

**ARCHITECTURE FOR LIVING WITH DYING AND DEATH:  
THE DESIGN OF A HOSPICE AND FUNERARY COMPLEX IN  
HALIFAX, NS**

by

Christopher J. Howard

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## **ABSTRACT**

Since 1900, Western culture has distanced itself from death and now depends on funeral homes to manage the care of the dead. Today, Western families have little interaction with the deceased in the interval between death and burial. This period, once filled with ritual and ceremony, is now a sales opportunity for the funeral home industry. By contrast, many non-Western cultures have maintained their funerary rituals, which often involve the deceased's family and friends. These rituals appear to be consistent with the ethos of compassion found in hospices. Therefore, Western culture may benefit from other cultural perspectives on death rituals as an extension of care in Western hospices. It is hoped that the proposed hospice and funerary complex in Halifax, NS, Canada will provide the opportunity for authentic experiences with the dying and recently deceased and will deepen the meaning of this universal human experience for all.

## **ACKNOWLEDGEMENTS**

To my family and friends who supported me through this experience, thank you!

## CHAPTER 1: INTRODUCTION

### A Changing Perception of Death in Western Culture

Until the early 1950's, death was far more prevalent in Western culture than it is today. Young, old, rich and poor succumbed frequently to illness and disease. The life expectancy at birth in the U.S. was between 40 and 60 years for the first half of the 20th century (Massachusetts Medical Society, 2012). However in recent decades this has changed:

..death is this country's greatest taboo. America's uneasy relationship with death and dying goes back almost a century... the end of life is now frequently a prolonged period carrying a heavy emotional, ethical, physical, and financial price. (Samuel 2013, ix)

Over the last 100 years, two major changes have had a significant impact on Western culture's experiences with death:

1) The place of death has moved from the home to the hospital.

2) The ceremonies to honour the dead, which were once family and community affairs, have become a commercial enterprise (Ideas 2014).

The following section examines how Western culture has lost touch with death, which is a phenomenon unique to the West. It also highlights an emerging countermovement in the West, which seeks to humanize death.

Alvar Aalto said, "architecture should protect man at his

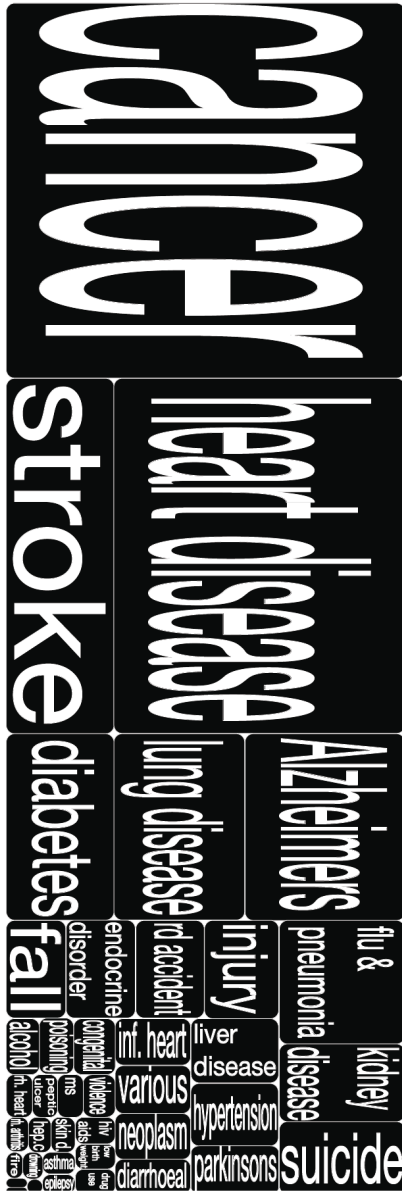
weakest.” (Worpole 2009, p. i) This statement inspired how I approached my thesis as I sought out a design that could shelter and improve our experiences with death.

### The Place of Dying

Prior to the 1900s, end-of-life experiences in the West had changed little from previous centuries. Sick and elderly family members were moved to a warm room near the kitchen/hearth to live out their final days. They would pass on words of wisdom, bequeath items of importance, and in certain religious traditions, receive last rites. They often would die in the room in which they had been born (Burkette 2012, 395).

During the 20th century however, research into the causes of illness and death developed rapidly. Hospitals were designed around the study of infections and disease. Technology improved, and with this came the discovery of even more microbes and diseases. Hospitals, universities, and national institutions increased funding to support research in the hope of discovering cures for these diseases.

Concurrently, an expectation gradually developed among the lay population that hospitals were places that could both treat symptoms of illness, but also cure illness outright. People began to conceptualize that going to hospital meant receiving treatment from trained physicians and nurses who could make the sick better; in turn people began to understand that many diseases could in fact be conquered, and they did not expect to die in hospital. Some came to believe that death should



A graphical representation of causes of death in Canada, based on 2012 data from Health Profile Canada. We predict and name how 99.99% of the population of the country will die.

be seen as an avoidable fate, one that would soon be a thing of the past (Kurzweil 2005). Yet paradoxically over the past 50 years, the location or place of death has gradually moved out of the home and into the hospital. Several ideas have been proposed and studied as to why this has occurred:

1. People who are ill seek and receive care in hospital. As their health declines, the level of medical care they require increases, and families often cannot sustain this care at home. Thus it is easier, safer, and more efficient, to obtain care in hospital. Unfortunate consequences of this reality include: a) the loss of familiarity with death—the loss of basic knowledge and skills among family members of how to care for the sick and dying in the home, and b) a ‘sanitizing’ of death, and a loss of the sense of death as an inherent part of the cycle of life. The average human has abdicated much of the care for their loved ones over to trained personnel in institutions (hospitals, nursing homes), who are strangers and may not know the patient’s needs as well. The move to the hospital has left children and family members at a distance from the daily care of the dying, and a loss of wisdom and acceptance about the inevitability of illness and death. Further, this distance has led to an increase in fear about “what to do” in moments of health crises, and an assumption that taking the sick to hospital will provide access to the professionals who will be able to “do something” about illness or impending death, even when death is the natural (and expected) outcome of the patient’s illness trajectory.

2. People often perceive that having daily doctor visits



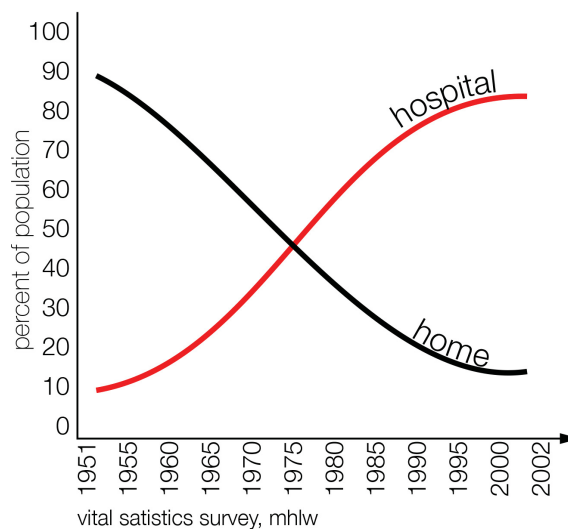
for recommendations regarding a treatment plan is an essential part of the medical process, and a practice of providing or receiving “best care” for their dying loved one. The idea of taking the loved one home to live out their remaining days in their own bedroom and familiar surroundings is seen as substandard care.

Despite the adage that only two things are certain in life—death and taxes—our inherent interest in survival (and the growing capacity of technology and medical knowledge to sustain life, or even artificially prolong life) has led many patients to seek out curative treatments for terminal illnesses. This trend continues today, and has created a situation where care at the end of life (directed at prolonging quantity of days lived over quality of life) has become some of the most expensive medical dollars utilized. A common example is when such patients nearing the end-of-life are brought to an intensive care unit, a medical setting focused on saving lives (Mosher, 2014).

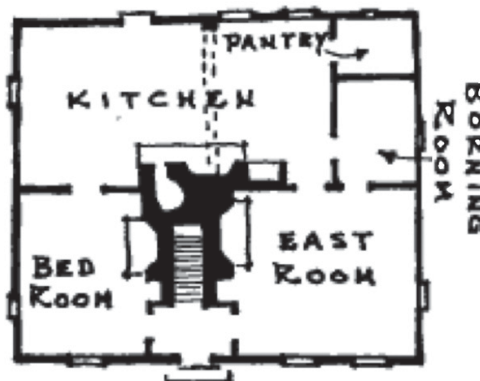
Worpole, an acclaimed writer on architecture and anthropology, writes that despite 85% deaths occurring in a hospital setting, the concept of death seems incongruent with the hospital as a place of treatment and cure (Worpole 2009, 1-2). This became a juxtaposition that many still cannot reconcile, since hospitals are places commonly understood to cure injury and sickness, and to prolong life. As such, one could argue that in a very real way, death lost its home or its familiar place in Western culture during the 20th century, despite the emergence of the modern Hospice movement.

