Communitas House: A Canadian Hospice Incorporating Medical Assistance in Dying

by

LINDSAY IMLAH

A Practicum submitted to the Faculty of Graduate Studies of

The University of Manitoba

In partial fulfillment of the requirements of the degree of

MASTER OF INTERIOR DESIGN

Department of Interior Design

University of Manitoba

Winnipeg

Copyright © 2019 by Lindsay Imlah

Abstract

Recently legalized in Canada, Medical Assistance in Dying (MAID) has generated a demand for interior environments that can adapt to the evolving rituals associated with end-of-life and death. In the case of MAID, the right to choose where and how to die puts emphasis on the quality of interior environments that accompany death rituals. Inspired by this human rights issue, this Interior Design Practicum project focuses on the design of *Communitas House*, a hospice that aims to enhance the quality of life for patients, their families and the caregivers providing access to MAID. The design aims to promote psychological, physical, spiritual and emotional wellness through the interior design experiences surrounding MAID. Located within Crescent Park Drive in Winnipeg, MB, Communitas House includes the design re-use of an existing resort building, which will be architecturally adapted and built on the site. Surrounded by the natural environment, Communitas House takes advantage of the healing benefits of biophilic design through the direct and indirect inclusions of nature, as well as symbolic connections. This practicum translates liminality and the study of collective end-of-life rituals to highlight the importance of social support through MAID death experiences. The essence of living in the moment and the associated feelings of sanctuary, security and comfort is explained through the concept of hygge. The resulting design solution emphasizes the benefits of social ritual practices and natural influences in supporting MAID end-of-life experiences.

Acknowledgements

Communitas House is truly about embracing life and living in the moment with your collective: the people you surround yourself with and who support you through life's important transitions. As a collective, we share together in those transitions, which we call life's rituals. Right now I consider myself a ritual subject, as I am about to transition from a Master's student to a Master's graduate and thus complete my academic career. Therefore, I would like to dedicate this practicum project to my collective, or rather my *communitas*, for with them this endeavour could not have been a success.

First and foremost, thank you to my practicum advisory committee – Dr. Shauna Mallory-Hill (primary advisor), Dr. Susan Close (internal advisor), and Dr. Kim Wiebe (external advisor) – for your support, guidance and encouragement throughout the project.

To Chelsea, Christine and Kerstin, I am so grateful to have had you alongside me for this Master's journey. I could not imagine having a more amazing group with whom I could have learnt design with and from. You will forever be my Van City babes.

To my parent's, Cathy and Ray Imlah, thank you for your unwavering support throughout my entire academic career. Thank you for listening to my ideas, constant progress updates and all my ups and downs. Your constant inquiries and interest into this project have kept me on track.

To my brother Michael Imlah, thank you for your support and interest in my project. You are always there for me no matter how near or far you may be.

Finally, thank you to Colby Hjorleifson for being my rock through my entire academic journey. Whether it was attending faculty events, chauffeuring me to and from school, discussing design, or simply trying to stay up with me on late work nights, you have been an amazing source of support for which there is no greater precedent.

Table of Contents

Abstract ii
Acknowledgements iii
List of Tables vii
List of Figures viii
List of Copyright Material xix

Chapter 1 – Introduction 01

1.1 Project + Scope 01
1.2 Rationale 03
    1.2.1 Faith- Based Institutions 06
1.3 Contemporary Death Protocols 07
1.4 Imagining the Modern Hospice for MAID 10
1.5 Summary of Main Issues and Rationales 14
1.6 Design Inquiry 15
1.7 Project Charter 15
1.8 Limitations 16
1.9 Key Terms 16
1.10 Chapter Summaries 17

Chapter 2 – Literature Review 20

2.1 Introduction 20
2.2 Liminality 20
    2.2.1 Introduction 20
    2.2.2 A New Death Ritual 22
    2.2.3 Phases of Liminality in the MAID Ritual 24
        2.2.3.1 Phase 1: Separation 25
        2.2.3.2 Phase 2: Margin 29
            2.2.3.2.1 Pipe Ceremony 31
            2.2.3.2.2 Opening a Window 33
        2.2.3.3 Phase 3: Aggregation 34
2.3 Biophilic Design 37
    2.3.1 Introduction to Biophilia and the Issues 36
    2.3.2 Dimensions of Well-Being 40
    2.3.3 Spirituality in Nature 44
        2.3.3.1 Water 44
2.4 Hygge as a Design Concept 46
    2.4.1 Introduction 46
    2.4.2 Defining Hygge 46
    2.4.3 Social Cognition 48
    2.4.4 Interior Atmosphere 51

2.4.4.1 Natural Materials 55
2.4.4.2 The Fireplace 55
2.4.4.3 Food 56
2.4.5 Nature 56
2.5 Conclusion 58
2.5.1 Summary of Design Strategies 60

Chapter 3 – Precedent Studies 61

3.1 North London Hospice 60
3.2 Bridgepoint Active Healthcare 79
3.3 Deer Lodge Sakura Suite 93
3.4 Dignitas House 117

Chapter 4 – Programming 126
4.1 Client Profile 126
4.1.1 Clients Needs and Future Goals 126
4.1.1.1 Clinical 126
4.1.1.2 Residence 126
4.1.1.3 Administrative 130
4.1.1.4 Educational 131
4.2 Users 132
4.2.1 Storm Miller 133
4.2.2 Esther Supernault 139
4.2.3 Primary Users 143
4.2.4 Secondary Users 143
4.2.5 Tertiary Users 144
4.3 User Profile Chart 144
4.4 Functional + Aesthetic Requirements 147
4.5 Spatial Analysis 151

Chapter 5 – Location Analysis 152

5.1 Project Overview 152
5.2 Site Analysis 155
5.2.1 Site History 156
5.2.2 Surroundings 164
5.2.2.1 Climate 166
5.2.3 Neighborhood Demographic 169
5.2.4 Site Opportunities and Constraints 172
5.3 Building Analysis 173
5.3.1 Building History and Reasoning for Relocation 173
5.3.2 Features 183

5.3.3 Building Opportunities and Constraints 184

Chapter 6 – Spatial Concept and Design

6.1 Spatial Concept 185
6.1.1 Design Features 186
6.2 Design 186
6.2.1 Exterior Landscaping 188
6.2.2 Entry and Spatial Organization 192
6.2.3 Lobby, Reception and Meet and Greet 200
6.2.4 Breakout an Seminar Area 206
6.2.5 Patient Suites 211
6.2.6 Dining Area 224
6.2.7 Kitchen and Utility Areas 232
6.2.8 Lounge 234
6.2.9 Spiritual Areas 240
6.2.10 Outpatient Clinic 245
6.2.11 Exterior Design Features 247
6.2.12 Administration 251
6.3 Design Summary 252

Conclusion 257

Bibliography 263

Appendix A – Material Selections 269
Appendix B – Furniture Selections 282
Appendix C – Reflected Ceiling Plans and Detail Drawings 291
Appendix D – Access and Life Safety Requirements 308
Appendix E – MAID Request Form and UHN Framework 332

List of Tables

Table 1 – Elements and attributes of biophilic design [Table]. Table by author. Pg.39

Table 2 – Table showing Mental health was the largest to increase after the renovation of Bridgepoint [Graphic Image]. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg. 86

Table 3 – Chart showing that patient mental health was the largest category to increase at Bridgepoint [Graphic Image]. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg. 87

Table 4 – User Profile Chart [Table]. Table by author. Pg. 146

Table 5 – Spatial requirement chart [Table]. Table by author. Pg. 150

Table 6 – Spatial Adjacencies chart [Table]. Table by author. Pg. 151

List of Figures

Figure 1. Levitt's diagram of the human psyche [Graphic Image] Retrieved from Levitt's Inner Studio, (Cambridge: Riverside Architectural Press, 2007), 10. Pg. 27

Figure 2. Aboriginal Medicine Wheel [Graphic Image] Image by author. Pg. 31

Figure 3. Communitas House warming hut [Graphic Image] Retrieved from https://www.flickr.com/photos/benrogerswpg/8580862138/in/photolist-e5gamW-dEfR7S-dQJRBe-e2pivX-9eTcs9-F7ZV4a-QUQgs8-2eFb8i6-23Jf7Kt-2eAzLDo-Sx4UeA-rfwG3R/. Pg. 53

Figure 4. Primary North elevation with landscaping in foreground 09080_149 [Graphic Image]. Retrieved from http://timothysoararchive.co.uk/project/12860. Pg. 61

