exercises and physiotherapy (Ibid.). Barts' Hospital shows clear appreciation of its staff through this programme; recognising that their workforce are more likely to experience emotional trauma due to the stressful nature of their jobs. Through the 9 centuries is has stood proud, the hospital has proven to consistently evolve and remain at the forefront of medicine and healthcare in the UK.

My interviews with healthcare professionals highlighted the inadequacy of staff respite spaces in institutional healthcare settings. Participants expressed they felt unable to mentally separate themselves from the hospitals' clinical environment due to proximity of break rooms to the medical ward, and the absence of windows and views to the outside (Appendix A). Holl's Maggie's Centre, and the wellbeing hub in the North Wing, demonstrate a deep understanding of this recurring institutional design failing; both respite facilities are separated from the users' epicentre of stress – the clinical hospital environment. What we can learn from both these case studies is that mental rehabilitation is unfathomably supported by environments that are physically removed from the root cause of tension. This strategy presents a potential antidote to the challenging sensory conditions associated with medical environments.

Figure 2
Dianne Campbell- Outpatients
As captured by Matthew Andrews' 'A Portrait of the Second Wave' photographic study of St Barts hospital staff during the Covid-19 Pandemic

Figure 27
Kulvinder Lall- Consultant Surgeon
As captured by Matthew Andrews' 'A Portrait of the Second Wave' photographic study of St Barts hospital staff during the Covid-19 Pandemi

05 | Conclusion

This thesis has investigated how the spatial design of healthcare settings psychologically impacts the mental wellbeing of patients and staff. My interviews with healthcare professionals illuminated the failings of institutional healthcare models in providing environments that make patients and staff feel psychologically supported (Appendix A). The data gathered provided me with a framework of positive and negative spatial conditions which I proceeded to explore on a theoretical level. This analytical lens aimed to uncover why the spatial conditions informed each participants' perspective. Following this I discussed how the spiritual based treatments performed at the Asklepion in Epidaurus reflected the Ancient Greek's holistic understanding of healing as encompassing the body, mind, and spirit of a person. Next, I investigated how the Maggie's Centres' architectural brief shapes therapeutic environments, specifically analysing the Maggie's Centre at St Bartholomew's Hospital [Barts] as a case study. I explored the entrances' progression of spatial sequences, the kitchen table, the social dynamism facilitated by its open plan layout, and the use of natural light. Finally, I provided insight into St Barts Hospital, focussing on the recent restoration of the North Wing and how this connects with the institutions strive to improve the wellbeing of its hospital staff. I believe that this final case study is setting an excellent example for the future of institutional healthcare by demonstrating that holistic healing transcends physical cure, while using hospital staff as its driving force for change.

The Asklepion at Epidaurus established a foundation in healthcare where mental and physical health were inextricably linked. Modern institutional healthcare has diverged from that understanding, viewing healing as only referring to curing physical illness. However, we must recognise that Asklepion principles are entirely relevant today: the power of nature in psychological wellness, the value of art and entertainment in the healing process, and the role of rest and diet in recovery. Modern neuroscience and biophilic design theories validate that the therapeutic practices and natural environments associated with Asklepieia's healing power were truly successful examples of early established healthcare facilities.

The strategy of the Maggie's architectural brief inspires architects to consider their designs not as healthcare facilities, but as facilities that care for health. Reiteration of how the architecture should support the emotional wellbeing of cancer patients, without the clarification of specific aesthetic requirements, prevents architectural homogeneity across the numerous centres. The brief understands that cancer patients may take multiple attempts before entering a Maggie's Centre, requiring proposals to incorporate 'pause' spaces into the arrival spatial sequence. At Barts the thoughtful design creates a transitional space between watching and participating through the incorporation of a secondary pause space overlooking the open plan kitchen. Using Cameron Duff's theory of 'enabling places', the kitchen table serves as a crucial material resource that enables therapeutic social interactions through its large 12-person capacity, and setting in the inherently domestic country style kitchen. At every opportunity the thoughtful design of Barts Maggie's reinforces that within its spatial volumes, visitors are considered as people, rather than a patients – an absence of institutional signifiers such as corridors, fire exit signs, and rows of toilet cubicles, creates an environment that feels more like a home than a hospital. The use of light as a tool to guide visitors in the dark, as revealed through the illumination of the building through its matt white glass envelope, presents the centre as a beacon of hope.

As this thesis draws to a close, I want to take a moment to look to the future. How can institutional healthcare models reflect upon, and learn from, the successes of these explored case studies? As revealed through my interviews, clinical hospital environments – though necessary – detrimentally affect the psychological wellbeing of both staff and patients. Medical environments often have limited access to windows, nature, art, and natural light, which contribute to feelings of "anxiety" and "isolation" (Appendix A). Not only are these spatial environments psychologically challenging, so are the requirements and pressures of medical professions. St Barts Hospital has taken a pioneering step in acknowledging that maintaining its position at the forefront of medical care requires robust psychological support of its staff. The new wellbeing hub project in the North Wing aims to improve the operation of Barts by providing medical workers with a dedicated place of respite away from the clinical environment of the hospital.

My interviews revealed that participants felt unsupported in staff break spaces centred on the hospital ward, as they were unable to psychologically detach themselves from this medical environment. Healthcare institutions can learn from St Barts Hospital by providing

respite spaces which are removed from clinical settings. These facilities could involve the repurposing of under-utilised buildings on site, or even replace them [as seen at Barts, the West Atrium of the North Wing was repurposed for the wellbeing hub, and Holl's Maggie's replaced the disused 1960s brick building adjacent to the North Wing]. However, it must be addressed that Barts Hospital had financial aid from the National Lottery Heritage Fund for their wellbeing hub, as it was combined with the historic restoration project of the North Wing. Those NHS hospitals which do not have the luxury of being set within a historically charged site may be dependent on NHS funding alone. During their interview, Participant 3 expressed that:

"people have lots of ideas of what they want to do, and how to make things better, and it's not happening because there is no money"
(Appendix A)

It's not happening because there is no money.

Perhaps therein lies the problem. While this thesis cannot solve all the challenges of healthcare design, it aims to reveal the transformative potential of reimagining these institutional spaces.

The End.