## Losing the Place of Death

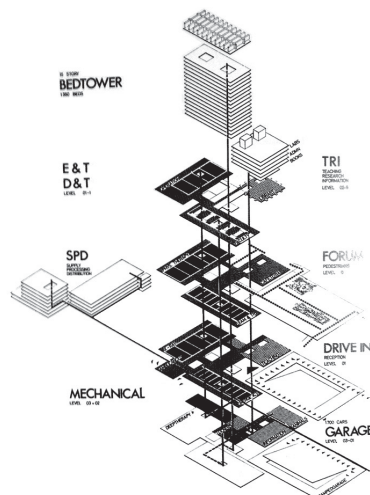
According to Ken Worpole, over the course of the last century the place of death shifted rather quickly from the home to the hospital. This shift he argues, has changed our perceptions of death and perhaps as well our treatment of those nearing the end of their lives (Worpole 2009, 1-2).



The Cape Cod house is one of many traditional dwelling types with a room for giving birth and for dying, the 'borning room'. After about the 1930's this room disappeared from house design (Burkette 2012, 395).



Cologne University is a typical mega-hospital designed for the systems and machines of health (Verderber and Fine 2000, 102).



## **Countermovement to Hospital Deaths**

The model of the modern hospice originated with St. Christopher's Hospice in London, England in 1967. Dame Cicely Saunders, a nurse and social worker who became a physician in midlife, dedicated her career to caring for the dying, and to the building of a hospice in London for patients with incurable cancer who were nearing the end-of-life, in part to honour the wishes and donations of two of her former patients who had died. She had also worked as a nurse at St. Luke's Home for the Dying Poor, then as a pain researcher for many years, and at St. Joseph's Catholic hospice. These experiences led her to develop a hospice specifically for the holistic care of the dying (to provide expert symptom relief, especially with regard to her concept of "total pain", which she envisioned as physical, social, psychological, spiritual, and social distress). Dr. Saunders felt that hospitals with their busy wards were not the best environment for providing relief of the pain of terminal cancer, nor for tending to the needs of the patient as a whole person, alongside the needs of the family. She also saw dying (or the final stages of life) as a time with significant potential for growth and on-going healing. The building of St. Christopher's hospice still stands with a window at the entrance, a symbol of the request of her first benefactor (former patient David Tasma) who asked that he be "a window in your home." Dr. Saunders was famous for stating that it took her "19 years to build a home around the window".

Indeed, a hospice is a 'home' where persons nearing the end of their natural lives go to live out their final days,

weeks, or months. Their diseases historically have had clear prognostic paths that will end in death, usually in a matter of weeks to months. Modern hospices in the UK and North American have followed Dr. Saunders' model, and have focused on the comprehensive needs of the dying person and his/her family: physical comfort, an environment that is calming, a space for prayer and quiet contemplation, gardens etc. But hospices have rarely included space to address the needs of the families and companions of those who have died. In this graduate thesis project, I aim to create a hospice that incorporates such spaces.

### **Palliative Care**

Palliative care is provided to dying persons in hospices to reduce their suffering from symptoms of disease, and relieve caregivers of the burden of care. Palliation remains the focus of care, rather than interventions aimed at fighting diseases or cures. This specialized purpose of the hospice sets it apart from hospitals, long-term care facilities and nursing homes. At the time of this project undertaking, there are no hospices in Nova Scotia.

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (World Health Organization 2014).



St. Joseph's Hospice, est. 1905, was one of the first institutions to provide care for the dying in London. Today, the hospice is recognized as an architectural building type (Verderber and Refuerzo 2006, 12-13).



St. Christopher's House est. 1967, London UK marks the beginning of the modern hospice movement. The first hospice in the US was built in 1974 (Connecticut Hospice, by Lo Li Chan) (Worpole 2009, 7-8).



The influence of Aalto's and his Tuberculosis Sanatorium (Paimio, Finland, 1930) on the modern hospice movement is far reaching. Aalto is referenced in hospice design briefs for connection to nature, dignity, and patient-centred design (National Board of Antiquities 2005, 12).

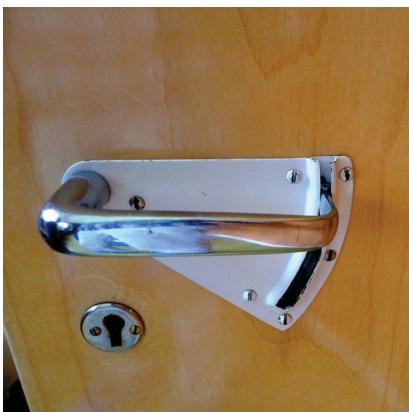
## Tuberculosis Sanatorium (Paimio, Finland, 1930)



Aalto's chair was designed to help tuberculosis patients breathe (National Board of Antiquities 2005, 19).

For Aalto, the patient's physical and mental comfort was essential to the design criteria. The sanatorium was oriented for best quality of light and to bring fresh air into the building. He further designed for lighting, temperature, colour, furniture, views as well as the function of the building.

Many of Florence Nightingale's ideas for patient compassion and dignity (stemming from her experiences treating soldiers during the Crimean War) shaped Aalto's design philosophy.



The door handles prevent sleeves from getting caught, an effort to reduce accidents and spills (National Board of Antiquities 2005, 19).

An excerpt from Nightingale's 1860 diary entry:

I mention from experience, as quite perceptible in promoting recovery, the being able to see out of a window, instead of looking against a dead wall; the bright color of flowers, the being able to read in bed by the light of a window close to the bed-head. It is generally said that the effect is upon the mind. Perhaps so, but it is not less so upon the body on that account...(Anderson 2009)



A case study model of a patient room. Large windows extended below the bed level to allow patients views of the surrounding forests while lying in bed.

## **Changing Experiences for the Families of the Recently Deceased**

The second way in which Western culture's perception of death changed is an increased reliance on professional funeral service providers.

In the West, the ceremonies and rituals for the dead used to be community events. The deceased person would be laid out in the parlour, a room at the front of the house used for weddings and funerals. Family and friends would visit the home to view the deceased and pay respects to the family (Burkette 2013, 400). A carpenter or boat builder would have built the casket (Ideas 2014). This practice was widely followed throughout Canada, and anecdotal accounts show similar death ceremonies in Manitoba, Newfoundland, Nova Scotia and Quebec as recently as 1965 (interviews, Mosher, Smith, 2014).

As local family-owned funeral parlours became more common, the parlour room became obsolete as a "home" for the deceased, and ultimately disappeared from house design, suggesting a shift in societal perceptions of death (Burkette 2013, 407). By the 1950s, the funeral home had become an established business in most communities run by the emerging profession of funeral directors.

Today, large multinational corporations whose stocks are traded on the NYSE have been buying up privately owned funeral homes, cemeteries and crematoria. In many ways, the funeral industry has largely turned

Cruikshank's Funeral home is one of several in Halifax owned by Dignity Memorial and Service Corporation International (SCI on NYSE) owns Dignity Memorial "North America's Largest provider of funeral, cremation and cemetery services." (Cruikshank's Funeral Home 2014)

the funeral director into a sales person who reports to stock-holders. Some funeral companies even offer reward points as incentives to purchase 'packages' that include caskets, cremation and double-capacity burial plots (Ideas 2014).

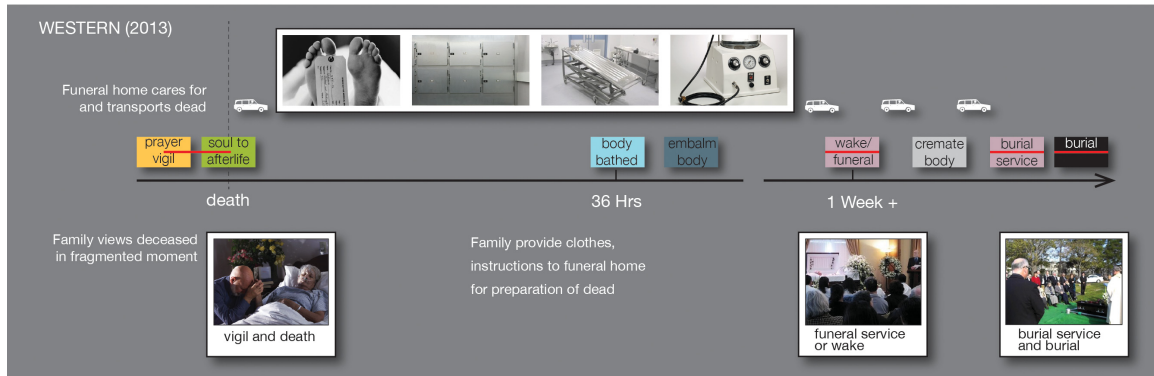
Funeral services are now a \$12 billion industry in the United States. The reliance on the funeral home industry to manage our rituals and experiences with the deaths of family members is now fairly universal. With funeral service providers increasingly serving as the primary coordinators for our experiences with death, family and friends in turn have less and less contact with their recently deceased loved ones. Moreover, while in theory these rituals are undertaken in spaces that cater to all, in reality they have limited flexibility in terms of financial cost or personalization outside of set "funeral home packages".