Figure 5. Tim Soar. (Photographer) South east Corner 09080_125 [Graphic Image]. Retrieved from http://timothysoararchive.co.uk/project/12860. Pg. 62

Figure 6. Tim Soar. (Photographer) Approach from Barrowell Green 09080_15 [Graphic Image]. Retrieved from http://timothysoararchive.co.uk/project/12860. Pg. 65

Figure 7. Ground Floor plan [Graphic Image]. Image by AHMM. Pg. 67

Figure 8. Tim Soar. (Photographer) Meet and greet area looking out onto garden 09080_126 [Graphic Image]. Retrieved from http://timothysoararchive.co.uk/project/12860. Pg.68

Figure 9. Tim Soar. (Photographer) Open plan kitchen, dining and café 09080_133 [Graphic Image]. Retrieved from http://timothysoararchive.co.uk/project/12860. Pg. 68

Figure 10. Tim Soar. (Photographer) View from the kitchen and dining through south-facing courtyard 09080_135 [Graphic Image]. Retrieved from http://timothysoararchive.co.uk/project/12860. Pg. 69

Figure 11. Tim Soar. (Photographer) Daycare 09080_128 [Graphic Image]. Retrieved from http://timothysoararchive.co.uk/project/12860. Pg. 70

Figure 12. Tim Soar. (Photographer) View from the kitchen and dining through south-facing courtyard 09080_168 [Graphic Image]. Retrieved from http://timothysoararchive.co.uk/project/12860. Pg. 71

Figure 13. North London Hospice second storey [Graphic Image]. Image by AHMM. Pg. 72

Figure 14. Tim Soar. (Photographer) Open plan office within the primary pitch 09080_137 [Graphic Image]. Retrieved from http://timothysoararchive.co.uk/project/12860. Pg. 73

Figure 15. Tim Soar. (Photographer) Staff room looking out onto terrace, GRP brick soffit and green beyond 09080_140 [Graphic Image]. Retrieved from http://timothysoararchive.co.uk/project/12860. Pg. 74

Figure 16. North London Hospice third storey [Graphic Image]. Image by AHMM. Pg. 75

Figure 17. Tom Arban. (Photographer). (n.d). Exterior of Bridgepoint Active Healthcare [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 79

Figure 18. Tom Arban. (Photographer). (n.d). Hospital entrance [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg.80

Figure 19. Diagram showing daylighting into patient room [Graphic Image]. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg.81

Figure 20. Diagram showing adjacent green/social spaces – South and North [Graphic Image]. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg.82

Figure 21. Diagram showing meaningful views from outdoor social spaces – East and West [Graphic Image]. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg.82

Figure 22. Diagram showing meaningful views from interior patient lounge space [Graphic Image]. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg. 82

Figure 23. Axonometric view of interior program elements at Bridgepoint Active Healthcare. [Graphic Image]. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg. 83

Figure 24 Tom Arban. (Photographer). (n.d). Patient room with view [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 84

Figure 25 Tom Arban. (Photographer). (n.d). Corner patient room with view [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 84

Figure 26. Tom Arban. (Photographer). (n.d). Therapy pool [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 85

Figure 27. Tom Arban. (Photographer). (n.d). Labyrinth courtyard [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 85

Figure 28. Tom Arban. (Photographer). (n.d). Seminar room [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 88

Figure 29. Tom Arban. (Photographer). (n.d). Open staircase [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 89

Figure 30. Main floor plan Main floor plan [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plusMAID patient request form page 1 [Graphic Image]. Public domain license. Retrieved from http://www.wrha.mb.ca/MAID/assets/pdf/MAIDRequestForm.pdf. Pg.90

Figure 31 – Exterior entrance to Deer Lodge [Graphic Image]. Image by author. Pg. 93

Figure 32 – Location of Sakura Suite in rehabilitation wing of second floor. Floor Plan NTS [Architectural Drawing] Image courtesy of Deer Lodge and edited by author. Pg. 94

Figure 33. Sakura Suite layout and adjacent rooms. Floor Plan NTS [Architectural Drawing]. Image courtesy of Deer Lodge and edited by author. Pg. 95

Figure 34. Entry door to Sakura Suite. [Graphic Image]. Image by author. Pg. 96

Figure 35. Cherry blossom art work inside the Sakura Suite [Graphic Image]. Image by author. Pg. 96

Figure 36. Communal area of Sakura Suite. [Graphic Image]. Image by author. Pg. 97

Figure 37. Kitchenette in Sakura Suite. [Graphic Image]. Image by author. Pg. 98

Figure 38. View of Sakura Suite bedroom showing patient bed, medical equipment and corner window [Graphic Image]. Image by author. Pg. 99

Figure 39. View of bed and closet area in patient room [Graphic Image]. Image by author. Pg. 99

Figure 40. Accessible washroom inside patient bedroom of Sakura Suite, showing tub assembly [Graphic Image]. Image by author. Pg. 100

Figure 41. Accessible washroom inside patient bedroom of Sakura Suite showing tub assembly and medical waste storage [Graphic Image]. Image by author. Pg. 101

Figure 42. Common area showing sitting areas, cabinet, TV, corner coffee cart and view to the outside [Graphic Image]. Image by author. Pg. 102

Figure 43. Reclining chair in common area of Sakura Suite [Graphic Image]. Image by author. Pg.104

Figure 44. Sitting area located on same floor as Sakura Suite [Graphic Image]. Image by author. Pg. 105

Figure 45. Bar of Chad's Place [Graphic Image]. Image by author. Pg. 105

Figure 46. Seating area of Chad's Place [Graphic Image]. Image by author. Pg. 106

Figure 47. Communal kitchenette located outside of Sakura Suite [Graphic Image]. Image by author. Pg. 106

Figure 48. Deer Lodge café sitting area [Graphic Image]. Image by author. Pg. 107

Figure 49. Green space and fountain in exterior courtyard [Graphic Image]. Image by author. Pg. 108

Figure 50. Exterior courtyard to the café area, featuring resident gardens [Graphic Image]. Image by author. Pg. 108

Figure 51. View of bath that MAID patients can use before procedure [Graphic Image]. Image by author. Pg. 109

Figure 52. View from bath [Graphic Image]. Image by author. Pg. 110

Figure 53. Meeting room close to Sakura Suite. Used by staff and WRHA MAID clinical team to meet and prepare [Graphic Image]. Image by author. Pg. 111

Figure 54. Medical supply room that can be used for preparation of drugs for MAID team [Graphic Image]. Image by author. Pg. 112

Figure 55. Front of the Dignitas House [Sketch]. Image by author. Pg. 117

Figure 56. Rest area and pond in front of the house. Retrieved from http://www.dignitas.ch/index.php?option=com_content&view=article&id=52&Itemid=86&lang=en. Pg. 118

Figure 57. Living area in Dignitas House [Graphic Image]. Retrieved from http://www.dignitas.ch/index.php?option=com_content&view=article&id=52&Itemid=86&lang=en. Pg. 120

Figure 58. Kitchenette in Dignitas House [Still Image from Video]. Retrieved from https://vimeo.com/45117071. Pg. 120

Figure 59. Smedley, wife and others sitting at kitchen table in Dignitas House. [Still Image from Video]. Retrieved from https://vimeo.com/45117071. Pg. 121

Figure 60. Smedley and his wife sit on couch with Dignitas representative beside. [Still Image from Video]. Retrieved from https://vimeo.com/45117071. Pg. 123

Figure 61. Timeline showing how MAID currently proceeds in Manitoba, along with integration of proposed timeline for Communitas House. [Chart] Image by author. Pg. 129

Figure 62. Chart showing numbers of persons receiving MAID services in Manitoba, where it occurred, genders and ages [Graph] Image by author. Pg. 131

Figure 63. Chart showing unassisted deaths, active cases and inquiries [Graph] Image by author. Pg. 131

Figure 64. Chart showing transfers within Winnipeg, MB and MAID patients who acted within 10 days [Graph] Image by author. Pg. 132

Figure 65. Storm (left) and Dave Miller (right). [Graphic Image]. Retrieved from https://www.cbc.ca/news/canada/british-columbia/dave-miller-storm-medical-assistance-in-dying-physician-assisted-death-good-good-bye-1.4475736. Pg. 133

Figure 66. Storm hugs an old friend at her home in Comox B.C. [Graphic Image]. Retrieved from https://www.cbc.ca/news/canada/british-columbia/dave-miller-storm-medical-assistance-in-dying-physician-assisted-death-good-good-bye-1.4475736. Pg. 135