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Figure List

Figure 21: *Maggie's Centre Barts/ Steven Holl Architects, n.d.* [Online Image] Available at: https://www.archdaily.com/885886/maggies-centre-barts-steven-holl-architects/5a3b7c57b22e384b3a000158-maggies-centre-barts-steven-holl-architects-first-floor-plan (Accessed: 26 January 2025)

Figure 22: Bann, I. (2017) *Maggie's SHA Façade* [Online Image] Available at: https://iwan.com/portfolio/maggies-london-steven-holl/#21650 (Accessed: 28 January 2025)

Figure 23: Bann, I. (2017) *Maggie's SHA* [Online Image] Available at: https://iwan.com/portfolio/maggies-london-steven-holl/#21650 (Accessed: 28 January 2025)

Figure 24: Hayes, K. (2025) *A brief history of St Bartholomew's Hospital* [Diagram]

Figure 25: Captivate Heritage Laboratory (2025) *3D LiDAR scan with Leica BLK2GO depicting the Hogarth Stair at St Bartholomew's North Wing* [LiDAR scan]

Figure 26: Andrews, M. (2020) *Dianne Campbell – Outpatients* [Online Image] Available at: https://bartsheritage.org.uk/sharing-historic-barts/learning/second-wave/ (Accessed 18 February 2025)

Figure 27: Andrews, M. (2020) *Kulvinder Lall - Consultant Surgeon* [Online Image] Available at: https://bartsheritage.org.uk/sharing-historic-barts/learning/second-wave/ (Accessed 18 February 2025)

Research Methods Statement

for

The Third Caregiver

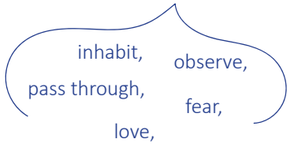
How does Spatial Design Impact Patient and Staff Experiences in Healthcare Settings?

ARCT 1060 Architectural Thesis
Kaja Hayes

Research Focus

Fundamentally, this thesis is investigating the spatial volumes of architecture.

It questions what it means to a space.



My spatial focus is healthcare environments, and how they impact the mental wellbeing of the people who use them. The users of healthcare spaces, as pertaining to my research, are patients, medical staff, family members, pilgrims, historians, painters, and individuals affected by cancer in various ways.

My research seeks to understand how medical spaces can be improved to psychologically support its users. One way in which I do this is through semi-structured interviews that give healthcare professionals a platform to voice their opinions about the environmental quality of their workplaces. The interviews aim to capture both the emotional resonance of these spaces, and identify specific architectural and design elements that either support or hinder psychological comfort and functionality.

A collation of healthcare user experiences, sourced both first- and second-hand, will be explored. The thesis will attempt to paint a holistic picture of healthcare – encompassing its spiritual beginnings in Ancient Greek Asklepieia, the therapeutic non-clinical spaces of Maggie's Centres, and the historically charged site at St Bartholomew's Hospital in London.

This research proposes solutions in the improvement of healthcare space design, arguing that the spaces themselves have the capacity to care for health- they are the third caregiver of medicine.

Thesis Structure

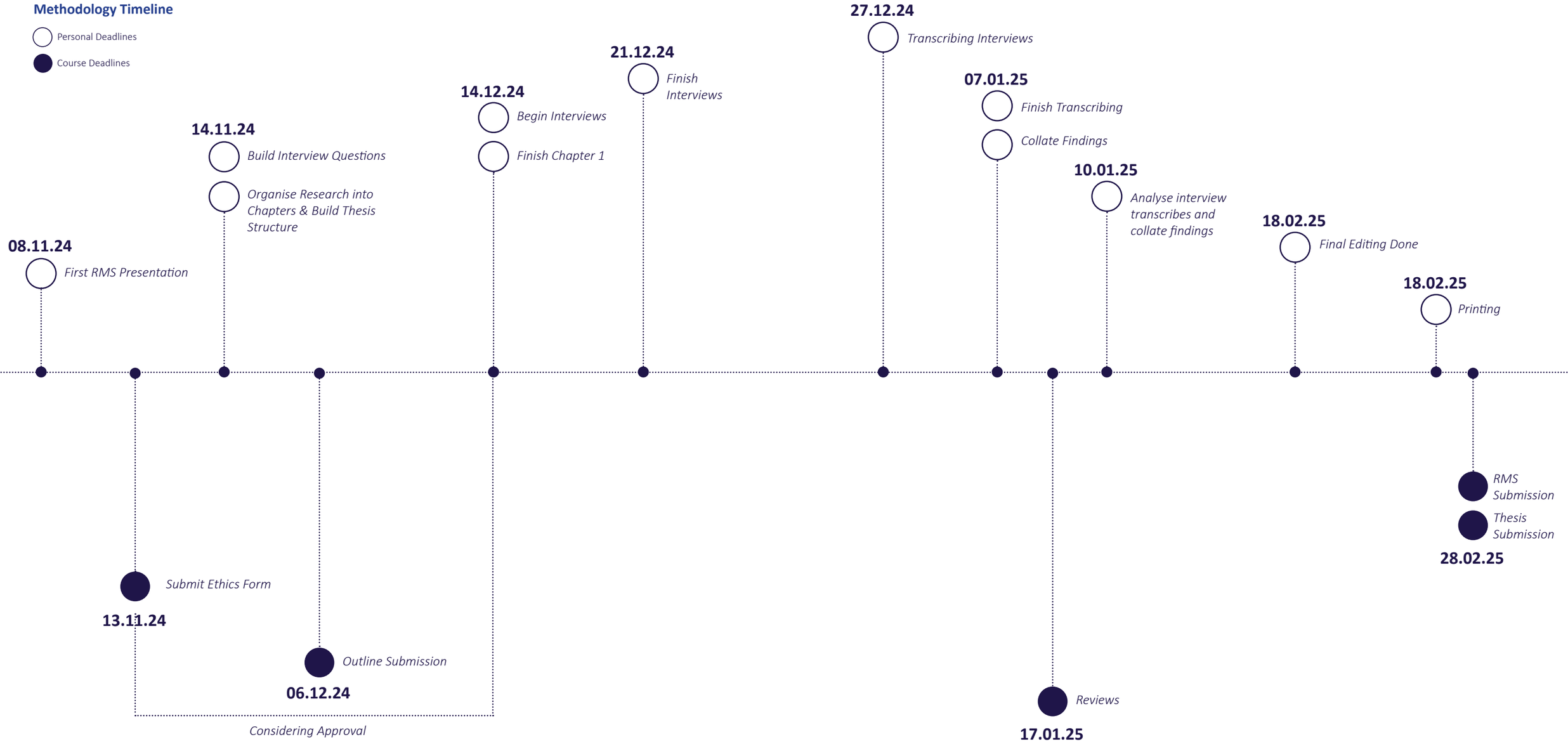
Chapter 1
- Analysis of interviews with NHS staff about medical environments
- Documentation of challenges: privacy issues and inadequate rest areas
- Examination of environmental factors: noise levels and lighting design
- Identification of successful elements: transitional spaces and diverse respite areas

Chapter 2
- Study of Asklepieia healing centers and their spatial design principles
- Detailed analysis of Epidaurus Asklepieion
- Key therapeutic elements:
  - Integration with natural landscape
  - Sleep therapy in the abaton
  - Theatrical spaces for music therapy
  - Patient accommodation in the katagogion

Chapter 3
- Analysis of architectural brief's impact on therapeutic design
- Case study of Barts Maggie's Centre
- Examination of key design elements:
  - Entry sequence
  - Kitchen as social hub
  - Varied spatial configurations
  - Natural light strategy
- Critical evaluation of 'starchitect' selection
- Challenges of implementing principles in institutional settings

Chapter 4
- Documentation of North Wing restoration
- Analysis of historic spaces:
  - Hogarth Stair
  - Great Hall
  - West Pavilion
- Integration of staff wellbeing initiatives with heritage preservation

Methodology Timeline



Overview of Research Process

This thesis was carried out using primary and secondary research

Primary

I conducted semi-structured interviews with four healthcare professionals, questioning them on the quality of their workplace environments, and how this impacted their psychological wellbeing. See 'Interview Methodology' for more information.