## Western Themes in Death Rituals

There are three main traits common to western funerary rituals:

1. We pay strangers to care for the recently deceased.
2. The dead are left alone, often for extended periods of time between death and burial or cremation.
3. We embalm our dead, to preserve appearance of life (North American Christian/Catholic, non-Jewish, non-Muslim traditions).





A graphical timeline of how families and friends typically experience funerary ceremonies and rituals.

## Global Themes in Death Rituals

Most non-Western cultures have vibrant ceremonies to honour their dead, which differ from the ways in which the modern West views and treats its deceased (Helman 2001, 162). There may be lengthy, personalized rituals that take much longer to complete than the traditional funeral rituals commonly held in the West. The individuals responsible for looking after deceased persons are either family members, or “traditional death attendants” (TDAs) who are community members (Helman 2001, 162). Death rituals in other cultures include traditions such as: a period of prayer and vigil with the dying, wherein the dying person is never left alone, with family members taking turns to ensure someone is always awake watching on vigil. This “watching over” or ‘gathering around’ by family members may continue once the person has died. In many traditions there is a ceremony to wash, bathe and/or dress the dead, usually performed by women in the family (Ideas 2014). There is often a ritual gathering wherein friends and family convene to pay tribute to the deceased, and finally

there is some method of disposing of the remains. This is often dictated by geographic circumstances, but may also be governed by social customs, or space limitations. For example, burials are becoming less possible in high-density urban areas due to a lack of physical space.



India, a funeral pyre is a public event where a community will gather and share the experience of grief. (Kermeliotis 2011)



Sikhs and Hindus cremate their dead and pour the ashes into the nearest river- tomb stones for remembrance are never used. (SS8 2011)



Taiwan: The quality of the afterlife is determined by the attendance at their funeral, sometimes there are incentives. (Patton 2010)



Japanese, Hindu, Tibetan Buddhist and Jain traditions have a purifying fire ritual (homa) to bless nine brass kumbhas (water pots) and one clay pot. (Buddhistdoor 2012)



Tana Torja of Indonesia celebrate funerals above all else. The 'dead' are part of the family long after they stop breathing. (Swazey 2013)



Tana Torja community gather in horn shaped huts for funeral celebrations. (Douglas 2007 )



The Dogon bury their dead in condo-like caves, carved into the Bandiagara Escarpment, above their village. (Beckwith and Fisher 1994)



In Tibet, Buddhist living high above the tree line and cannot cremate their dead- they instead have a sky burial where the dead are offered as alms to birds. (Minnesotastan 2010)

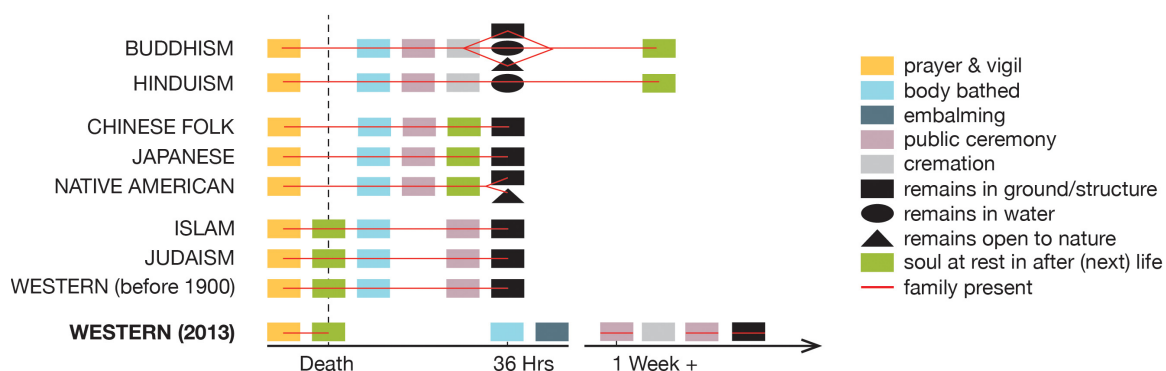


In the northern Canada many nomadic first nations living on the tundra will bath and dress their dead and leave them lying face up away from the camp - the ground is too hard to dig a grave. (Walk 1998)

### **Comparison Between Global and Western Methods of Honouring the Dead**

Other cultures make a distinction between biological and social death. Biological death is the physiological shutting down of the body—the heart ceases to beat, the brain dies, the body cools, the process of decomposition begins. Helman cites Hertz with a contrasting view in which social death is unique and distinct:

...in most Non-Western societies, death is seen as not a single event in time but as a process whereby the deceased is slowly transferred from the land of the living to the land of the dead; simultaneously there is a transition between social identities from living person to dead ancestor. (Helman 2001, 161)



A graphical comparison of death rituals from several cultures - note the similarity of Western culture's death rituals prior to 1900.

## Countermovement to Funeral Home Death Rituals

Thomas Lynch is an internationally acclaimed poet and novelist; he is also a mortician. He writes:

The bodies of the newly dead are not debris nor remnant, nor are they entirely icon or essence. They are, rather, changelings, incubates, hatchlings of a new reality that bear our names and dates, our image and likenesses, as surely in the eyes and ears of our children and grandchildren as did word of our birth in the ears of our parents and their parents. It is wise to treat such new things tenderly, carefully, with honor. (Lynch 1997, 22)

There exist already several examples of hospices where care providers extend their attention from the dying to the deceased. This may be in the form of a space dedicated for families to gather around a loved one who has died, or the symbolic rituals in which staff partake to honour the deaths of their patients, as they go about their business caring for their other patients still alive.

For example, at Helen and Douglas house in Oxford, UK (the first children's hospice in the West), there is a 'cold room' decorated to look much like a child's

bedroom. Any child who dies at the hospice can lay in this cold room, surrounded by favourite stuffed animals or possessions, for up to a week to allow time for family to come and visit. The temperature is kept cool enough that the body does not decompose, and in this way is similar to a morgue but designed to be a far more inviting space. Therefore, no embalming is necessary and the setting is private and comfortable for visiting family. There is also a window in the room that offers the grieving family a connection to natural light and darkness (ie, the normal cycle of the day), and a view out to nature and the garden outside the hospice. In addition, the hospice staff always add sugar to their afternoon tea when a patient has died that day. A small ritual, but a reminder to all staff of the child who has died, and the work that they do to honour these children in life and in death (Mosher 2014).



Helen & Douglas House Children's Hospice (UK) photographed by Pam Mosher 2008

During my visits to the hospice in St. John New Brunswick, I was informed that the staff light candles and line the hallways as the deceased are taken from the hospice. Memory leaves are added to a tree in the kitchen after a resident dies, and glass angels are placed on a tree in the lobby.

Steven Verderber, a professor of Architecture at University of Toronto who has written and lectured across North America about hospital and hospice design, via email correspondence, writes "The Connecticut Hospice displays the body for a about 6 hours [for family and staff] in its grieving area. This space and any associated outdoor terraces, gardens, water elements, seating places, are all a part of this

grieving continuum” (email Nov 8, 2013).

These are a few small examples of how hospices and their staff have chosen to honour and support the deceased and deceased person’s family, and these are professionals who see death on a daily basis. But what about the average person in the West? How do they create rituals outside of funerals in which to honour their dead loved ones? The lay public is increasingly seeking authentic experiences ‘for the heart and hands.’ Growing movements in this vein include 1) Death cafes, where people gather to speak about their experiences with loved ones dying, 2) DIY/‘Do-it-Yourself’ or at-home funerals mediated by death doulas and 3) On-line interest, blogs, and websites to increase sharing of, and community connectedness to, experiences at the end of a loved one’s life (<http://www.finalpassages.org/>) (Ideas 2014).

### **Advantages of a Hospice with Space to Honour the Recently Deceased**

Is it possible that we might to be able to enhance the experience of the families of the dead in Nova Scotia by providing a physical space – thoughtfully designed and programmed, contiguous with a hospice – that would allow the loved ones of the dead to engage in their own therapeutic rituals and/or their own grief work? Could we envision and create a space for the process of social death to occur in Western society?

Death and dying are still considered taboo in our society – could the creation of a ritual space help ease the discomfort around death? Could it lower rates of

'complicated grief' and other distressing symptoms that often occur in the those left behind following the death of a loved one? Could it help families cope better with loss? When palliative care in hospices takes place, the dying and their families benefit. The question is – could they benefit even more if there were a physical space, central to a hospice, where they had the option to undertake rituals *after* the death of a loved one, and thereby allow space and time for the 'social death' of the individual to occur? This might also permit more immediate grief work, acceptance, and closure, through architecture. If so, what would or could such a space look like?

There is only one hospice in Atlantic Canada, but three more are planned for Halifax in the next few years due to the efforts of The Hospice Society of Greater Halifax ([http://www.hospicehalifax.org/making\\_it\\_happen\\_here.html](http://www.hospicehalifax.org/making_it_happen_here.html)). This change reflects a growing demand for hospices across Canada, and this demand creates an opportunity to discuss how architecture may improve experiences related to dying and death. The Western death paradigm has already demonstrated signs of change in its support of the hospice movement. As shown, a few hospices have integrated ritual spaces, but this thesis proposes to investigate this aspect further.