Figure 67. Dave holding his wife with her bouquet of roses. [Graphic Image]. Retrieved from https://www.cbc.ca/news/canada/british-columbia/dave-miller-storm-medical-assistance-in-dying-physician-assisted-death-good-good-bye-1.4475736. Pg. 136

Figure 68. Esther Supernault. [Graphic Image]. Retrieved from https://necrocanada.com/obituaries/karen-esther-supernault/#.W7Y_ji--LOQ. Pg. 139

Figure 69. Family and friends of Supernault gather to share stories and good memories. [Still Image from Video]. Retrieved from http://aptnnews.ca/2017/02/17/aptn-investigates-dying-with-dignity/. Pg. 140

Figure 70. Cliff Supernault places flowers in the water to guide his wife to the creator. [Still Image from Video]. Retrieved from http://aptnnews.ca/2017/02/17/aptn-investigates-dying-with-dignity/. Pg. 142

Figure 71. Map showing Crescent Park location within Winnipeg, MB and close up of park within surrounding neighborhoods. [Graphic Image]. Image by author. Pg. 152

Figure 72. Golf course with path [Graphic Image]. Image by author. Pg. 157

Figure 73. Golf course [Graphic Image]. Image by author. Pg. 157

Figure 74. Crescent Park Drive. [Graphic Image]. Image by author. Pg. 158

Figure 75. Forest path [Graphic Image]. Image by author. Pg. 159

Figure 76. Forest path 2 [Graphic Image]. Image by author. Pg. 160

Figure 77. Playground [Graphic Image]. Image by author. Pg. 160

Figure 78. Fallen tree with moss. [Graphic Image]. Image by author. Pg. 160

Figure 79. Foliage [Graphic Image]. Image by author. Pg. 161

Figure 80. Bench by river [Graphic Image]. Image by author. Pg. 161

Figure 81. Picnic area [Graphic Image]. Image by author. Pg. 162

Figure 82. View of river [Graphic Image]. Image by author. Pg. 162

Figure 83. Entrance to site [Graphic Image]. Image by author. Pg. 163

Figure 84. Map showing site adjacencies [Graphic Image]. Image by author. Pg. 164

Figure 85. Site map showing surrounding park, river, residential area and main roadways [Graphic Image]. Image by author. Pg. 165

Figure 86. Windrose showing wind direction and distribution for Winnipeg, MB [Graphic Image]. Image by author. Pg. 166

Figure 87. Graph showing historic temperature and precipitation for Winnipeg, MB [Graphic Image]. Retrieved from http://climate.weather.gc.ca/climate_normals/results_1981_2010_e.html?searchType=stnProv&lstProvince=MB&txtCentralLatMin=0&txtCentralLatSec=0&txtCentralLongMin=0&txtCentralLongSec=0&stnID=3698&dispBack=0. Pg. 167

Figure 88. Sun path diagram [Graphic Image]. Image by author. Pg. 168

Figure 89. Map showing Winnipeg transit stops [Graphic Image]. Image by author. Pg. 169

Figure 90. Chart showing population demographic of Crescent Drive Park [Graphic Image]. Image by author. Pg. 170

Figure 91. Chart showing labour force demographic of Crescent Drive Park [Graphic Image]. Image by author. Pg. 171

Figure 82. Chart showing income demographics for Crescent Drive Park[Graphic Image]. Image by author. Pg. 171

Figure 93. Chart showing modes of transportation for Crescent Drive Park [Graphic Image]. Image by author. Pg. 172

Figure 94. Exterior entrance of Lakeview Resort and Spa [Graphic Image]. Image by author. Pg. 175

Figure 95. Existing architecture of Lakeview Resort and Spa [Graphic Image]. Image by author. Pg. 176

Figure 96. Back exterior of Lakeview Resort and Spa, showing patio deck and large expanse of windows [Graphic Image]. Image by author. Pg. 177

Figure 97. Lakeview Resort and Spa lobby [Graphic Image]. Image by author. Pg. 179

Figure 98. View towards sitting area in lobby [Graphic Image]. Image by author. Pg. 180

Figure 99. Corridor between lobby and restaurant Graphic Image]. Image by author. Pg. 181

Figure 100. Lobby sitting area to the right of entrance [Graphic Image]. Image by author. Pg. 182

Figure 101. Exterior entrance perspective [Graphic Image]. Image by author. Pg. 185

Figure 102. Site map showing Communitas House, Crescent Drive Park and surrounding residential area [Graphic Image]. Image by author. Pg. 188

Figure 103. Site plan, showing existing buildings to be demolished in dashed lines [Graphic Image]. Image by author. Pg. 190

Figure 104. Rendered site plan showing Crescent Park Drive and main access roads into site, parking, landscaping and prominent architectural features [Graphic Image]. Image by author. Pg. 191

Figure 105. Perspective of entrance to Communitas at night [Graphic Image]. Image by author. Pg. 192

Figure 106. First floor plan showing programme of rooms and location of elevations [Graphic Image]. Image by author. Pg. 195

Figure 107. First floor plan rendered [Graphic Image]. Image by author. Pg. 196

Figure 108. North building elevation NTS [Graphic Image]. Image by author. Pg. 197

Figure 109. South building elevation NTS [Graphic Image]. Image by author. Pg. 197

Figure 110. East building elevation NTS [Graphic Image]. Image by author. Pg. 198

Figure 111. North interior section NTS [Graphic Image]. Image by author. Pg. 198

Figure 112. West building elevation NTS [Graphic Image]. Image by author. Pg. 199

Figure 113. Entrance floor plan rendered [Graphic Image]. Image by author. Pg. 200

Figure 114. Interior entrance showing water wall and reception area [Graphic Image]. Image by author. Pg. 201

Figure 115. Reception area and corridor to outpatient clinic area [Graphic Image]. Image by author. Pg. 202

Figure 116. Meet and greet perspective [Graphic Image]. Image by author. Pg. 204

Figure 117. Reception - E1 - West Elevation - Scale: 3/16"= 1’ – 0” [Graphic Image]. Image by author. Pg. 205

Figure 118. Meet and Greet - E2 - West Elevation - Scale: 3/16" = 1'-0" [Graphic Image]. Image by author. Pg. 205

Figure 119. Meet and Greet-E3-South Elevation-3/16"=1'-0" [Graphic Image]. Image by author. Pg. 205

Figure 120. Meet and Greet-E4-East Elevation-3/16"=1'-0" [Graphic Image]. Image by author. Pg. 205

Figure 121. Seminar and break out area floor plans rendered [Graphic Image]. Image by author. Pg. 206

Figure 122. Break out area perspective showing seating, memorial wall at back and view to exterior landscape [Graphic Image]. Image by author. Pg. 207

Figure 123. Break Out- E5- North Elevation- NTS [Graphic Image]. Image by author. Pg. 209

Figure 124. Break Out – E6- South Elevation - NTS [Graphic Image]. Image by author. Pg. 209

Figure 125 – Patient suite corridor perspective -NTS [Graphic Image]. Image by author. Pg. 210

Figure 126. Patient suite floor plan rendered with alternate plan showing fold out bed in entrance [Graphic Image]. Image by author. Pg. 211

Figure 127. Perspective showing entrance to patient suite and small gathering area [Graphic Image]. Image by author. Pg. 212

Figure 128. Patient Suite Entrance – E7- East Elevation -NTS [Graphic Image]. Image by author. Pg. 215

Figure 129. Patient Suite Entrance – E8- East Elevation -NTS Graphic Image]. Image by author. Pg. 215

Figure 130. Patient Suite Entrance – E9- South Elevation -NTS [Graphic Image]. Image by author. Pg. 216

Figure 131. Patient Suite Entrance – E10- West Elevation -NTS [Graphic Image]. Image by author. Pg. 216

Figure 132. Patient Suite Entrance – E11- North Elevation -NTS [Graphic Image]. Image by author. Pg. 216

Figure 133. Patient suite bathroom perspective [Graphic Image]. Image by author. Pg. 217

Figure 134. Patient suite bathroom – E12- North Elevation-NTS [Graphic Image]. Image by author. Pg. 218

Figure 135. Patient suite bathroom-E13-South Elevation-NTS [Graphic Image]. Image by author. Pg. 218

Figure 136. View of patient resting area [Graphic Image]. Image by author. Pg. 219

Figure 137. Patient suite living area-E14-North Elevation-NTS [Graphic Image]. Image by author. Pg. 220

Figure 138. Patient suite living area-E15-South Elevation-NTS [Graphic Image]. Image by author. Pg. 220