Alongside the interviews I participated in two public events to deepen my knowledge on specific chapters of the thesis. In November I attended the book launch of Dr Caterina Frisone's book The Therapeutic Power of the Maggie's Centre (Frisone, 2024), one of my key literatures. I also took part in a tour of St Bartholomew's North Wing restoration, where I was able to see the works underway, learn more of the hospitals history, take photographs, and ask questions to the volunteers.

Secondary

A wide variety of literatures were utilised in this research, of note is Frisone's publication mentioned above (Frisone, 2024). Her extensive research was carried out during her PhD and entailed ethnographic work in three Maggie's Centre where she experienced first hand how the buildings operated, and how visitors interacted within them. This book guided me heavily through this chapter, as the author was exploring key concepts within my own research.

Interview Methodology

The interviews were semi-structured; and covered a variety of aspects relating to their experience within their workplace environments. Questions reflected upon daily experience, patient-space interaction, social dynamics, atmospheric qualities, desired design, and institutional constraints. The interviews began with two structured questions:

"What is your job title?"

"Where do you go when you need a moment of respite during your shifts?"

My strategy aimed first to understand the participants' hierarchical role within the hospital structure, which in turn may influence their perceptions of the workplace. The interview structure progressed deliberately from questions about daily experiences and spiritual impacts to more complex theoretical inquiries. The transcripts were analysed using AI and categorised into three domains: positive, negative, and desired spatial features or experiences. These findings were then visualised through radar charts, where each noted point represents a specific spatial or experiential element, and the frequency of mentions is indicated by concentric rings radiating from the centre.

Interview Questions

Daily Experience & Spiritual Impact

Where do you go when you need a moment of respite during your shift?

Ideal Scenarios

If you could redesign any space in the hospital, what would you change?

What elements from non-hospital environments would you incorporate?

Social Dynamics

How does the environment support or hinder family prescence?

Patient-Space Interaction

What spatial elements seem to cause stress or anxiety in patients?

Where do you notice patients and families gravitate towards for comfort?

Professional Insight

What institutional constraints most affect the quality of care spaces?

Atmospheric Qualities

What sensory aspects of the environment are most challenging?

Spiritual / Emotional Support

How does the built environment support or hinder dignified care?

Comparative Understanding

Have you worked in different healthcare facilities? How did they compare?

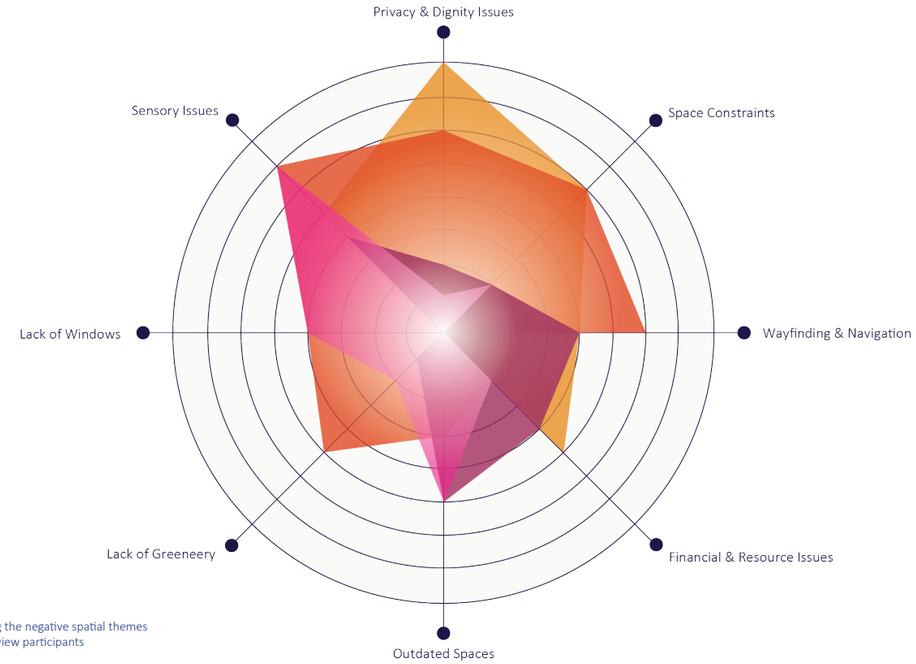
Interview Results

Decleration of AI

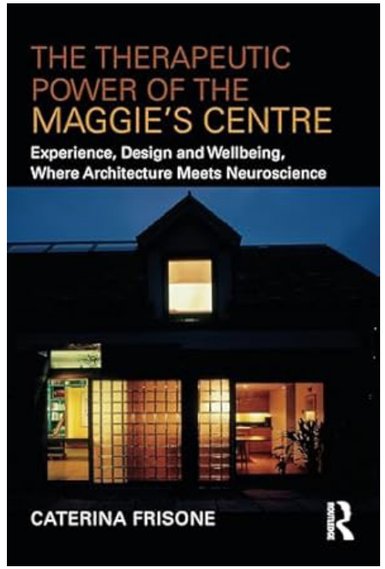
I utilised Claude Opus 3 as part of my research and methodology. This AI tool outperform other AI tools academically as it gathers its information from undergraduate level expert knowledge (MMLU), graduate level expert reasoning (GPQA), basic mathematics (GSM8K) (Anthropic, 2024).

Benefits to my research

Claude was able to accurately quantify my interview data; I provided this engine with my transcripts and asked it to isolate the frequently positive and negative discussed themes. I then asked it to quantify this information, which provided me with the exact number of times each participant mentioned each theme – allowing me to create the radar charts. Using AI reduced the time taken in analysing this data, and potential for personal error.



Radar Chart illustrating the negative spatial themes discussed by the interview participants
(Hayes, 2025)



Caterina Frisone
The Therapeutic Power of the Maggie's Centre: Experience, Design and Wellbeing, Where Architecture meets Neuroscience
(Frisone, 2025)

Summary and Analysis

Frisone's ethnographic research across three Maggie's Centres explores how their flexible design enhances visitor agency through themes of movement, hybridity, and therapeutic spaces. Drawing connections to the Ancient Greek concept of therapeutikos, she examines how the interplay between architecture and users facilitates a five-step healing process. Her work positions Maggie's Centres as a pioneering model for healthcare architecture that challenges traditional institutional approaches.

Main Themes

- Healing and therapeutic as incorrect terms for Maggie's
- The power of hybrid flexibility in design
- Phenomenology
- Absence of signs of sanitary architecture
- Maggie's Therapeutikos
- Thresholds

Frisone, C. (2024) *The therapeutic power of the maggie's centre: Experience, design and wellbeing, where Architecture Meets Neuroscience.* Abingdon, Oxon: Routledge.