My research revealed recurring themes in hospice design and death rituals. In addition to a substantive literature review, I also completed first-hand interviews with medical anthropologists, hospice historians, palliative care physicians, and hospice staff. The findings from

my site visits led me to envision this master's project as a 'hospice campus' that contains within itself a sequence of ritual spaces for the care and final disposition of the recently deceased.

## **Design Process**

I approached the design of this campus from the perspective that the ritual spaces should be designed first, and that the design of the hospice could be informed by these elements. As the process moved on, I found that I was monumentalizing the ritual spaces and that the intention of the hospice was being overwhelmed by these early designs.

The following section will show some early interpretive photomontages set in Halifax. I will then show the site selection and analysis. The importance of the site leads to the program for the campus. I will then discuss my architectural precedents with accompanying images of my intentions for key spaces in the campus.

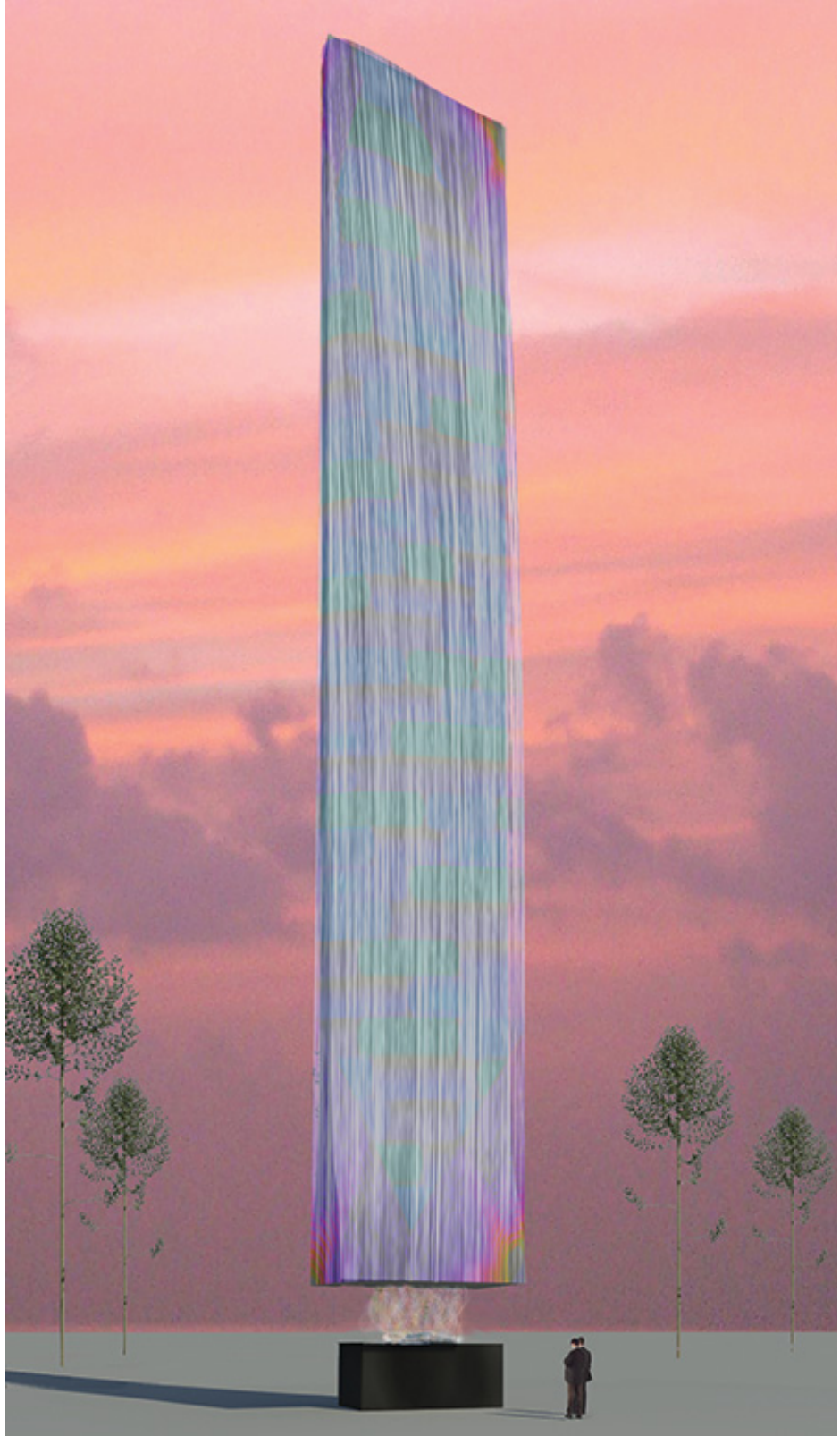
## **Interpretive Studies**

An anthropological view of death revealed several different ways in which the living care for the dying and the recently deceased. These studies inspired some interpretations for ceremonies in Halifax, NS.





The Bell Aliant office tower has a niche like facade, reminiscent of the caves in the Bandiagara cliffs of Mali where the Dogon bury their dead.



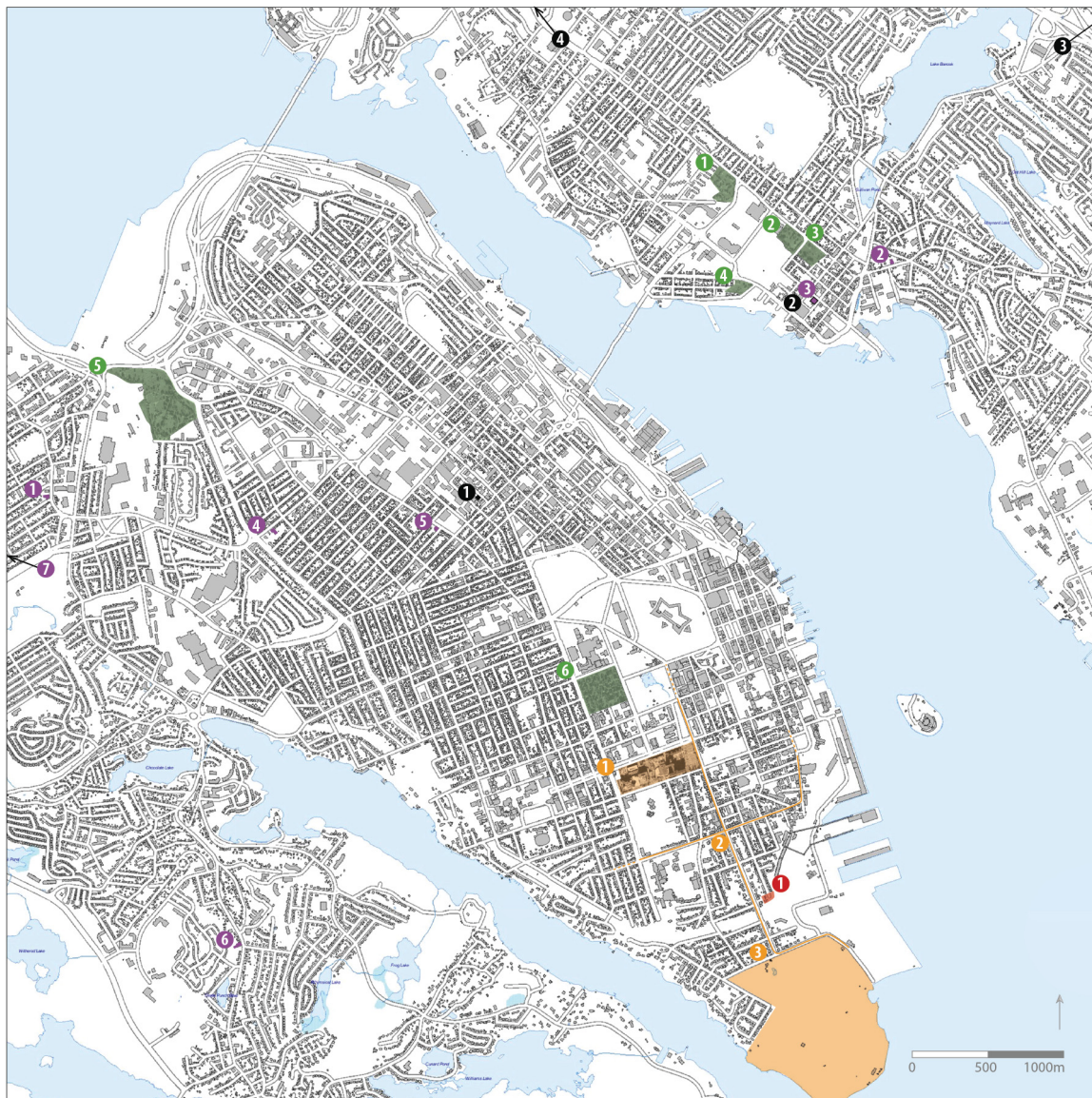
Inspired by public cremations in India. The pyre illuminates upon contact with the elements of the human body, creating a spectacle based on the individual's life.