Figure 139. Patient suite living area-E16-West Elevation-NTS [Graphic Image]. Image by author. Pg. 221

Figure 140. Patient suite living area-E17-East Elevation-NTS [Graphic Image]. Image by author. Pg. 221

Figure 141. Perspective of patient living area and rest area [Graphic Image]. Image by author. Pg. 222

Figure 142. Patient suite private patio perspective [Graphic Image]. Image by author. Pg. 223

Figure 143. Dining area floor plan rendered [Graphic Image]. Image by author. Pg. 224

Figure 144. Entrance to dining area perspective [Graphic Image]. Image by author. Pg. 225

Figure 145. Perspective of dining area [Graphic Image]. Image by author. Pg. 227

Figure 146. Exterior dining patio perspective [Graphic Image]. Image by author. Pg. 228

Figure 147. Private dining-E18-South Elevation-NTS [Graphic Image]. Image by author. Pg. 228

Figure 148. Dining area-E19-21-South Elevation-NTS [Graphic Image]. Image by author. Pg. 229

Figure 149. Dining area-E22-North Elevation-NTS [Graphic Image]. Image by author. Pg. 229

Figure 150. Dining area-E19-West Elevation-NTS [Graphic Image]. Image by author. Pg. 229

Figure 151. Dining area-E20-East Elevation-NTS [Graphic Image]. Image by author. Pg. 229

Figure 152. Perspective of exterior dining patio at night [Graphic Image]. Image by author. Pg. 230

Figure 153. Perspective of private dining room at night [Graphic Image]. Image by author. Pg. 231

Figure 154. Kitchen and utilities floor plan rendered [Graphic Image]. Image by author. Pg. 232

Figure 155. Lounge floor plan rendered [Graphic Image]. Image by author. Pg. 234

Figure 156. Perspective of lounge showing different sitting areas [Graphic Image]. Image by author. Pg. 235

Figure 157. Lounge fireplace-E23-West Elevation-NTS [Graphic Image]. Image by author. Pg. 237

Figure 158. Lounge sitting area-E24-North Elevation-NTS [Graphic Image]. Image by author. Pg. 237

Figure 159. Lounge nooks-E25-East Elevation-NTS [Graphic Image]. Image by author. Pg. 238

Figure 160. Lounge library Wall-E26-South Elevation-NTS [Graphic Image]. Image by author. Pg. 238

Figure 161. Lounge perspective showing gathering areas and stairs to spiritual area [Graphic Image]. Image by author. Pg. 239

Figure 162. Spiritual floor plan rendered [Graphic Image]. Image by author. Pg. 240

Figure 163. Perspective of semi-private spiritual area [Graphic Image]. Image by author. Pg. 242

Figure 164. Perspective of group spiritual area [Graphic Image]. Image by author. Pg. 243

Figure 165. Semi-private spiritual area-E27-South Elevation-NTS [Graphic Image]. Image by author. Pg. 244

Figure 166. Spiritual group area-E28-North Elevation-NTS [Graphic Image]. Image by author. Pg. 244

Figure 167. Spiritual group area-E29-South Elevation-NTS [Graphic Image]. Image by author. Pg. 244

Figure 168. Outpatient clinic floor plan rendered [Graphic Image]. Image by author. Pg. 245

Figure 169. Exterior wall of memorial perspective [Graphic Image]. Image by author. Pg. 247

Figure 170. Fire circle inside memorial at night [Graphic Image]. Image by author. Pg. 249

Figure 171. Pond perspective showing man dropping flower petals into the water. Inspiration from Esther Supernault's MAID journey [Graphic Image]. Image by author. Pg. 250

Figure 172. Second floor plan rendered [Graphic Image]. Image by author. Pg. 251

List of Copyright Material

Table 2 – Table showing Mental health was the largest to increase after the renovation of Bridgepoint. Used with permission from Methologi. December.11, 2018. [Graphic Image]. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg. 86

Table 3 – Chart showing that patient mental health was the largest category to increase at Bridgepoint. Used with permission from Methologi. December.11, 2018. [Graphic Image]. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg. 87

Figure 1. Levitt's diagram of the human psyche. Used with permission from Andrew Levitt. December 14,2018. [Graphic Image] Retrieved from Levitt's Inner Studio, (Cambridge: Riverside Architectural Press, 2007), 10. Pg. 27

Figure 3. Communitas House warming hut. Used with permission from Creative Commons. December 2018. [Graphic Image] Retrieved from https://www.flickr.com/photos/benrogerswpg/8580862138/in/photolist-e5gamW-dEfR7S-dQJRBe-e2pivX-9eTcs9-F7ZV4a-QUQgs8-2eFb8i6-23Jf7Kt-2eAzLDo-Sx4UeA-rfwG3R/. Pg. 53

Figure 7. Ground Floor plan. Used with permission from AHMM. December.19, 2018 [Graphic Image]. Image by AHMM. Pg. 67

Figure 13. North London Hospice second storey. Used with permission from AHMM. December.19, 2018 [Graphic Image]. Image by AHMM. Pg.72

Figure 16. North London Hospice third storey. Used with permission from AHMM. December.19, 2018 [Graphic Image]. Image by AHMM. Pg. 75

Figure 17. Exterior of Bridgepoint Active Healthcare. Used with permission from Tom Arban. December 10, 2018. [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 79

Figure 18. Hospital entrance. Used with permission from Tom Arban. December 10, 2018. [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 80

Figure 19. Diagram showing daylighting into patient room. Used with permission from Diamond Schmitt. December.17, 2018. [Graphic Image]. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg. 81

Figure 20. Diagram showing adjacent green/social spaces – South and North. Used with permission from Diamond Schmitt Architects. December.17, 2018. [Graphic Image]. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg. 82

Figure 21. Diagram showing meaningful views from outdoor social spaces – East and West [Graphic Image]. Used with permission from Diamond Schmitt Architects. December.11, 2018. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg. 82

Figure 22. Diagram showing meaningful views from interior patient lounge space [Graphic Image]. Used with permission from Diamond Schmitt Architects. December.11, 2018. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg. 82

Figure 23. Axonometric view of interior program elements at Bridgepoint Active Healthcare. Used with permission from Diamond Schmitt Architects. December.11, 2018. [Graphic Image]. Retrieved from https://www.bridgepointhealth.ca/en/what-we-do/resources/research/Architectural_Comparative_Analysis_Report.pdf. Pg. 83

Figure 24 Patient room with view. Used with permission from Tom Arban. December 10, 2018. [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 84

Figure 25 Corner patient room with view. Used with permission from Tom Arban. December 10, 2018. [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 84

Figure 26. Therapy pool. Used with permission from Tom Arban. December 10, 2018. [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 85

Figure 27. Labyrinth courtyard. Used with permission from Tom Arban. December 10, 2018. [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 85

Figure 28. Seminar room. Used with permission from Tom Arban. December 10, 2018. [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 88

Figure 29. Open staircase. Used with permission from Tom Arban. December 10, 2018. [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 89

Figure 30. Main floor plan. Used with permission from Diamond Schmitt Architects. December.11, 2018. [Graphic Image]. Retrieved from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus. Pg. 90

Figure 56. Rest area and pond in front of the house. Used with permission from Dignitas. December.16, 2018. Retrieved from http://www.dignitas.ch/index.php?option=com_content&view=article&id=52&Itemid=86&lang=en. Pg. 118

Figure 57. Living area in Dignitas House. Used with permission from Dignitas. December.16, 2018. [Graphic Image]. Retrieved from http://www.dignitas.ch/index.php?option=com_content&view=article&id=52&Itemid=86&lang=en. Pg. 120

Figure 65. Storm (left) and Dave Miller (right). Used with permission from CBC. December. 17, 2018. [Graphic Image]. Retrieved from https://www.cbc.ca/news/canada/british-columbia/dave-miller-storm-medical-assistance-in-dying-physician-assisted-death-good-good-bye-1.4475736
Figure 66. Storm hugs an old friend at her home in Comox B.C. Used with permission from CBC. December. 17, 2018. [Graphic Image]. Retrieved from https://www.cbc.ca/news/canada/british-columbia/dave-miller-storm-medical-assistance-in-dying-physician-assisted-death-good-good-bye-1.4475736. Pg. 133

Figure 67. Dave holding his wife with her bouquet of roses. Used with permission from CBC. December. 17, 2018. [Graphic Image]. Retrieved from https://www.cbc.ca/news/canada/british-columbia/dave-miller-storm-medical-assistance-in-dying-physician-assisted-death-good-good-bye-1.4475736. Pg. 136

1.0 | Chapter 1 - Introduction

1.1 Project and Scope

In the following University of Manitoba, Master of Interior Design practicum project I explore the design of "Communitas House," a new hospice typology to incorporate Medical Assistance in Dying (MAID) in Winnipeg, Manitoba, Canada. I am proposing the design of an end-of-life facility where terminally ill Manitobans can seek the provision of an assisted death. This design will also allow for the patients family and friends to support them in the experiences leading up to, during and after the provision of MAID.