Appendix A

24 December 2024 Radiographic Assistant (Participant 1)

ME: Do I have your consent to interview you for my thesis research today?

P1: Yes

ME: Thank you. Interview commencing at 14:00 on the 24th of December 2024. Firstly, what is your Job Title?

P1: My current job is as a Radiographic Assistant, and I previously had a job as a Theatre Support Worker.

ME: Okay, and in the case of your current job, where do you go when you need a moment of respite during your shifts?

P1: So, during my shifts, I would typically go to the staff room and that's only if I have someone else's permission. So I'm allowed one 15 minute break plus lunch per day, and so in those cases I would go to the staff room. I need a break during my shift time, then perhaps I would take up a task that needs me to be in a different part of the hospital. Then I can then walk through the hospital to get there, which can be quite a nice a break during a hectic shift. So, yeah.

ME: What spatial elements seem to cause stress or anxiety in patients?

P1: So in patients, um it's fairly similar to the workers, I think, in that, during my first job, when I was working in a theatre, there were no windows anywhere, and that's not really the fault of the department. It was more just where it was in the hospital. But the staff room on the ward area and the theatre didn't have any windows, and this can be quite claustrophobic. I know it made me feel a bit isolated. I had no clue what was going on outside. So that's one thing that I would mention. Otherwise, I'll have a think in terms of other elements. Um, I think when patients are kept in areas where everything goes on [staff working] they're quite close to the reception desk and it's quite crammed, then it feels as though they're just plopped in the middle of everything. And so I, well, I feel like they might feel a bit stressed out from being around while they're doing the work. So perhaps a different area might be a bit more quiet and um, you know, relaxing for them.

ME: Thank you. That was really insightful, actually. On that note, do you notice where patients and families gravitate towards for comfort?

P1: Patients usually don't have the luxury of changing where they are held. So they'll be in the ward or just waiting, and they're kind of at the mercy of where they're placed really. Families will typically just be by their side, and then they'll stay in bed or where they're meant to be. If they were given the option, perhaps [they would gravitate to] just outside the hospital, I don't know, or by the vending machines, but I think most of the time there's no kind of communal space for them. And I'm not sure if there should be really, because they're meant to be in their bay so people know where they are and so everything's documented. And if there's anything wrong with them, help can easily be accessed. And so I think, yeah, it's different if you think about the families by themselves, um without the patient as the families are mobile not ill, so I think that's a whole different question.

ME: Thank you. That's really that's really helpful. It's something that I hadn't necessarily considered as well, the fact that there is a reason why the patients aren't allowed to wander and have spaces that aren't being monitored, from a safety point of view. My next question is, what sensory aspects of the environment that you work in are the most challenging, would you say? You already mentioned the lack of windows and the lack of natural light, I would argue are sensory. So in that sense, are there noises or smells or anything else that would affect your senses that you find a challenging?

P1: Yeah, so for me personally, the temperature can be quite sensitive. I don't like it when it gets too warm and on quite a few wards that I would go to to get patients the temperature is kept very high. And this is probably due to the patients being a bit older and being a bit colder. I think it's for them, but for me, this is a bit stressful to have to wait there for a while as it can feel quite suffocating. But that's just a personal preference. In theatre, so during surgery, it's kept very cold, and it was kept very bright because you need to see everything. So that's good. But in terms of how that um affects me. I think it's unnatural to be in a very bright place with no windows all day and so I think that can kind of mess with your natural circadian rhythm and stuff like that. Hospitals can just smell very sterile, but that's because it has to be. And so I think any kind of fragrant nice smells are a bit risky because some people like them, some people wont like them and also it's easier just to keep it very plain and very clean because everyone is generally okay with that.

ME: Thank you. Another question I have is if you could redesign any space in the hospital that you work in, which space would that be? And what would you change?

P1: So the place that I think probably needs the most changing would be the staff room at my old job as this also didn't have any windows and it felt quite outdated. It was very plain. It had this blue kind of typical carpet that you find and lots of classrooms. It was just right next to theater, so we didn't really feel thought through. And so I think to change that, I would either relocate it to an area that has windows, and then that can be repurposed to be anything else, but otherwise, in terms of areas that patients actually go and um they're like…

ME: Uh I have a question, actually, um in regards to what you said about the staffroom. Could you tell me a little bit more about the colour palette and the materiality of the staffroom? If you do remember what that was like?

P1: Yeah, so it was kind of um kind of 00's style in that it was just a blue carpet, which felt quite school like. The um cupboards and chairs were very just plain, wood, it was kind of like a beige. Everything fell very outdated and not fresh. But in my current job, it's quite a bit better as there's a window going onto the main street. It's slightly brighter in that it's more white. So it's kind of more modern. I think that helps you actually take a break rather than just feel trapped.

ME: Thank you. That was a really interesting comparison as well and I'm glad that the staffroom in your current job is a lot more appealing and is more helpful making you relax. Okay, next question. What elements from a non-hospital environment would you incorporate into a hospital environment and why?

P1: So in non-sterile areas, I would include more plants, and like green spaces. And I think that would really aid the perception of the area to feel more rejuvenating. I think plants and green spaces have a subconscious effect on many people just to make them feel happier without them noticing. It's something that you only really notice when you go without it for a long time and then feel the difference So um I think that could be definitely incorporated more. Obviously natural light, I think is quite important. Yeah, those are the main two things I would say.

ME: Thank you. I'd have to say I entirely agree with you on that. And what you were talking about there with being surrounded by greenery subconsciously making people feel better and calmer is actually something called biophilia, which is a person's innate connection to nature. So that's scientifically proven to be true. I'm going to

round up this interview now by asking you one more question. Which is, what institutional constraints most affect the quality of care spaces in your job?

P1: Well, the easier answer would be lack of funding, but it's not as simple as that as I'm sure if there was more money than it would be easier to fix the issues The fact is it's just been spent poorly in the first place. So I think there's a reluctance to knock down and start things over again. And that comes from a place which is quite logical in that if you have a hospital that on all accounts works to some degree, then why would you knock it down and build a new one? But I think some things are simply too far gone and that you should really start again. If something's built in the mid-forties and it's got everything's set up wrong, then trying to make everything work you might even end up spending more money to make that happen than if you just built a new hospital. So I think, there should be greater risk taken in that aspect. Otherwise I think just a complete restructuring of how that money is spent and that would long to better, healthier, outcomes for all.

ME: Thank you so much. Really appreciated you taking a time to talk to me today. I will wrap up this interview at 14:16 on the 24th of December, 2024.

26 December 2024
Cancer Clinical Nurse (Participant 2)

ME: Do I have your consent to interview you today for my thesis?

P2: Yes

ME: Thank you interview commencing at 17:52 on the 26th of December 2024. Firstly, can I ask you what is your job title?

P2: It is cancer clinical nurse specialist

ME: Thank you. And the questions I'm going to be asking you today are surrounding the spaces that you work in. My first question is where do you go when you need a moment of respite during your shifts?