## **Site Selection Criteria, in Halifax NS**

The intention of this thesis is to show how we might better live with death, as many other cultures do. As such it makes more sense for the hospice to be in an urban location rather than hidden away in the countryside. Worpole discusses challenges to urban and rural hospices claiming that in the end both have equal merits (Worpole 2009, 48).

1. Urban lots tend to be smaller, making it harder for accessibility. Ideally the hospice is on one or two floors.
2. Land tends to be more expensive.
3. The red tape with city planning and zoning generally means it takes longer for the project to move forward.
4. It is challenging to find ways for patients to feel connected to nature due to limited outdoor space or through views
5. Less likely to find a peaceful setting.

Choosing the site meant minimizing these challenges while establishing a criteria based on maximizing the advantages of an urban hospice.



#### Site Selection Influences

- ① Adult Palliative Care (Victoria General Hospital) and Pediatric Palliative Care (IWK Health Centre)
- ② Major transit routes close to site
- ③ Point Pleasant Park

#### Thesis site

- ① The view of the sunrise over the harbour entrance and a large lot for improved accessibility are great features for a site on the Peninsula

#### Funeral Homes

- ① Barnard, T K, Funeral Home Ltd (Independent)
- ② A.L. Mattatall Funeral Home (Dignity Memorial)
- ③ Dartmouth Funeral Home (Arbor Memorial)
- ④ Atlantic Funeral Homes Ltd (Arbour Memorial)
- ⑤ Cruikshank's Halifax Funeral Home (Dignity Memorial)
- ⑥ J. Albert Walker Funeral Home LTD. (Independent)
- ⑦ JA Snow Funeral Home (Dignity Memorial)

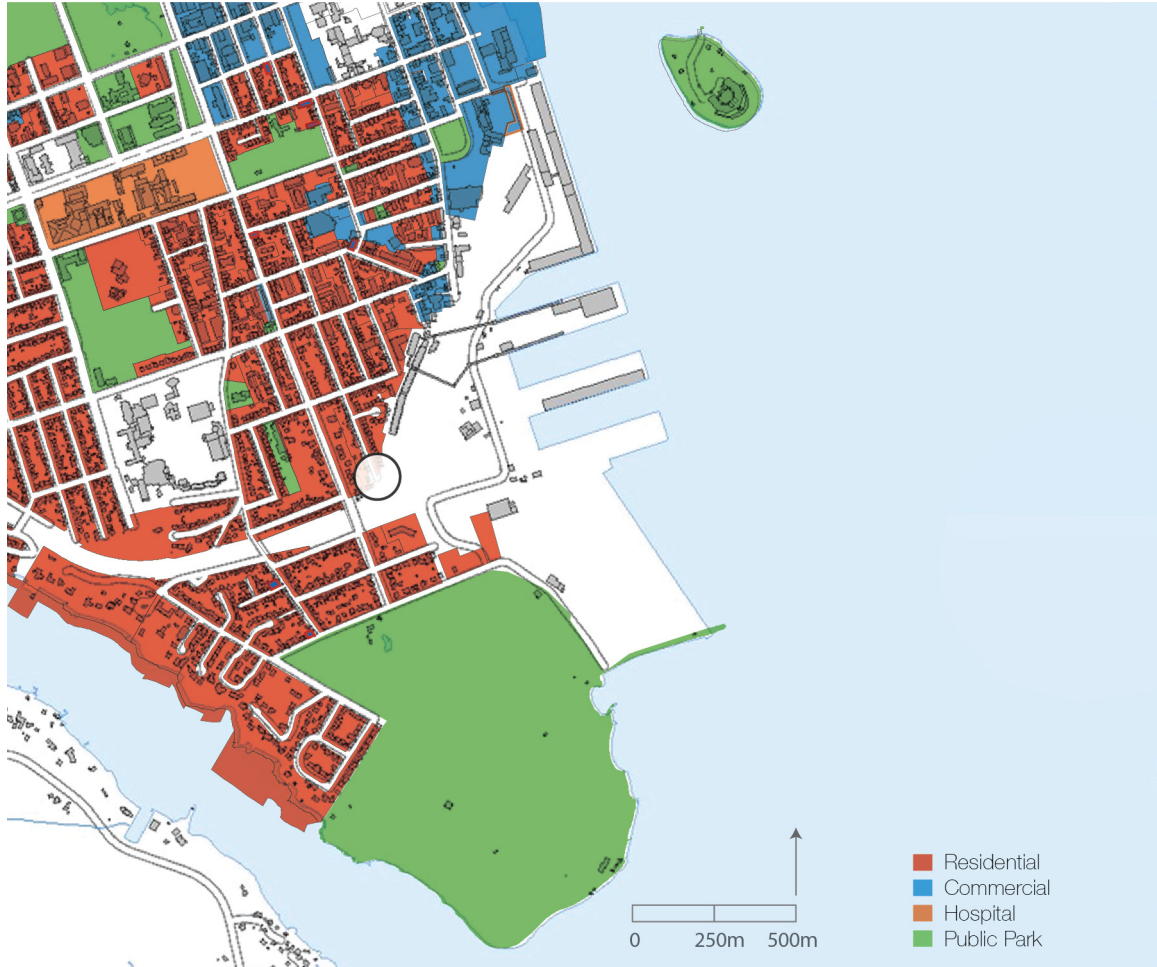
#### Crematoriums

- ① Harbourside Crematorium (Dignity Memorial)
- ② Dartmouth Funeral Home (Independent)
- ③ Oakridge Crematorium (Arbor Memorial)
- ④ Cole Harbour Crematorium (Arbor Memorial)

#### Cemeteries with Vacancies

- ① Mount Hermon Cemetery (Arbor Memorial)
- ② Saint Peter's Cemetery
- ③ Dartmouth Common (Park Avenue) Cemetery
- ④ Saint Paul's Cemetery
- ⑤ Fairview Lawn Cemetery
- ⑥ Camp Hill Cemetery

### Site Selection and Related Funerary Services



Site location in relation to nearby parks, hospital, commercial and residential areas in Halifax.

### Site in the City

The site is 10- 15 minutes walk from the Victoria General Hospital, where there is a dedicated palliative care unit. There are two bus routes with stops a few minutes walk from the site. Within 15 minutes walk there are many options for restaurants and coffee. It is a 5 minute walk to Point Pleasant Park. The site also allows for sunrise views over the harbour.

## **Approach to Site Analysis**

The relationship of the site to its surroundings was explored to better understand how the design of the campus would emerge, including type and height of trees on the lot and on neighbouring properties, sight lines to the harbour, the composition of flat and sloped terrain, and the patterns of light that strike the site throughout the day.

Notes about the site:

i) The site location has two buildings on it which have been acquired.

ii) There two neighbouring properties to the North of the site, which should also be acquired at a later date to help expand the operation of the hospice. In the meantime I have taken some minor liberties with their property lines.

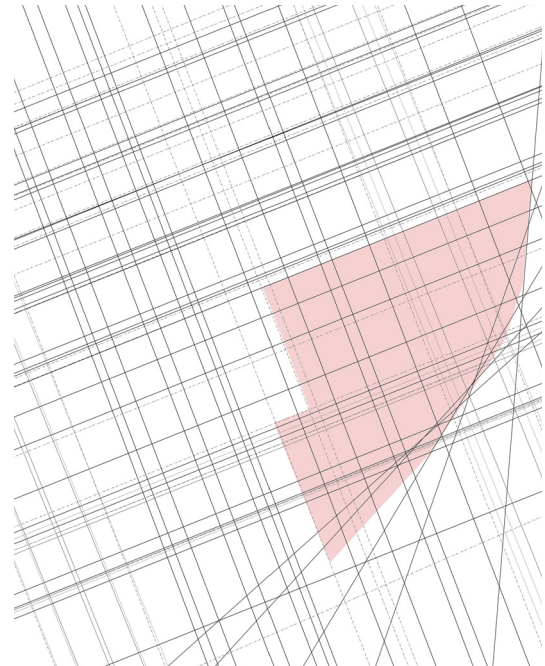
iii) The mapping information found in GIS, HRM maps and Google Earth have discrepancies and missing data. I have interpolated some of the missing topography lines in my maps and site model.

## **How the Site Fits into the Neighbourhood**

The site is in a residential neighbourhood at the end of McLean Street. The neighbouring lots run perpendicular to the streets, where the lots and streets define a rectilinear urban grid. The exception is the topography by the railway cut, a 40' escarpment cutting diagonally across the grid.