Communitas is a Latin noun that refers to an unstructured community in which people are equal, allowing them to share a common experience. This shared experience usually develops when people experience a ritual, rite of passage, or other transitional state. For these reasons Victor Turner in his writings on liminality (Chapter 2), uses communitas, rather than community, to reflect the powerful nature of a unified collective in the midst of important life transitions. In turn, MAID symbolizes a contemporary liminal transition where the communitas, is at the foreground of this contemporary death ritual. Therefore, Communitas House embraces the spirit of the collective, the coming together and sharing in final end-of-life experiences and rituals.

The program of Communitas House is one that is meant to carry individuals, their families and friends through the process of dying, death and beyond. A large component of empowering death for MAID patients will be providing full access service, through a clinical team developed by the Winnipeg Regional Health Authority (WRHA). The facility aims to be a place to seek information about the MAID process, medical options, as well as carry out document filing, assessments, MAID provision, and grief counselling. The services do not end with death but carry on by supporting families as long as required. It will also act as an educational center to support continuing education and workshops specific to MAID.

The primary intention of the project is achieved through designed interiors, supporting terminally ill Manitobans challenged in seeking full range MAID services and support. Individuals seeking MAID are being denied full access to this service by faith-based medical institutions, and are not being offered the same 'quality' of death as is conventionalized in 'quality of life'. In order to provide quality end-of-life experiences, Communitas House acknowledges the empowerment of choice associated with a medically assisted death. Empowerment is a key component of social power dynamics and wellbeing. If wellbeing is sought within life, it should also be within death and dying. Communitas House offers a quality of death that is not currently recognized in healthcare environments. The design provides this by allowing patients and their collectives the ability to adapt to their immediate space and create their own procession of celebrating life and death, like that of a funeral.

The research and literature presented in the following document support the vision of a MAID hospice that aims to push the boundaries of existing death spaces. By enhancing the foundations of current end-of-life interiors, it is the intention of Communitas House to elevate the experiences of individuals and families seeking peace and comfort in the midst of illness and pain.

With this in mind, the design of a MAID hospice supports the collective by emphasizing quality of life, death and wellbeing through the design concept of hygge. Discussed later in Chapter 2, hygge pushes the boundaries on the notion of a 'home at the end' of life in order to capture feelings of sanctuary and security that are enhanced by social interactions in end-of-life spaces. As a design concept, hygge merges the social rituals of death and the effects of the natural environment on physical, emotional, psychological and spiritual wellbeing.

Through the proposed design re-use of the existing Lakeview Hecla Resort and Spa building, architecturally adapted to the Crescent Drive Park area of Winnipeg, MB, the design aims to

demonstrate the interior's important role in supporting end-of-life narratives. Focusing on design elements from spatial layout and volume, to materiality and colour, to health and wellness, to furniture and decorative elements, and finally, to adaptability and user-control, the practicum project has allowed Communitas House to provide a new model for built environments inclusive of MAID. Ultimately, this is one that embraces the communitas and the new rituals of death surrounding medically assisted death, allowing the collective choices and support in how they experience one moment to the next.

1.2 Rationale

My practicum was born out of a desire to bring attention to MAID within the evolving realm of end-of-life healthcare in Canadian society. In addition to this, I recognized that associated built environments with this type of healthcare must adapt alongside the changing journey of death and its rituals. Finally, the most practical rationale is that there is a need to provide adequate access to all Canadians seeking MAID services.

Currently there is no space in Canada that explicitly offers end-of-life care and support services specifically for MAID. Susan Martin (2018), the Canadian author on 'good deaths', states that there is a need to normalize the mysterious concept of death by talking openly on end of life wishes. I believe that this challenge has the ability to be met with the design of a hospice that incorporates MAID and that it can allow for reconciliation by providing individuals at end-of-life a sanctuary in which to carry out their final days. By embodying and focusing in on the direct experiences of the patient, my design takes a humanistic approach. Communitas House seeks to remove the taboo surrounding medically assisted death, and even rituals of death, through the design of a built environment for MAID.

In February 2015, assisted death became federally legalized in Canada (Dangerfield, 2016). Within the next year, guidelines for its provision were developed. MAID's legalization

responded to the observance of the Criminal Code of Canada's infringements on several rights and freedoms as stated within the Canadian Charter of Rights and Freedoms. According to the Charter "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principals of fundamental justice." ("Schedule B," 1982) The previous criminal code, banning MAID deprived adults of their right of such justices ("Carter vs Canada," 2015). The argument that led to legalization pled that the law was forcing people to commit suicide before they wanted to go, because they were afraid to wait until they might need assistance, therefore burdening a loved one to break the law (Martin, 2018). Suicide had been legal in Canada since 1976, but assistance in it was not (Martin, 2018). In conclusion, the law was depriving suffering persons the right to life as laid out in the Charter (Martin, 2018).

As the advocating of human rights sparked legalization of MAID, it has also generated an issue for its accessibility. Those who can provide assistance include physicians and nurse practitioners, in provinces where allowed ("Medical Assistance," 2017). However, current legislation also protects the rights of the providers to act according to their beliefs and values ("Medical Assistance," 2017). Essentially this means that not all of these providers will be comfortable providing medical assistance in dying and the legislation does not force any person to do so ("Medical Assistance," 2017). The Government of Canada recognizes this as an issue and is working towards a referral program and supporting better access to care ("Medical Assistance," 2017).

The Government of Canada has outlined several criterions required by individuals applying for MAID. Some of these criterions include being the legal age of eighteen or over, having a grievous and irremediable medical condition, and that the prospect of death is within the foreseeable future ("Medical Assistance," 2017). Since legalization 3,714 Canadians who

have met the government's criterion have acquired their version of a dignified death through MAID (Health Canada, 2018). To date this number of MAID deaths only represents 1.07% of all deaths in Canada, however, interim reports conducted by Health Canada show that in the span of six months MAID deaths have increased by 29.3% (Health Canada, 2018). These statistics, in parallel with the infancy of the legalization, allude to the continued growth of MAID in Canada.

The demand for MAID may increase in the coming years. Currently, those who are mature minors, those with mental disabilities, and others who wish to fill out a request for MAID in advance are denied under the current legislation. However, there is a timeline to revisit these credentials at the end of 2018 (Martin, 2018). This partially stems from the fact that while requesting the government to create legislation for MAID, the Supreme Court did not define various critical terms such as grievous, irremediable or suffering (Chochinov, 2016). Support towards this reassessment was acknowledged through a vote, which occurred during the Canadian Medical Association' s annual convention in 2017 (Martin, 2018). The results showed an 83% vote for permitting MAID's guideline of grievous illness to include dementia with the inclusion of advanced request while still of sound mind. In relation to permitting MAID access to terminally ill minors, the vote stood at 66%. Finally, 51% voted for the inclusion of psychiatric patients.

In the nearly four years MAID has been legalized in Canada, over 200 Manitoban's alone have acquired a MAID death and the rate is increasing annually. Although in its infancy, healthcare design has had time to respond to MAID, however, not as rapidly as demand for the provision of it. Assisted death space has been forced to fit into existing healthcare design models, while healthcare providers focus on fine-tuning the medical process and procedures. In some cases, MAID simply does not fit into existing healthcare facilities. Ultimately, the increasing demand for MAID demonstrates, in turn, an increasing demand for interior spaces like those

modelled in Communitas House, found in Chapter 6.

1.2.1 Faith- Based Institutions

Arguably, the greatest MAID issue that is limiting access to its services is that of publicly funded faith-based institutions and long-term care facilities, which have the ability to refuse MAID on their premises (Martin, 2018). This proves to be a far greater struggle for patients than refusal from a single doctor or nurse practitioner. It is not always the case that terminally ill individuals can go directly to their healthcare facility of choice in situations of health decline. If the patient is not already at a facility that allows MAID, then they may find themselves in a difficult situation. When emergencies occur, patients are taken from their home to the nearest hospital, regardless of their religious beliefs (Martin, 2018).