P2: So, I think the first place I would probably go to it depends a bit on where I am, but if I am the in the main department for dermatology, there is a staff kitchen stuff, staff room basically. We can go pick up a tea or coffee, and it's away from the patients and that's quite nice. It's got a window to a little garden but if I work in the outpatients department, which is not sort of ours, then I'm just very much beholden whatever is in that particular department and generally speaking, I don't really know where to go because I just go to this one room that day and home again. So if I do need to get away for a second, it'll probably go and find a Costa coffee and get a coffee and then come back again, just away from everything.

ME: So that cost of coffee would be off site?

P2: It would be out of the out-patient department have to go into the kind of main part of the hospital, like a few minutes away, away from where I am and then come back in again. But having said that I don't do that very often because that takes time away from my clinic.

ME: So you don't get time

P2: No, not really.

ME: Okay that's interesting, thank you very much for your answer. My next question is what spatial elements seem to cause stress or anxiety and patients?

P2: I think often a sort of an overly clinical feel is the first thing, it's very alien to them because it's not homely. It's not friendly generally speaking and out-patient is quite a sterile and bland.

ME: I'd be interested in hearing how you yourself feel within those spaces. Is it similar?

P2: Yes, similar, but obviously is my work environment so I'm there five days a week. So you get used to it and you get a bit blind to it as you see it all the time and, you know, if you then go into a new department, you notice lots of new things. But then if you go there every day for the next two years, you don't see things again.

ME: You get a bit blind to all of it, basically.

P2: Yeah. And um I think what I noticed is when things start to get too old and falling apart and get a bit rickety and that kind of stuff.

ME: I understand that, uninspiring that's a good word. On that note, what elements from a non-hospital environment would you incorporate?

P2: It is difficult because obviously with patients you have to be so clean and clinical and sterile and, you know, you can't introduce any potential allergens or anything that might upset people, it has to be to the sort of lowest minimal kind of thing that might fit everyone, which is why everything is very bland. But I think what you can do is introduce perhaps more, I'm not sure about material the colour, more the friendly colours, warmer things, just a bit more bit more visually friendly.

ME: Yeah. What is the main colour palette of the majority of the spaces?

P2: Most of them, I think it is probably white cream, magnolia, and the furniture might just be a sort of dull green, dull blue, just a bit a bit dull and you know, beige.

ME: Beige.

P2: Yeah, yeah.

ME: Thank you. My next question would be, how does the built environment support or hinder dignified care?

P2: I think in my work you do I think we provide dignified care because it is very much one-on-one in a clinic room which a door is shut to so it's not really an issue. However, if they come in with relatives and I need to examine people on the bed, then obviously I have to draw a curtain and the curtain is only a curtain and I think it's a big misconception that you get privacy behind a curtain. The only thing you get is that people don't see, but they hear everything. I think in terms of what I do, patients do get that if it's just them in the room.

ME: Thank you for your response. On the note of families visiting with patients, where do you notice that patients and families gravitate towards for comfort?

P2: Again, a bit difficult to say in an outpatient's department because it's such a transient place. People know they're not going to be there for long they're there for their appointment and then they go again. But if they're there together, they will tend to find and more comfortable seat perhaps, and obviously a place where they could sit together if

there's more family members. Somewhere that they have a view of what's happening so that they're not missed in case someone calling the name for doing an appointment, but at the same time comfort, but, control of the environment if you like.

ME: Another question I have is, what institutional constraints most affect the quality-of-care spaces in your department?

P2: Institutional constraints?

ME: So that would be constraints which are not able to be controlled by you or the department itself, but is constrained by something higher up. So, for instance, funding or regulations.

P2: It is lack of funding, massively, in terms of modernising, in terms of new equipment, in terms of the general spaces. Many of them that I work in personally are barely fixed for purpose. They are so rundown old, you know, been there for like the last 50 years and there's might have seen the lick of paint if um CQC [Care Quality Commission] come around, you know, but it's really quite run down. I think funding is the main thing because people have lots of ideas of what they want to do, you know, and how to make things better and it's not happening because there is no money.

ME: If you could redesign any space in your place of work, what space would it be and what would you change?
P2: Interesting. I think a big thing for me, which I notice lots of people, not just patient but staff as well, particularly if they're in a new hospital and new space, it's the lack of clear direction. You go in and it might be that someone's put up a thing and a map and you know, pointed to this say and that. But if it's a big area, you have lots of areas, C, B, D, colours; you get really confused really easily, even as a member of staff working there. And you're trying to explain to someone else but to find something, it's really hard to explain because it's not a clear nice, follow the red line to this area. I know some areas do, mine doesn't.

ME: So, better circulation that's clearer to everyone and user friendly to people that might find that difficult and confusing.

P2: I think confusion and being worried about not getting there in time and not finding it makes everything worse for people as well. Both patients and stuff.

ME: Thank you. That was really insightful. And on that note, I will end the interview at 18:02. Thank you very much.

P2: Thank you.

26 December 2024
Nurse in Emergency Dept (Participant 3)

ME: Do I have your permission to interview you today for my thesis?

P3: Yes, you do.

ME: Perfect. The interview is commencing at 18:11 on the 26th of December 2024. First question I have for you is, what is your job title?

P3: I am a staff nurse in an emergency department.

ME: Thank you. And where do you go when you need a moment of respite during your shift?

P3: Either I go to the staff room, which is in the centre of the whole department, with a little sort of kitchen area. Um, no windows and normally someone else in there, so it's not really peace and quiet, but it's just somewhere to go where there's no patients. Or I go outside of the department because it's quite close to the front of the hospital you can just go out and get some fresh air.

ME: What is the colour palette of your staff room? Can you tell me a little bit more about how it feels to be in there and if it helps you feel better?

P3: No, no, it doesn't. The flooring is just normal, just, you know, lino flooring and it's, there are off white walls where there's just loads of um what do you call them boards that you put-

Me:- pinboards-

P3: -everywhere. Kitchen cupboards are, slightly rickety, with like a kettle, fridge, nothing really exciting.

ME: Would you almost describe the space for staff members as being an afterthought?

P3: Yes, very much so. It's literally, there's not even the same in there, it's a bit here and a bit there, different chairs. One is comfortable, which is always taken by whoever sits in and then the others are just kind of old kitchen chairs that you can't even sit and rest properly on them. You can sit down, which is nice when you're on your feet all day, but um yeah, not really a place to rest it's just literally a bit of room away from everyone. You can shut the door and, you know, you know you're on your break and you can say to someone looking for you that I'm on a break. You can say that, you know.

ME: Perhaps like you're hiding.

P3: Yeah, kind of yeah, away from everyone and away from the noises, yeah so 10 minute break perhaps and then off again. So yeah.

ME: That doesn't sound very nice.

P3: No, no, it's very busy.

ME: In your work, what spatial elements seem to cause stress or anxiety in patients?

P3: I think I have to say it's the noise and the light. So, most of the department, I would say doesn't have windows. Some do, but not in the kind of centre, not the actual emergency area. It doesn't have any windows, I guess for obvious reasons, you know, when you're dealing with emergencies.