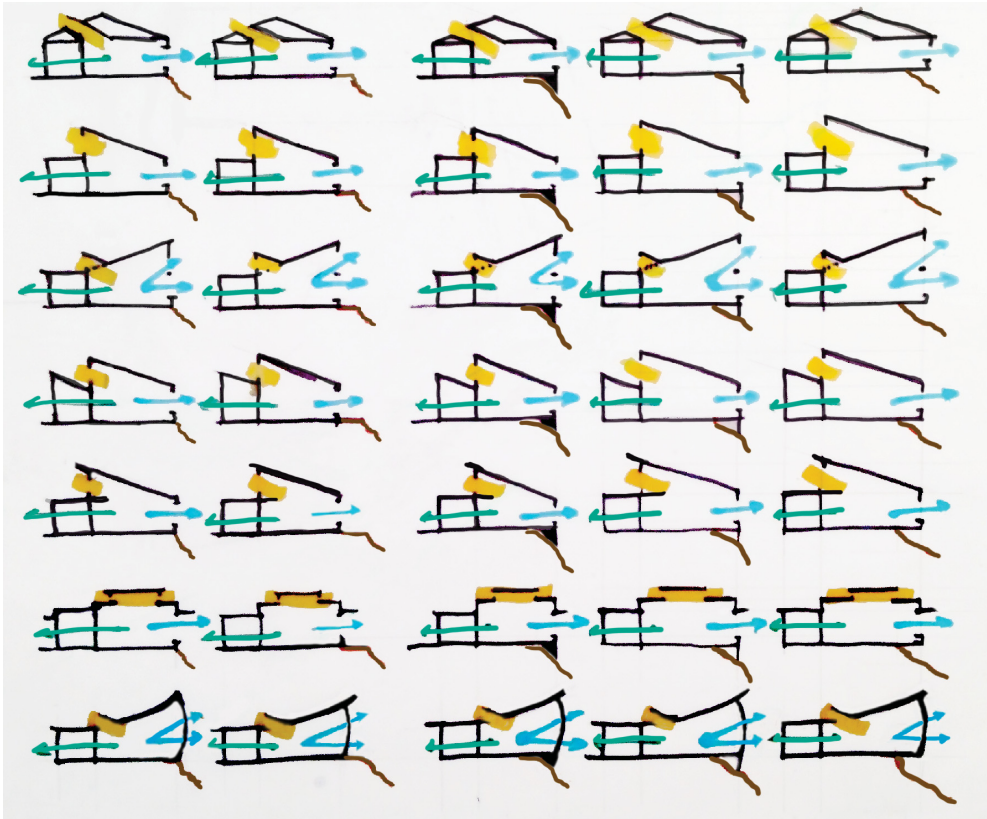
The existing neighbourhood in relation to the site.



An interpretive study of the urban grid, the site, and the edge of the escarpment.

The southern most part of the site has a lower plateau, 15' below the rest of the site. This geographic feature is an opportunity for the death ritual component of the campus as the descent resonates with some aspects of Western views of death.

The houses on McLean Street are modest in scale in comparison to those on Young Avenue. The residents live in detached houses and townhouses, with a mixture of owners and renters. On Young Avenue the houses are much larger and most are single-family owners. The exception is the third house from the escarpment, which is subdivided and is occupied by renters.

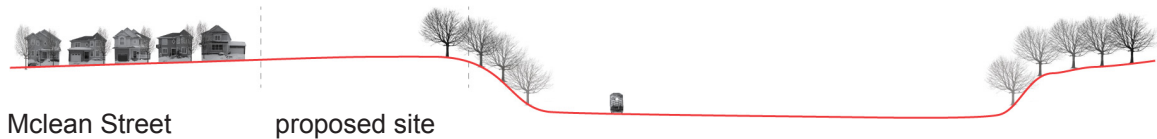


Seven versions of a patient room, each with five ways to meet the escarpment.

As I studied the site, I drew sketches of how the patient rooms might be arranged. Most of this was done in plan as I focused on how the program elements might fit on the site. This proved to be challenging and I ended up with many room types and no clear way to decide between them.

A critical study was to compare the rooms in section and then look at how each could meet the edge of the escarpment. Some versions seemed to be more versatile than others which offered much needed flexibility. The study further clarified the relationship between room and path.





The section through the site along Mclean Street shows the site in relation to the escarpment. The predominate view is of the Halifax harbour mouth which is due East and thus benefits from the rising sun, a symbol of hope and the natural cycles of life.

## Design Intentions for the Hospice

The hospice and ritual spaces will jointly be referred to as a spiritual campus; this is derived from the origin of the hospice, which has its roots in the monasteries, convents and abbeys of medieval Europe. The primary goal of the hospice is to comfort the living through the end of life. Patients should be empowered as much as possible to control their environment—with options for views, light, temperature and social connectivity. They should have opportunity for solitude without isolation. Therefore the physical and spatial qualities necessarily contrast the institutional qualities common in hospitals.

In Arthur Kleinman's book *The Illness Narratives*, Gordon Stuart (a 33 year-old cancer patient in his final week of life) describes the importance of watching his

garden, the birds, the flowers, and the “rhythm of it all” (Kleinman 1988, 146-149). Likewise, in a hospice setting the patient rooms and common spaces must be designed to allow for ongoing views and experiences of this same ‘rhythm’ of life.

Worpole also alludes to this when he discusses the interest that hospice patients held in the construction work that was transpiring on a neighbouring building (Worpole 2009, 52). While the staff feared the noise would disrupt the peace of the hospice, the patients viewed this as a welcome connection to the ongoing ‘life’ of the outside world.

As I attempted to integrate and understand the importance of these anecdotes, it struck me that the mundane events hold significance, perhaps because they are understandable elements (accessible to any hospice patient), and that familiarity is representative of the larger continuum of life, which may be something too difficult to comprehend as a whole. And as a hospice is supposed to be like a ‘home’ in a way, the familiar world would be welcomed and perhaps could perhaps lead to a sense of empowerment.

The research I have done suggests each hospice program varies based on the location—urban vs. rural—as well as the budget for the hospice. While the following program is idealized, it is informed based on the present needs of the community. The overall approach to the program is to separate the administrative areas from patient and family living areas, in order to preserve the intent of their respective roles. The areas for patient

support, while visibly separated, will be on the same level as the patient living areas to facilitate accessibility.

### **Design Intentions for the Recently Deceased**

The intentions of the ritual spaces closely follow the ethos of the modern hospice movement, an ethos of compassion and patient centredness, which has been gaining acceptance in Western culture over the last 50 years.

The overarching paradigm is to provide room for three important ritual activities to occur—bathing, viewing, and cremating—all on the same site where the loved one died, so that family and friends may participate in these lost rituals, and begin their grieving and bereavement without temporal or physical separation from their loved ones. A further benefit of having the ritual spaces all on one site is to avoid the expenses associated with transporting the deceased.

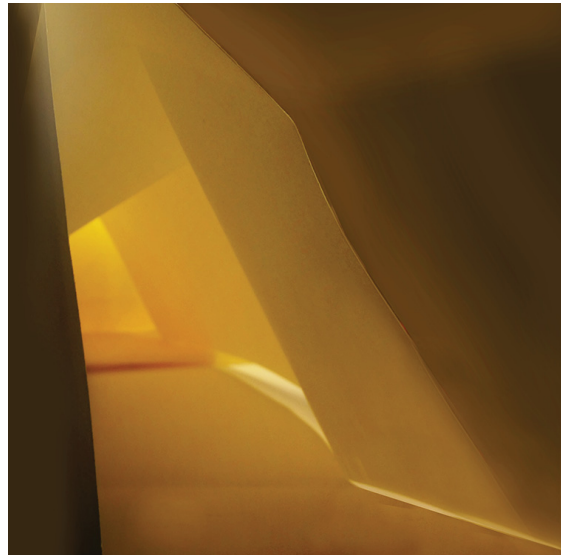
While the hospice remains the central building and anchoring structure on the site, the three ritual spaces and chapel are linked to the hospice in a way that allows for both connection and transition, and echoes back to the themes of cloister and outbuildings in older monasteries and convents.

The role of architecture is to thoughtfully approach and provide for these rituals with the gravity they deserve. As these spaces may help families cope with loss, they should be arranged in a way for families to choose how they would like to use the spaces rather than prescribing the use of all the spaces, and in a particular order.

Three ritual spaces and possible attributes



Bathing room: even light for preparation of the body for ceremony, views to nature, horizontal window, thick walls.



Viewing room: to remember and celebrate, light, ethereal, evokes memory, freedom

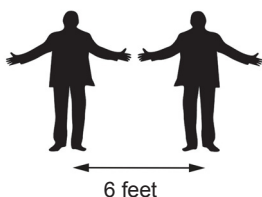


Cremation space: for closure, rebirth. The cremation entry: water and fire, procession, cave, other-world, enclosed, cleanse

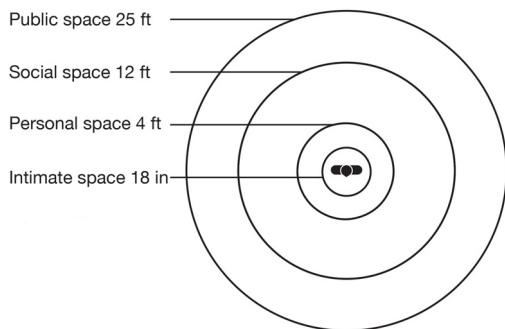
## Proxemics



I imagine that “intimate space” of a person grieving is larger than a person who is happy. Thus they are less tolerant of strangers sharing a park bench with them.