Once Manitoba introduced its own policy on MAID, the newly developed WRHA MAID Clinical Team was allowed to assess patients at St. Boniface Hospital (Malone, 2018), which is a faith-based institution. However, the Clinical Team was, and is still not, allowed to carry out the actual assisted death on site (Malone, 2018). As a result, MAID patients require transfer to an appropriate care facility that can offer the provision. Since legalization, 25 MAID patients under care at Winnipeg hospitals have been transferred to another facility because of faith-based discrimination (WRHA, 2017). Transfer of terminally ill patients from one facility to another is stressful, unnecessary and dangerous for those whose condition is already unstable (Martin, 2018). There is also the case of patients who do not wish to die at home and have difficulty being admitted for the sole purpose of MAID.

Malone (2017) reported the thoughts of many Manitobans, what is the role of a publicly funded faith-based institution in regards to MAID? Should the public not have a say in the matter? Should faith interfere with the rights of MAID patients? More importantly, are the

Charter rights upheld when healthcare providers are prevented from providing medical services (Martin, 2018). Whatever the answer may be, healthcare providers associated with MAID do not see an 'immanent end' to these faith-based regulations and therefore there must be a facility to carry out assisted death.

1.3 Contemporary Death Protocols

Legalization of MAID is Canada-wide, demonstrating a united national front with human rights support. The federal government has detailed the circumstances in its legislation to which a person may be eligible for assisted death. However, universal health care services mandated under the Canada Health Act are controlled and delivered provincially (Martin, 2018). This means as long as they do not conflict with criminal law, provinces and territories can create and act on additional health-related laws and policies (Government of Canada, n.d). Therefore, when searching for information on MAID services individuals, must refer strictly to their residing province. In Manitoba for example, the WRHA outlines that if eligible under federal guidelines, Manitoban residents can acquire MAID services at no cost if also eligible for insured medical services (WRHA, n.d). This protocol is nationally mandated if the patient is in a hospital or another primary care setting within their own province, because of the universal health act (Ubelacker, 2016). Yet, this is only one instance of coordinating provincial protocols. There are other protocols to consider that must be devised by the province themselves, including:

- the use of specific forms to fill out
- special medical training for providers of the service
- how information and data on the service are provided
- rules or requirements for either type of medical assistance in dying

(Government of Canada, n.d)

This separation between federal and provincial entities poses significant problems in establishing a consistent death protocol for MAID. One issue is that there are inconsistencies in the level of specialty training for healthcare providers. Another issue is that evolving information and data will be inconsistent across Canada. Finally, it has been up to the provinces and even individuals, to source research on death protocols in order to provide what they visualize as best practice for Canadian MAID.

In Toronto, the United Health Network (UHN) has developed a different protocol (see Appendix E for diagram showing MAID service model) for a hospital-based MAID program (Li et al., 2017). Responsibility for the program is assumed by the Department of Supportive Care at Princess Margaret Cancer Centre, offering psychosocial oncology and palliative care services (Li et al., 2017). The program consists of a Supportive Care Team, divided up into different groups: Clinical Team, Assessment Team and Intervention Team (UHN Framework, n.d). These groups interact with the patients and families at various stages of the MAID process. UHN's provision of MAID in a healthcare facility requires that institutional obligations are met, such as: (1) ensuring effective and appropriate delivery of care, (2) support and protection of families and healthcare providers and (3) education of staff about MAID practices (Li et al., 2017). Their newly developed procedure hopes to increase the quality of palliative care and evolve best practices as MAID evolves in the future.

The previous example help to demonstrate the issue that yes, educational collaborations are happening, but only in small, scattered groups across Canada. Where the nation came together to legalize the issue, it can be said that the provinces must do so as well. The UHN recognizes that the institution-based delivery and hospital-wide education have brought MAID into the public space of medical care (Li et al., 2017). In turn, protocol has created transparency and accountability for end-of-life practices, while encouraging conversation about wishes, fears and

preferences (Li et al., 2017). While the previous example shows that MAID protocols are being developed, it should be reiterated that they are healthcare based and not design-based.

Medical protocols and programs are being fit into existing institutions that have never previously accommodated assisted death but are now attempting to do so. Hospital-based programs like UHN Toronto, while ideal because of the medical implications of assisted death, are not necessarily equipped to offer the elevated support that a facility specifically designed towards MAID could. However, what the protocols do offer to the design profession is the highlighting of important ideas such as support and protection, which factor into the consideration of the design programme. This strengthens the importance of an educational component through seminar and conference space within Communitas House.

As the heart of Canada, Winnipeg, with the provision of an international airport, offers the ideal site where MAID clinicians could gather and learn from one another. An association such as the Canadian Association of MAID Assessors and Providers (CAMAP) is just one example of the need for a programmed educational space in Communitas House. Although predominately an online source of MAID resource, CAMAP held their first meeting in 2017 (Martin, 2018). This assembly suggests the importance of physically gathering to share ideas and further the conversation on assisted death. As the knowledge of MAID evolves, it should be the right of all Canadian healthcare providers to be a part of the conversation. Also, it should be the right of the Canadian people to do so as well.

The notion of public dying reflects the evolving open discourse on assisted death in Canadian society (Li et al., 2017). The UHN states that this societal conversation “may diminish stigma and fear about the end of life and may help break down the barrier of silence and isolation between dying people and the world to which they have belonged” (Li et al., 2017, sec.1, para.5). These rights can be exercised and serve to improve MAID services on a national level.

Thus, an appropriate location and adequate spatial programming can allow for education and open discourse.

1.4 Imagining the Modern Hospice for MAID

In reimagining the conventional hospice to incorporate MAID, there is a complexity stemming from the range of individuals invested in end-of-life care, such as family, friends, spiritual leaders and medical staff. Therefore, not only is patient-based design a requirement but so is a sense of well-being for all users. Communitas House aims to outline how healthcare design can and must be responsive to the evolving rights of those dying and seeking assistance in their illness, as well as managing for the experiences of a larger collective. Not only is MAID a political issue, but also is reflective of an evolving Canadian culture, demanding adaptive healthcare design for contemporary death rituals. The proposed project aims to improve quality of life and death through constructing an environment of physical, mental and spiritual well-being for individuals transitioning between life to death and for their loved ones who are supporting them in their transition.

As mentioned earlier, there is currently no design model for a healthcare facility that services solely to MAID, in Canada or any other country where physician-assisted death is legal. In stating this, it should be clarified that, although the well-known “Dignitas House” near Zurich, Switzerland is considered to be a death clinic, when it is, in fact, a residential-industrial property and has no credentials to be included as a healthcare design example. This statement will be clarified further in section 3.5 of Chapter 3.

Hospice and palliative care environments appear to be the best solution towards developing a model for MAID facilities. Palliative care has always been a component of hospice facilities. The World Health Organization (n.d, para.1) defines palliative care as “prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and

other problems, physical, psychological and spiritual." This definition perfectly describes the programmatic elements necessary for a built environment with MAID services. In essence, palliative care means to improve the quality of life for patients near death and for their loved ones (Chochinov, 2016).

Offering a holistic approach to end-of-life care, palliative care emerged in Canada during the 1970' s (Martin, 2018). Since then, palliative care has broadened its horizons into multiple healthcare settings, such as hospitals, hospices, and homes, all the while carrying a patient-centered philosophy (Martin, 2018). Michael Gardam, an infectious disease specialist at the UHN in Toronto indicated that "it was a common assumption in the medical community that palliative-care doctors would take on assisted dying (Martin, 2018, sec.2, para.22)." However, upon legalization of MAID, this was not the case. Prior to the legalization of MAID, the Canadian Society of Palliative Care Physicians (CSPCP) were aware of the situation, officially stating in October 2015 that "Palliative care does not include physician-hastened death (Martin, 2018, sec.2, para.24)." Thus, the palliative care that was once synonymous with the hospice, cannot be integrated into a MAID environment in the same format as was previously carried out within the Canadian healthcare landscape.

Despite the CSPCP's reaction to MAID, the definition of palliative care along with its patient-centered approach and regard for improving quality of life near death, are all very real aspects of what a terminally ill patient requires. This is a fact that cannot be changed, whether or not the CSPCP believes this, the human rights actions that legalized MAID prove it to be true. Alleviation of pain and security of physical, emotional and spiritual components of our being are all universal human desires.