ME: What are obvious reasons?

P3: Well, you know, confidentiality, windows, people walking past if there's any sort of, you know, you need to kind of be able to sort of have it kind of, you know but it's always noisy because there are loads of machines all the time. The bling, beep, you know, lots of stuff all the time. And this is 24/7. It's always noisy because you have to

have these machines on to help people. And there's constant blip beeps, you know things happening and people talking. If not shouting, talking loud because they need to be heard over other people screaming or shouting. So, there's always noise. So there's noise and very bright light so people can see what they're doing, obviously when you're trying to put a canula in, trying to do things, you have to have these lights. So even at night, I mean, you can't turn them off because people come in the middle of the night needing care. So you have to. So, I think that's the one thing, which I guess also it is difficult to change for the people that are stable and don't need any input on that time, but it's still um it's um quite scary, I think, for patients.

ME: Yeah. Yeah, it does sound it. How do you think the built environment supports or hinders dignified care for the patients?

P3: Well, I think um in terms of support, there are curtains between each bay, that you can draw across. So you get privacy in terms of not being seen at that time. But however, when you give someone a commode, the one where you go to the toilet behind a curtain, and sit on the commode, you can imagine yourself if you have to sit, you know, behind a curtain-

ME: -Is that in the ward?

P3: That's emergency care. So if someone is perhaps not you know, not well enough to walk out to the toilets or they can't really kind of mobilise, or they need to stay in that area with all the monitors on. You bring a commode and they have to do what they need to do behind a curtain which isn't always dignified, if you know what I mean. So I think the privacy is a bit of a, you know, misconception also conversations that are had behind the curtains, the doctor might come in, have a chat with the patient and tell them, you know, this is what it is, this is how this might go, it could be quite serious conversation which is behind a curtain, yes, but everyone else in the baby can hear it. So you know, and I think we're all aware that this happens, but it might give you the feeling of a sort of a full sense of security, that this is private, but I think we all know that it isn't. And obviously when people are hard of hearing trying to speak quietly, it doesn't work, then you have to shout out what you say to them. But I think other than that, in terms of the way it's structured, because again, in an emergency department, you need to have an overview of all the patients, particularly those that are more critically ill that need to be in front of you and you need to be able to see them, and you need to be able to see the monitors and things. You can see it in a sort of central area. But to be able to see them clearly is really important that's useful. All the poorly people have to be in front of the nurses station as they can monitor them closer.

ME: And is that the typical hospital arrangement where you categorise patients based off of how severe their illness is, and group them together?

P3: Well, there are bed spaces that are given to the patients that are the most poorly or need the most monitoring and more input, whether that is in terms of physical, ill health or mental health. Because again, it's all about monitoring. So we have a number of beds that are closest and then invariably they get filled up and then you have to move someone, the most stable, to somewhere else and you have to try and continue that sort-

ME: Shuffling around

P3: Yeah, and this is the standard thing in the whole hospital. It's a mathematical problem that needs to work out and then invariably there aren't enough beds, you know, and this is the standard thing.

ME: So, would you argue there's not enough space?

P3: Yes, absolutely space, but there's not enough staff there's not enough, yeah, it's difficult, I think yes.

ME: I'd be interested to find out a bit more about how hospital structures could be improved on based on your experience, if the structure and organisation of hospital spaces and wards were to change how do you think they could be improved?

P3: So I think it's important to try and make it friendly, it's difficult to specify what I mean by that, but more user friendly or friendlier to both staff and patients. Whilst also maintaining the fact that it needs to be clinical, of course is a clinical space, so it's not a hotel, more I want to say that it doesn't need to look like either. But, um, to make it a slightly more comfortable area to be in, whether you're a patient or not.

ME: How does the environment support or hinder family presence?

P3: So, I think it doesn't. It's not easy to support family visiting patients. Well, obviously you want them to be present and sometimes the patient will want them to be there or the loved one want to be there, but then again it's a spatial issue and they will often feel they're in the way, particularly if there's lots of wires and, you know, cannulas and things and leads hanging everywhere, they don't want to touch things. So, it's difficult for them to feel comfortable in that space.

ME: And do you think that there's something, I kind of noticed in the way that you talk about hospitals and these spaces that you work in, is that you don't think they should be too comfortable in a sense that you don't want people and patients to feel like it's a hotel and to get too comfortable there and not want to leave. Or is it kind of, is that due to efficiency? Is that due to the way hospitals work or wanting to get patients in and out and fixed?

P3: Not so much that no, I think I think there's a space for everything and I think on the wards where you are likely to have to stay a bit longer, because in the emergency care centre, you are just basically stabilising patients and you decide whether they're fit enough to be discharged or whether they need to be admitted. So it's sort of like a triage area, if they're coming in really poorly, you have to stabilise and obviously make sure they're okay. Sometimes that can be done within a day and they can go home once you've done your investigations. And that's all clinical that needs to be quite fast, you know, in terms of sorting everything out, but when you get to the ward, that's a very different environment. If people are staying in for a bit. So I think ward environments are very different to where I work.

ME: Okay. Have you ever worked on a ward environment?

P3: I have been a student nurse on the ward and um yeah, and I often transfer patients to the ward.

ME: Have you ever worked on a ward that has specified patient outside areas, like is there opportunity for patients to walk outside securely and have access to greenery?

P3: Certain wards have, and I've been to one who had a brilliant, lovely outdoor area. A little garden. I think it was actually something that was sponsored by relatives and friends or someone, kind of getting together to use an outdoor space that this area had, and made it into a lovely garden with benches with plants and we could sit down, and little tables so you could bring your relatives and have a coffee and chat and that's really lovely.

ME: Did you see an improvement in patient's mood?

P3: Definitely. They loved it. They love that space. Really lovely. And I was a student there for I think 11 weeks so that I could see that was used regularly. In the summer, not so much in winter, of course.

ME: Is that the only place you've worked where you've seen that implemented?

P3: To that extent, yes, but I've seen other places also have a sort of a garden area outdoor area. And I think those spaces are few and far between, but they're always loved by everyone alike, you know, whether it's, you know, staff or patients or relatives. Because you are still connected because I think if you're poorly and you are there for a reason, you don't want to go too far away just in case something happens, particularly with a relative then oh, 'I'll take you know my dad out' you don't want to go too far because you might be a bit worried in case something happens you want be close by to where the safe area is. But um sitting outside, you know, in the nice area, shut the door, don't hear the noise on the ward and you literally we could be another garden, which is quite nice bit of an oasis if you like.

ME: That does sound really beneficial, I'd like to see more hospitals implement that.

P3: Yes, absolutely. There is another one that you can have like indoor courtyards as well in hospitals, I've walk past one but haven't used it, but that's also a really useful because it's kind of an internal area, but it feels a bit more enclosed, but it's useful still as an outdoor space.

ME: Definitely. Are there any views to nature in the department that you're working in? Is there any connection to the outside at all? And if so, how much is that? What is it?

P3: Uh No. So one part of the place I work will have a few windows, which have got a blind film on them.