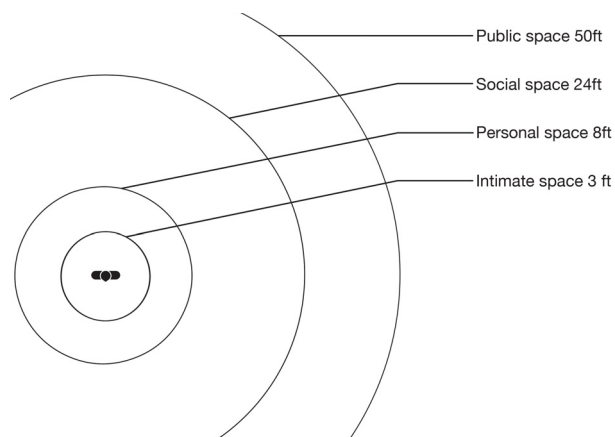
I propose grief doubles the radius of Hall’s behavioural spaces. Looking at spaces from the perspective of someone grieving, we can for example determine dimensions for hall widths, the space between chairs in a waiting areas or windows.



Hall explains how physical boundaries influence on behavior

Edward T. Hall defines proxemics as “the interrelated observations and theories of man’s use of space as a specialized elaboration of culture” (Hall 1990, 1). The study of proxemics may help us understand the spatial needs of those grieving as distinct from those who are not. Through informal testing and anecdotal research, I propose that the sphere for intimate space grows from a radius of 18” to 3’ so that those standing more than 6’ apart cannot touch each other in Western culture, those who are grieving seem to need more space from strangers. Further intimate expressions such as touch can be expressed from a greater distance. With this in mind, the public spaces of the hospice and death rituals are designed with the idea that a little more physical space is needed for those who are grieving.

This design principle would be incorporated into seating areas of the lobby and dining rooms and to hallway widths, etc.



Reframing the theory, I propose that underlying behaviors related to grief can inform the design of physical boundaries.

## CHAPTER 2: DESIGN

I conceived of the layout as a small community resembling a monastery, where the origins of the hospice in Europe began. The campus is composed of two parts, one for the living, the hospice, and one for honouring the deceased, the funerary and ritual spaces.

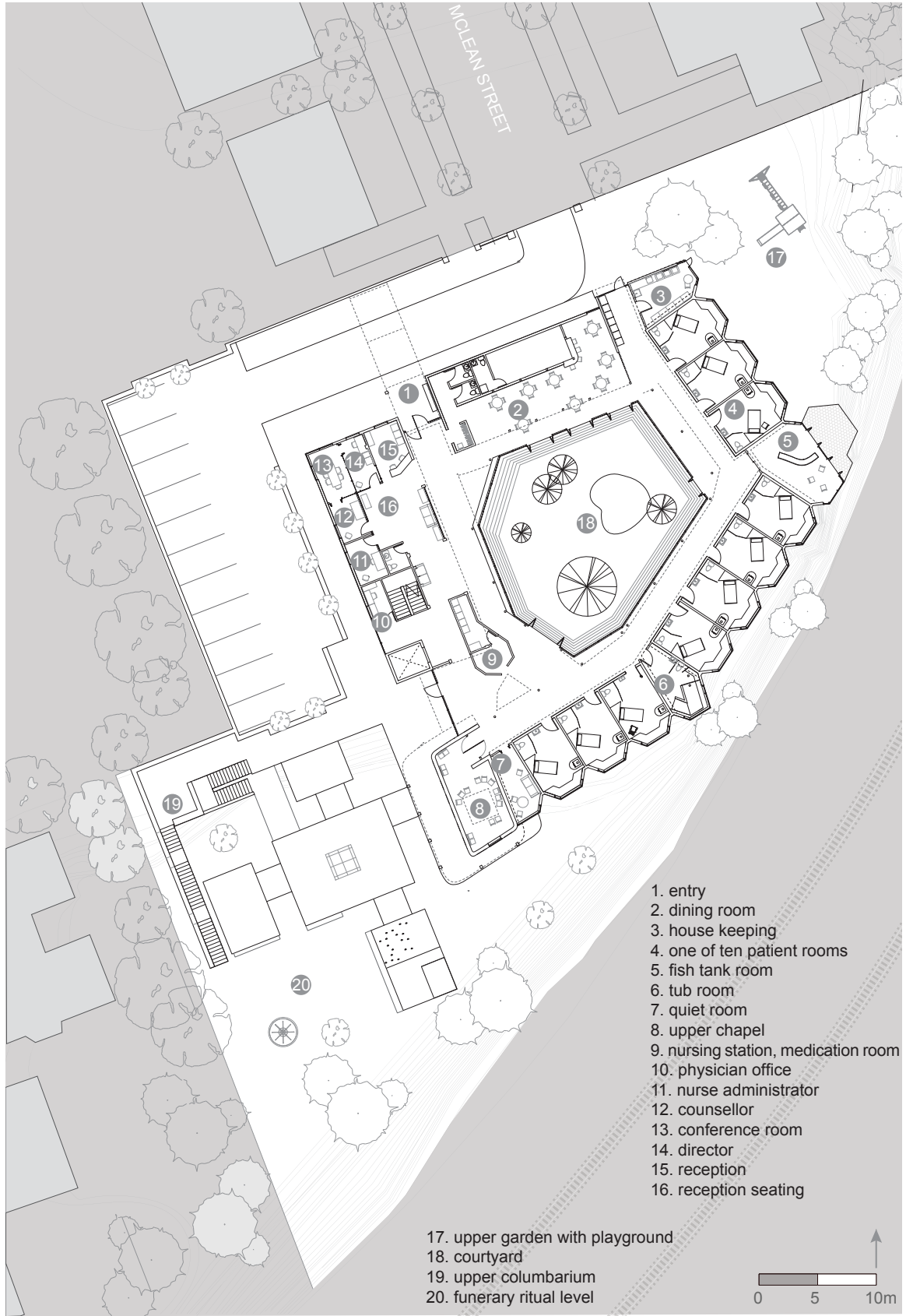
The hospice portion of the campus is a group of pavilions connected by a path, which surrounds a courtyard, similar to cloisters of a monastery. The pavilions of the hospice include an administration building, a dining hall with a kitchen, the chapel, and three patient pavilions for the ten patient rooms. There are three support spaces nested between the pavilions.

The support spaces are house keeping, a fish tank room and a tub room. The housekeeping room opens onto the upper garden, where linens can be air dried. The smell and texture of line-dried linen is a remembrance of home and a welcome change from hospitals linens. The fish tank room provides a therapeutic and calming atmosphere for family conversations and is also a great place for kids to hangout. This is also the main access to the upper garden and playground. The tub room is wet room like a Turkish bath. Patients can lie weightless in a wheelchair accessible in-floor jacuzzi tub.

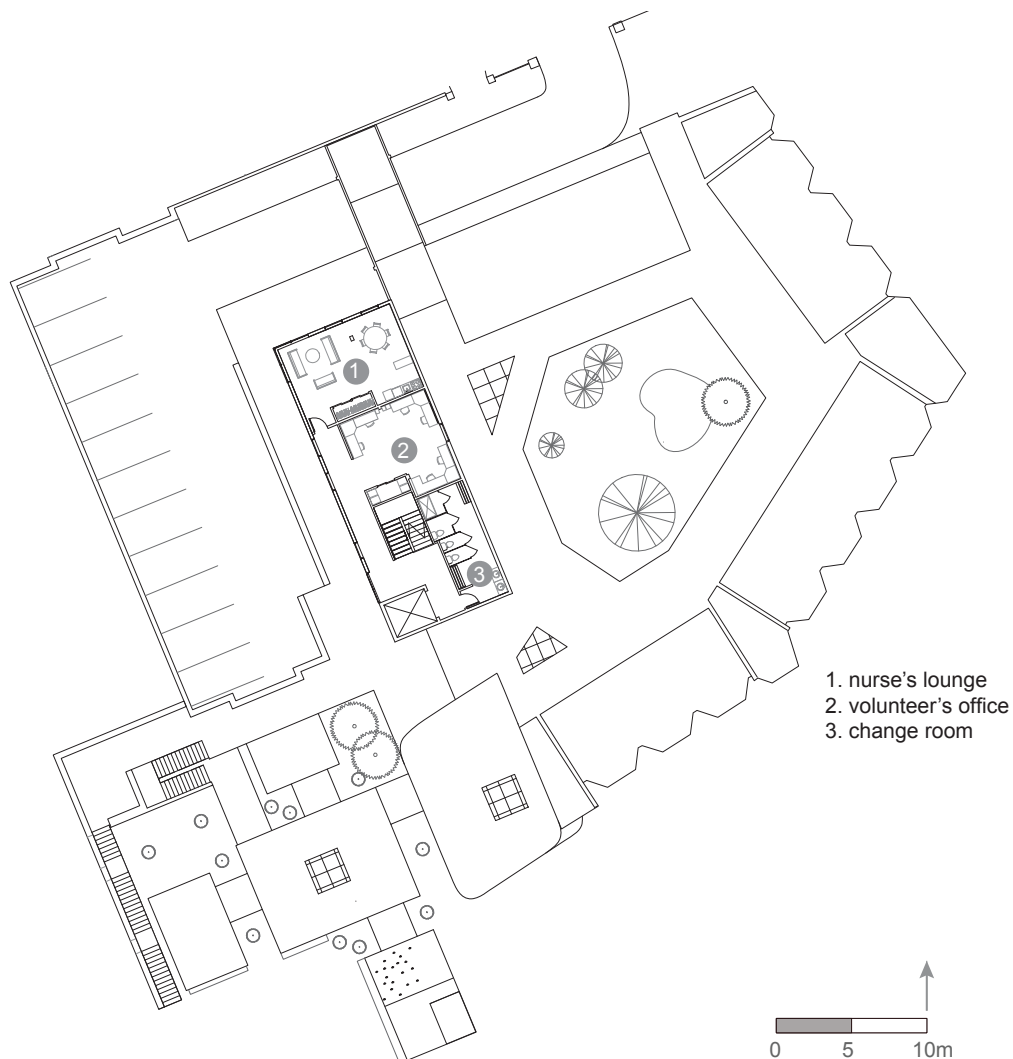


Perspective view of campus from south end of the site

The administration building has the operational components of the hospice on the main floor: a reception area, offices for director, the nursing administrator, a counsellor and a physician. The nursing station floats into the circulation path for increased visual connectivity to the patient rooms.