Another issue underlying palliative care and MAID is that medical institutions such as hospitals cannot offer the quality of death and opportunity for end-of-life rituals that terminally

ill patients need. Also, faith-based facilities simply disallow it. As for palliative care at home, there are circumstances where this is not ideal for the patient or healthcare staff. For caregivers, this requires an incredible amount of organization and travelling to and from the patient's residence. Some patients will not wish to die at home because it will mean a great ordeal for their dependents. Also, the memory of death within a residence cannot always be dismissed and may cause future grief in what should be a sanctuary. However, there are many patients who will wish to die at home, because it will provide them solace within death. It is not the intention of the Communitas House to care for every person wishing to acquire MAID but to allow the provision for those who are unable to within their current hospital or hospice and those who do not wish to die at home. Therefore, without palliative care available for MAID, the hospice design will aim to provide a place for individuals to carry out their journey of death.

Ken Worpole, writer and social historian of architecture, landscape, and public policy states that the hospice has always included end-of-life care and therefore it is an evolution of the hospice that is needed (Worpole, 2009). Originally hospices have been known as a 'home at the end of life,' but it is not the intention of a modern MAID hospice to create that feeling of the authentic home. Communitas House is a shelter and place of safety and security, that aims to incorporate elements to support quality of life, death, and well-being. Worpole (2009) states that due to a shift in cultural attitude, society is demanding end-of-life spaces with more privacy, more personal attention and increased attention to spiritual and psychological well-being. Therefore, the modern hospice presents architects, landscape and interior designers with one of the most complex building types (Worpole, 2009).

So, if not a hospital and not a home, what is the nature of an evolved hospice and furthermore, how does it tie in with MAID? Hospice design tends to act as a compromise between home and hospital by incorporating care, comfort, security and wellness of the psyche.

Chochinov (2016) states that physician-assisted death has been described as a human and societal response, with less consensus on characterizing it as a medical treatment. Evidence suggests that existential considerations such as being a burden to others, loss of autonomy and lost sense of dignity are primary motives for patients seeking death assistance options (Chochinov, 2016). By considering the addition of these existential entities and the emotional and spiritual elements they invoke in end-of-life space, there is less emphasis on Communitas House strictly as a clinic or medical facility. Thus, when implementing MAID, the hospice deals with spirituality as it evolves into a space requiring contemporary death rituals. Furthermore, the short duration of stay for those occupying a MAID facility creates the feeling of a hotel. This does not mean to insult the idea of MAID as a luxury lodging but rather highlight its temporal nature. Lodgings of any sort often seek to provide the comforts of home, while creating an elevated experience of retreat from everyday situations.

Hospice evolution, in adaptation to this social-cultural movement surrounding end-of-life care, is well represented through the designs of Maggie Centres', in that they offer an excellent example of marrying typologies. Charles Jenks (2010), co-creator of the Maggie Centres', refers to these buildings as hybrids; a church that is spiritual, an art gallery that is inspiring, a hospital that is healing and a house that is comforting, all together fostering space that offers a sense of well-being. Naturally, the spatial demands of MAID parallel these spaces of care as Jenks (2010) explains that traditionally, they have constituted humans' entrance and exits from the physical world.

Communitas House aims to foster a sense of well-being, similar to the Maggie Centres by designing for spirituality, inspiration, healing, and comfort in different ways. However, the concepts described by Jenks such as church, hospital, and house are challenged in the face of MAID. In regards to church, the concept is challenged because of the negative implications of

religion with assisted death. This negativity stems from faith-based institutions and traditional perceptions of hospitals being clinical and sterile. Also the concept of the house is challenged as it negotiates with the ideas of a hotel due to the temporary nature of residence.

Looking at all of this I believe that a hybrid environment is ideal for Communitas House. The hospice interprets several ideas from the Maggie Centres but evolves on others. Thus, a MAID hospice space can embody four environmental components: (1) an environment for social and culturally inclined death rituals; (2) a healthcare environment that seeks to minimize suffering and enhance wellbeing; (3) a space that embodies safety found within sanctuary through elevated focus on quality of end-of-life experiences; and (4) an educational environment that aims to encourage understanding in the social and medical practices of MAID. In conclusion, Communitas can claim to be a hybrid of four typologies: (1) ritual space, (2) healthcare facility, (3) educational centre and (4) temporary home.

1.5 Summary of Main Issues Concerning MAID

The following is a list presenting the most important issues concerning MAID, which are addressed within my practicum design:

1. Lack of cohesive structure for death protocol with MAID across all provinces and territories.

2. No full-access service centre to see MAID patients through entire process

3. Lack of medical facilities willing to participate in carrying out MAID on premises due to faith-based affiliations.

4. Lack of supportive, quality space for a collective to participate in end-of-life experiences with loved ones

1.6 Design Inquiry

The exploration of various theories are used to inform the design of a hospice for MAID, such as: (1) biophilic design and the importance of the natural environment in medical environments; (2) liminality and the rituals of death through socio-cultural lens and (3) *hygge*, a design concept that joins ideas of nature and social relationships to create spaces of well-being and meaning in end-of-life experiences. Through a literature analysis and other research methods the practicum investigates the following questions:

1. Using biophilic design principals, how can nature enhance well-being at the end-of-life?
2. How can liminality, as a contemporary death ritual, support the dignified transition from life to death?
3. How can hygge be applied as a design concept to enhance social togetherness and well -being at end-of-life?

1.7 Project Charter

The following charter outlines the non-negotiable values of the practicum project. These values are essential to the final design outcome and are key in representing how interior spaces that deal with end-of-life care have the ability to influence the degree of wellness felt by terminally ill patients as they transition from life to death. The charter thus references key components of the design that must not be compromised in order to assure the best design possible for all users.

- Connection to the natural environment
- Enhanced well-being for all users
- Enhanced quality of death for terminally ill patients
- Accessibility through barrier free design

- Sustainability through green building practices, including those outlined by LEED green building rating system

- Environments that support contemporary death rituals as they occur within the bounds of MAID

- Recognition of the hospice facility under a new typology, as an in-between space of medical and ritualistic experiences

1.8 Limitations of Practicum project

The following is a list of limitations concerning my practicum project, which are addressed within my practicum programming and design:

- MAID legalities with the confusion of terminologies (refer to section 1.2 in Chapter 1)

- Hospice model will serve only a particular population of MAID users and their providers

- The building does not currently exist on the chosen site

- Transfer is not the best viable option for vulnerable patients

1.9 Key Terms

CAMAP – Canadian Association of MAID Assessors and Providers. An association of physicians, nurse practitioners and all professionals involved with MAID. This includes nurses, pharmacists, speech language specialists, administrators, law makers, lawyers, social works, counselors, policy analysts and more.

Collective – in the text this references social groups that are intimate with a terminally ill patient, such as family and friends. On a larger scale a social collective may mean those impacted provincially or nationally with MAID.

EBD – Evidence Based Design. Refers to the process of basing decisions about the built environment on credible research to achieve the best possible outcome. In the text, this term is used in association with studies conducted within healthcare settings to investigate means of developing quality of life and well-being through design.

MAID – acronym for Medical Assistance in Dying. It is a term conceptualized by the Government of Canada to describe a service for terminally ill patients where they can acquire assistance in ending needless suffering through death.

POE – Post Occupancy Evaluation. Refers to an evaluation conducted after the design is actualized in the built world. In terms of healthcare these are issued to investigate how the people experience their space, the issues and what design elements are enhancing productivity and well-being.

WRHA- Winnipeg Regional Health Authority. An organization that provides healthcare and support for the city of Winnipeg, rural municipalities of East and West St. Paul and town of Churchill MB. This organization is referenced in the text in association with their provincial MAID clinical team.

1.10 Chapter Summaries

Chapter 1 - The Introduction

The previous chapter provides a background on the topic of MAID and an overview of the entire practicum project. Chapter 1 sets a foundation for the document by introducing the critical concepts that are explored throughout the following chapters. The Introduction outlines the project topic, current issues and rationale behind this project. Also outlined are the goals and research questions that guide the project. Finally, the building model and site are identified.

Chapter 2 - Literature Review

This chapter has been organized into three sections: (1) liminality, (2) biophilic design and (3) hygge. The first section on liminality identifies the importance of social rituals in transitions of end-of-life experiences. The second section focuses on the benefits of nature within the built environment and how specific design applications can contribute to quality of life and wellbeing. The third section with the concept and research of Hygge is included in this chapter to highlight its application as a design filter influenced by the overlapping ideas of liminality and biophilic design. Therefore it is not an actual theoretical component to this practicum but rather a supplementary influence to the final design.