ME: So there's light, but it's filtered still light

P3: Yeah. And otherwise the other side has just got a few windows you haven't really got access to as a patient definitely, but as staff, you might see out and it just goes out to the front area of the hospital where the ambulance is come in. So again, nothing to look at other than car park and ambulances. So no..

ME: Do you think that would benefit your department to have that? to have views to nature?

P3: Yes, yeah, I think anything green and, you know, you can see everyone likes it. It's that feeling of a bit of organic, something organic and nice and live.

ME: Yeah absolutely. It's a very good point.

P3: Because obviously these days, you're not even allowed to bring flowers into patients in case someone's allergic. So the greenery is kind of very much outside and if you can't see it, there is none, but basically.

ME: Is there no opportunity to bring greenery inside into non-sterile environments?

P3: Not live greenery. You can have plants in that are fake.

ME: Is that purely a medical reason for that? Because of allergies?

P3: Yeah, I think well, that's one thing and also then who's going to be looking after that you know, is that kind of whose ownership is it to look after these plants if we have real plants indoors? So in terms of anything that could be a potential risk to someone, you have to remove that risk and soil plants, whatever they could be potentially, I guess, cause risk to someone. So it needs to be in a sort of a controlled environment perhaps, but you know, such as a garden outside.

ME: Are there are there any family areas or visitor spaces in your department? Any place that is non-sterile that people can congregate as a group?

P3: There's a room that we would show patients to or relatives rather to rather than patient themselves and this is called a family room, which is where we might take relatives in to give them not so good news if someone is likely to pass away in the next hour or two. So we can take them away and they can sit there in quiet. But there is not a room that is available as in go there if you want. There's basically somewhere that they need to go into this room and have a sit down just. So that's a different thing.

ME: Is that room tailored to somebody receiving bad news? Is it comforting at all?

P3: It's slightly more comforting, a bit more homely in terms of there's two so first are quite comfortable. It's um no bright lighting. There's a couple of normal lamps. It's a bit more homely and a sort of coffee table thing so you can sit down and have a calm conversation with someone. And also blankets sometimes people might stay there for a few hours, you know, and stay there if we're looking after the relatives. so yeah..

ME: Do you reckon more spaces like that would be beneficial?

P3: I think depending on the environment people work in, but I think if bad news is delivered on a more or less regular basis, then that's quite useful, then we only have one room such as that. So I think having a couple, you know, that can be useful that would be really useful.

ME: Well, thank you so much. I really appreciated you taking the time to talk to me today.

P3: You're very welcome.

ME: And I will close up the interview at 18:29 on the 26th of December.

27 December 2024
Specialist Nurse
(Participant 4)

ME: Do I have your consent to interview today for my thesis?

P4: Yes

ME: Thank you. Interview commencing at 16:18 on the 27th of December 2024. My first question for you is what is your job title?

P4: [redacted for anonymity] Specialist Nurse.

ME: Thank you. And where do you go when you need a moment of respite during your shift?

P4: On the ward there is our communal staff room, but that's not a very nice environment because it's still on the ward you can still hear all the noise, you still have people coming in to ask you questions. So instead, you can go to the staff canteen which is not very far from us to walk because that's quite easy to get to. In the staff canteen, there's other spaces you can sit down. You don't need to buy food to sit there. There's an outdoor area like a balcony, which is amazing in summer that's got like herbs around it, so you can just like sit in a completely different environment and forget about what's going on. And it doesn't look onto the hospital grounds. It looks out of the hospital grounds, so it's much nicer. You can try and forget what you're doing. um there's also like the spiritual, er I don't what you call it, it's like a communal space where people that want to go and pray on their shift or just take a moment to themselves. I've not been there for myself. I've taken a patient there before.

ME: Would you argue that there's a lot there's a lot of different opportunities for different people of different needs to go and relax and take a break?

P4: Yes, but they're not very well advertised, I only know about them because I've asked about where I can go on my breaks and things and when I have a student or a newly qualified nurse I always tell them where they are because I think it's beneficial to them, yeah that's what I would want to hear when you start.

ME: Absolutely. Are those spaces such as the outside garden area available just to staff or is patients as well?

P4: Annoyingly it's only for staff, and is only open between like sort of spring and autumn. It's not open right now in the winter but I probably wouldn't want to go out there and sit there in the winter anyway. Exactly. And I guess there's also like a lot of benches around it edges of the hospital in like the staff car park areas which are like wooded as well. So it's not like you're just sat in a car park you are sat like amongst trees granted there are ambulances like rushing past you, but it is sometimes an option to get there if you want.

ME: That's brilliant. I'm glad to hear that for you. So in terms of patient access to the outside spaces, are there any secure gardens or outside areas that are available to them?

P4: There are, so our hospital is on a site that was kind of between a residential area when it was built ten years ago. So there was no room for expansion once they'd built all the buildings they needed to. So there's there is green and wooded areas between buildings where anyone can go and sit on the benches um but there's not like a specific area, but there are, it's quite a spread out the site. There are areas available. You just have to go and find them. It's not well advertised. We do have there's a Costa in the middle of the hospital which does have doors out to a garden area, which is nice, but it's not very big and it's a big hospital so there's it does get filled up quite quickly, but there are options. I don't think there's anything inside.

ME: That's a great answer thank you. In terms of the built environment, so the building that you work in, how does it support or hinder dignified care for patients?

P4: Speaking from the ward that I work on, we have a lot of side rooms because the type of patients we look after. So that is a lot more dignified, closed door rather than curtains. There's a lock on the door. You've got your own bathroom with a lock on like that's very nice but we also have a lot of bays where you have four or five people and recently because of pressures and things we are using the fifth bedspace, which doesn't actually have curtain to go round it. And I don't like that. I don't enjoy looking after patients in that. I wouldn't want to be a patient in that bedspace. It's not very nice at all. It doesn't even have your own plug sockets; you have to lean across the next persons. It's just not a very nice place to be, five people sharing one bathroom and toilet when you're not. You obviously don't have access to your own light, all the lights have to be on. There's not even like a spotlight just for you. You have to put the light on and light up the whole room. Don't love that, and I know that other wards have a lot more bays with like four to six people in and I know that whenever patients get transferred to us they always complain about how horrible that area was, and utilising spaces at the moment that weren't specifically designed to be a patient bedspace. So like our physio rooms, we are allowed to keep ours, but other wards have to use it for patients and it's just like a big clinical room there. It's very, very horrible, no private toilet, no nothing. That one's not very nice.

ME: So a lack of privacy for patients impacts their emotions and their behaviour in your opinion?

P4: Yeah, and I agree with them.

ME: Yeah, I understand that. When it comes to visitors of patients, how does the environment support ot hinder family presence?