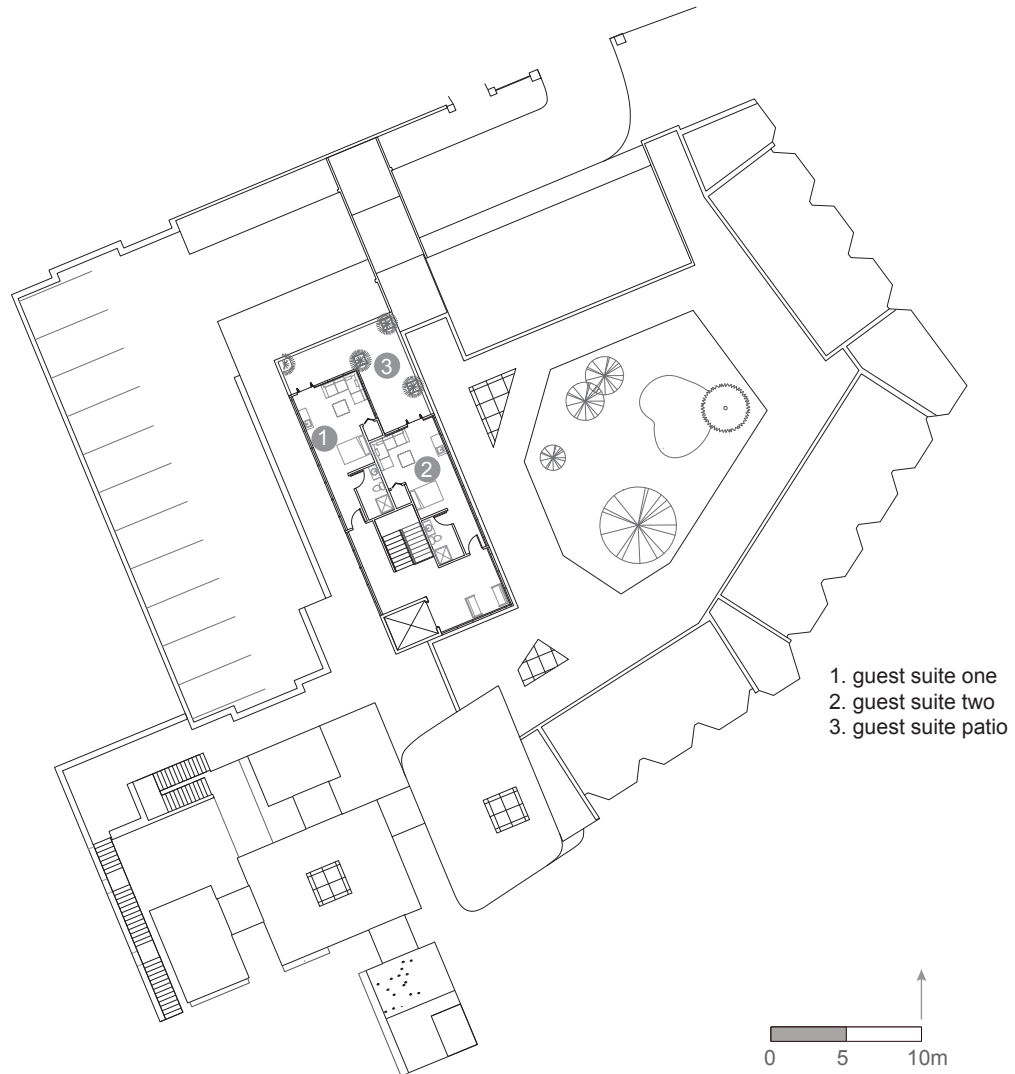
Site Plan Level 1 1:500



The Administration Building  
Level 2, 1:500

Level two (above) is more private than the level below providing a sanctuary for nurses and volunteers. Volunteers are connected to the hospice through a dedicated space integrated into the campus. The office also securely stores medical records. In the lounge, nurse's can prepare a meal, read, take a nap or watch television. This level also has a change room with a shower.





The Administration Building  
Level 3, 1:500

The third level is dedicated to family. While the patient rooms are designed for family members to share the accommodation with their loved ones, these suites are good for longer stays and for families with children. The two large family suites can accommodate four to six per room. The rooms have place to make tea and a balcony with plants.

The funerary and ritual spaces of the campus are situated on the lower plateau of the site 15' below the main campus. The main organizational difference between



Funerary and Ritual Spaces  
 Level -1, 1:500

the hospice and the funerary pavilions is the funerary pavilions are connected by a central room, rather than a path. Where a path implies a direction, and instruction, the central fountain room implies a choice of funerary rituals in which to participate. The fountain room, viewing room and crematorium open to the garden. This connection to nature allows one to step away from the ceremony for a private moment of reflection. The garden flows into the lower columbarium. The public is welcome to visit the columbarium at anytime and may use the stair from the upper columbarium to avoid passing through the fountain when it is in use.



Section through a patient room, the courtyard and the administration building.



Section through the crematorium, fountain room and bathing room.



Section through the chapel, fountain room and viewing room.

## Some Key Spaces of the Campus

### Entry



Entry Lobby

The hospice entry is often a critical patient experience because it signifies an admission of transition in one's life. The design cues began from this perspective and led me to create spaces that flowed together, all connected by a courtyard garden.

The first few steps into the hospice, one sees this courtyard garden and a dining room for community to gather. These two familiar elements, nature and community, help frame the experiences of the patient and their family.

### Patient Rooms

The patient rooms are located along the escarpment edge with easterly views of the harbour mouth. The patient beds are oriented with a view back into the courtyard, the town square of the campus, so at all times they are visually connected inwards to community and outwards to nature.

The rooms are designed as dwellings, large enough for family to gather around a loved one and with familiar totems of a home: outlook to nature, a hearth, and water.

Patients nearing the end-of-life often experience delirium, the symptoms of which are reduced by natural cycle of light through the day (Mosher, 2014). For this reason there are windows on opposite sides of the rooms, to gather light from the sunrise and sunsets.

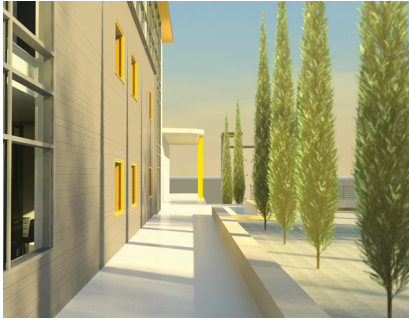


Patient room, a view to the courtyard



Patient room, a view to nature

## Access to the Funerary Spaces



Access to funerary spaces

For friends and family who come to honour the life of a loved one, they can enter the ritual spaces without going into the hospice. There are stairs down to the lower level as well as an elevator adjacent to the chapel.

## The Chapel

There is an upper and lower chapel which link the hospice to the funerary spaces. The chapel acts as a bridge between the spaces for the living and the spaces to honour the dead.



Lower Chapel





The Fountain Room

## The Fountain Room

The fountain room is at the heart of the funerary complex. From this space families have the opportunity to participate in different funerary practises. The room can be used in many ways, I imagine it to be a place for families to gather or for an individual to reflect quietly on a bench.



A partial section revealing the crematorium

### **The Crematorium**

Many crematoria, like the one in Halifax, attempt to hide the retort chimney, perhaps to disguise the purpose of the building form the public. By contrast, this crematorium is designed as a chimney with a space to sit and wait for the ashes. There is a veil-like wall of windows, which one can pass through for a walk in the lower garden. Adjoining the garden is the columbarium where one may choose to place the ashes.

## **CHAPTER 3: CONCLUSION**

It is hoped that a thoughtful discussion on approaches to death through architecture will result in better deaths with less fear and stigma for the dying and their families. By creating spaces for authentic experiences, and providing opportunities for good deaths to occur, perhaps those who bare witness to such deaths will be less afraid when they approach this defining element of what it means to be human.

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