P4: Well, we always have two chairs in there beside patients. We always have spare chairs on the ward for patients to come in. When visitors come into see the patients they are able to go in there whatever time. But again, the bays are like the bed spaces in there, and aren't really big enough to have a group of family members and if say, for example, all five patients in there have three family members you physically can't move in that room. Like it's just so many people who gets really loud. And I know that in older style hospitals, they used to have a TV room or a day room to spend time together away from your room, which is quite a nice thing in hospital to differentiate what you're doing in hospital from the care you're receiving. We don't have the space for that anymore, and we try and encourage the patients that are independent and mobile to go off the ward into like the cafés of their with their families, because it's nicer for them, but it also frees up the space for us.. And yeah, there's no privacy between the bedspaces, so the conversations you're having might be quite private, but there's no privacy between that and the bay. So yeah, We do have a lot of cafés. We've got like four cafés along the main walkway of our hospital. So there's a lot of spaces, but again, not everyone's able and people that are sometimes don't want to go downstairs, so it's not very nice.

ME: Thank you. Do you feel like the building you work in is designed for purpose and fit for purpose?

P4: Yes. The A&E department flows really well into theatres, into ICU, into the higher dependency care beds around like one side of the hospital, whereas then if you walk down the hospital, the dependency of care and the like types of the theatres that are there get like less and less high dependency. So it's designed like a flow system, so you'd come in at your worst, go into the wards where you need most care and slowly step down as you go down the hospital. So, it's designed quite well.

ME: So the circulation makes logical sense.

P4: Yeah, so it flows quite easily and you don't waste time running because our hospitals are almost like a mile long.

ME: So in terms of patients and staff who have never been to the hospital before, how would you describe the circulation and the user friendliness of the building? Is there anything indicating where to go, like colours or pathways or it's split into colour zones?

P4: Yeah, it's split into colour zones, we are the pink zone. I think there's blue and green off the top of my head, I think. And then it's built on a slope, the hospital, so our level has three floors but the other end of the hospital has six floors and it's split into gates like an airport. So for example you'd say that's gate 37, or it's not called the medical ward that's gate 31 A or B. So unless you know the gate, it's going to be red. If you're relative just says to you, I'm on a medical award, you're going to be like no idea what that is. And there isn't like a fact-finding way of sorting it out, you just have to know which gate they're on. Even I don't know what all the gates are.

ME: That sounds quite confusing.

P4: But you know it's great but as a person that's new to the hospital it's not very easy. So luckily like a lot of our outpatient appointment letters have the gate written on makes that easy, but yeah, if you're a visitor, it's quite difficult.

ME: Almost like it's been over engineered?

P4: I think so, people are used to hearing, oh, I'm in ICU, not I'm in gate 37. It doesn't make any sense. And then each gate has an A and B side.

ME: Interesting. So it lacks like the universal language of a hospital?

P4: It's great you know, yeah.

ME: So it's almost it's trying to be something new, and it's trying to push forward a new typology of design, interesting to hear your opinions about that, and what things work and what things don't in thinking about hospital designs for the future. So yeah, thank you for your comment on that. What institutional constraints most affect the quality of care and the spaces you work in? Do you know what I mean by institutional constraints?

P4: No.

ME: So that's basically constraints that you yourself are unable to change, or your department itself. So it's something that comes up higher up, like to do with NHS or the government or regulations, funding, that kind of thing. Is there anything? I know you work in a new hospital um, but do you find there's anything that-

P4: -actually we're still in debt from building the hospital site, 10 million pounds in debt.

ME: Wow. Could you elaborate further?

P4: So although it's great and it's very innovative and there's lots of modern technology and we're all online and all this sort of stuff, that debt still hangs over us and it means that now it's sort of trickled down into that they can't hire new staff at the moment. One, because of the government side of the lack of funding, but also because we were already in that debt in the first place. So that was ten years ago and it's sort of trickled on from then. And obviously the typical ones of the NHS is just like, yeah, lack of funding all over the lack of staff because of that funding and the growing population and the aging population.. And yeah, all the all the typical things that you hear on the news, unfortunately, are true to an extent, but every trust is different and the way they manage things are different. Yeah, I would say that it does affect the quality of care that we can give in the spaces that we do have. And the amount of people able to give that is a big factor. Our ratios have gone completely the wrong way and especially now with winter pressures that makes it a lot worse. But winter pressures don't really exist anymore, it's just an all year round pressure. So that's tricky.

ME: I wonder if the debt has anything to do with the sheer size of the building.

P4: Could be. I do know that there's clocks that no one can read because they're just light fixtures cost 100,000 pounds each and there are three of them. That has added zero benefit to the hospital at all because the only patient that could tell me what that was an architect who helped build those and even he thinks they were pointless.

ME: Wow. Ironic that it was an architect who had to explain that to you. What does it look like?

P4: Haha I know, they're like hanging lights, and lights that are like dots and then lights that are like circles the hour, the minute and the second and literally you can't read them. Unless you're standing at one point of the hospital and seeing all of them, you can't read the clock.

ME: That's interesting.

P4: It looks really it's like a sensory playroom for kids, which is lovely for the vibes, but as a working clock it has zero functionality to it.

ME: No. Interesting. In terms of sensory aspects in the building what sensory aspects of the building are most challenging for patients and also yourself?

P4: I think, I know hospitals need to be clinical but every area is very clinical. I feel like sometimes the patient's room should be almost less clinical feeling because the lights are just so bright. There are just noises all the time beeping everywhere. Sometimes I do feel they should make the actual bedspaces themselves more like home. I don't know how you'd do that maybe changing the colours maybe being able to dim the lights because we can't even do that. It's either on or off that would be nicer, but at the end of the day it is a hospital and you are there for clinical reasons. So it's difficult because what some people are there for like a day, some people are there for six months to live in that environment for six months would give you some sort of PTSD of the environment.

ME: I can imagine. And I don't think that's very nice. No, thank you. That was a really, really good answer. Out of interest, what elements from a non-hospital environment would you incorporate into a hospital in general, not necessarily yours?

P4: That's a really tricky question. I honestly do think bring back day rooms because having that space that you can go away to like in my ward for example, on our side of the unit, we have a separate room, the shower room where we take some complex patients to do their dressings because it's nicer for them to not associate their bedroom that they sleeping in for the three months with the painful dressing changes they have to endure. So it's nicer to take them away from that environment, take to a separate room, unfortunately, cause them some pain and then send them back to their room where they can recover. It's nicer to have that separation. So I feel like a day room could be quite nicer some patients or just, yeah, more communal areas in the hospital for patients themselves kind of like a library, maybe even because if people are there for ages, it might be nice to have a library they can go away and escape certain elements of things. It sounds very extreme, but like a movie theatre kind of thing that could be quite nice. One good thing about the bay beds is that like the three or four or five patients in there able to sort of sympathize each other and have a chat about the struggles in their life, how they're getting through it. So in more areas like that could be beneficial to people, especially those that get quite lonely if they're older without any relative visiting them. It could be nice to use other patients as kind of like a support system.

ME: Yeah, I'd agree with that as well. And I think from what I've researched already and the people I've talked to that seems to be an element which is missing, a lack of space and lack of like purpose built spaces that aren't necessarily surrounding stationary recovery or diagnosis. On that note, I can probably round off this interview at 16:34 on the 27th of December, 2024.