Chapter 3 - Precedent Studies

The third chapter is a precedent analysis of four existing design projects. Each project analysis is broken down into subsections including: (1) background, (2) concept, (3) programme

characteristics, (4) atmospheric and theoretical characteristics, and (5) conclusion with summary of the project's ideas that are relevant to my practicum project. These sub-sections allow for a thorough analysis of how various elements of each precedent can be applied within my own design. The four chosen precedents are North London Hospice, Bridgepoint Active Healthcare Hospital, Dignitas House and the Sakura Suite in Deer Lodge. North London Hospice and Bridgepoint Active Healthcare were chosen for the way in which they design for user wellness and challenge the ideas of contemporary healthcare models. Finally, Dignitas House and Sakura Suite were selected because they are examples showcasing the limitations of existing assisted death spaces.

Chapter 4 - Programming

The programming chapter sets the foundation for the final design presented in chapter 6. This chapter identifies the hypothetical client for the project and their needs for the proposed design. Next, the programming identifies the users of Communitas House. Proposed timelines for user occupation of the hospice, merges current MAID practice with what the project demands, based on the literature studies and user analysis. Two user profiles are included to strengthen the programme by highlighting the potential rituals that occur before, during and after MAID. The selected user profiles are of Storm Miller and Esther Supernault, both Canadians who went through with a legal assisted death. Furthermore, charts provide organization of primary user needs, functional and aesthetic requirements, and spatial layout.

Chapter 5 - Location Analysis

This chapter identifies the proposed site of the project and an existing architectural model that could be built on it. An analysis of the site illustrates its suitability for the project, investigating site history, nearby amenities, and access to the site. Furthermore there is an analysis of the local climate, neighborhood demographic and overall opportunities and

constraints of the site to the project. The building analysis identifies the reasoning for using the Lakeview Resort and Spa as an architectural template that can be adapted to the chosen site. Finally, the building analysis highlights the buildings history, aesthetic features and structural components.

Chapter 6 - Spatial Concept and Design:

In this chapter is the proposed design of Communitas House that is informed by the research elements of the project. A visual representation of the project is presented through drawings and renderings of floor plans, interior elevations and perspectives. These images illustrate how the overall design is informed by the research presented in preceding chapters.

Conclusion:

The concluding section ties together the research and design of Communitas House. A brief summary of the project is given, the design inquiries are answered and directions for future design implications of the project are identified.

2.0 | Chapter 2 – Literature Review

2.1 Introduction

The following chapter investigates how MAID can be applied within the design of a hospice setting. The hospice has been selected as the environment to achieve these goals as it is the most prominent palliative care typology to explore the hybrid nature of end-of-life experiences. The merging of (1) ritual space, (2) healthcare facility, (3) educational centre and (4) temporary home conclude what the modern hospice for MAID should be. The selected theories demonstrate how quality of life, death, and well-being can appear in a space where end-of-life practices occur and help inform these final experiences. In order to further investigate how these goals will be achieved, the literature review explores the spiritual, psychological, physical and emotional elements that influence human experience within space.

With a focus of MAID as a contemporary death ritual, the chapter begins with the anthropological concept of liminality as a framework informing how design can provide for ritualistic spaces as individuals and collectives manage the transitions between dying, death and beyond. Aspects of social groups, culture, religion, spirituality and customary norms are considered as influences within the bounds of design. Next, the theory of biophilic design is introduced, explaining research showing the positive impact of the natural environments on the built world. From the perspective of healthcare, biophilic principals investigate how design influences the physical, emotional and psychological portions of oneself experience well-being through natural forms and processes.

Applying the theoretical components of liminality and biophilic design, the concept of hygge looks at the impacts of social collectives and natural influences in order to source how well-being and quality of death can form within an end-of-life space. Hygge is applied as a

design filter, as it contains both socio-cultural elements and intrinsic factors contained in nature, both discussed in the previous theories.

2.2 Liminality

2.2.1 Introduction

Stemming from the Latin limen, meaning “threshold”, liminality is an anthropological term coined by Arnold Van Gennep in the early twentieth century (Wels, Waal, Spiegel, and Kamsteeg, 2011). Gennep established the threshold as a “liminal phase”, or middle phase occurring in any ritual process (Wels, Waal, Spiegel, and Kamsteeg, 2011). Within this process, an individual undergoes a transition from one social state to another, marked by three distinct phases: (1) separation, (2) margin (threshold) and (3) aggregation (Turner, 1969). Utilizing Gennep’s concept, Victor Turner (1969) evolved the idea to approach social progress by accounting for the ways in which rituals manage transitions for individuals and collectives. Turner’s approach to the liminal phase was conceptual, being that it could refer to almost everything temporally upending of a prior hierarchy, where reversals of power occur or at least ‘appeared’ to have done so (Wels, Waal, Spiegel, and Kamsteeg, 2011). The perception of power is a key factor in defining MAID as a liminal ritual. While those who are terminally ill ‘appear’ to be socially inferior, they have in fact taken back the power stolen from them by composing their own dignified exit from this world. Thus, the journey of death faced by terminally ill patients describes a liminal transition, both involving and affecting the individual and a collective. The collective most immediate to the individual includes their family, friends and medical staff aiding them through their journey. Affected secondhand is a societal collective, who in the wake of the individual’s death may see social progress and take part in managing the ritualistic evolution surrounding MAID.

2.2.2 A New Death Ritual

Death has always been associated as being a ritual process, where grief is expressed, and life is celebrated. While celebrations tend to uplift the spirit, grief takes a toll on individuals, manifesting itself physically and spiritually, unravelling effects of stress, depression, and anxiety (Doka, 2016). To manage emotions of mourning grieving processes and celebrations of life have often been linked to the funeral experience. Funerals have therapeutic value, as ritualistic memorials help to deal with loss (Doka, 2016). However, as the landscape of end-of-life is evolving, the process of MAID may be a paralleled ritual to that of a funeral. It is a chance to say goodbye to loved ones and to be part of their journey, as the act of dying transitions to death.

Funerals have often been a way in which to bring a scattered collective together, uniting them over the celebration of life. Ritualistic events that may occur during a funeral such as prayers, storytelling, the playing of music, preparation and consumption of meals are also possible for a collective engaging in a medically assisted death. This is where MAID offers a unique opportunity in that it allows these traditional funeral rituals to occur before the individual passes on. Being a hybrid space, Communitas House is designed to incorporate cultural, religious or spiritual rituals in accordance with the patient and their collective. For example, a special meal can be prepared, and favorite music can play in the background. Through advanced preparation, death rituals in Canada are allowed the opportunity to take shape in a way that was not possible before the legalization of MAID.

This is not to say that MAID is a funeral in itself, as a funeral ceremony or memorial service would proceed the individual's death correlating with a burial, cremation or interment. However, it may, in turn, affect the way in which these ceremonies are conceived and unfold in the future. Yet, the dynamic of the ritual changes in a 'funeralistic death,' as the individual is not taken suddenly or passes away in their sleep, amongst other circumstances. Having chosen a time

and a place to proceed with death, loved ones are allowed to take part in this ritual and process the end -of –life journey differently.

Shirley and George Brickenden, a married couple of almost 73 years are at the vanguard of patients and families creating these new rituals around dying in Canada (Grant, 2018). The Brickenden's, having the opportunity to outline the parameters of their joint death, gained the certainty of having a large social collective around them to support their end- of life journey. Over 20 family members, hailing from faraway places such as Vietnam, Norway, Sweden and Scotland were able to attend their finals days in Toronto (Grant, 2018). In the background of the Brickenden's final moments were prayer and an arrangement of Mozart, Bach and Scottish folk songs to fill the room (Grant, 2018). A final, "I love you all," was said by Mr. Brickenden as they smiled at their family surrounding them as they proceeded with "flying away" (Grant, 2018, para.75, para.19); an eloquent label they provided to death. This is the kind of ritual that is only possible when death comes at a previously appointed hour (Grant, 2018). The description of the couple's death provides an interior vignette where loved ones have sufficient space to gather and partake in familiar comforting rituals, such as listening to their favourite musical compositions. Thus, it becomes the requirement of an interior environment for MAID to empathize and support these rituals as they establish roots and strengthen within the Canadian death landscape.

The Brickenden's end-of-life experiences highlight those rituals that may occur before and during the MAID procedure. However, in other cases, the collective's ritual may include caring for the body of their loved one after they have died. Some examples may be washing of the body, prayers and ceremonial customs. These examples show potential to overlap with services undertaken by a funeral director, such as dressing the deceased individual in their best outfit. Thus, the rituals of MAID thus become less like separate stages of end-of-life experiences from admission into a healthcare facility, to comfort care, to death and movement of the body, to

memorial arrangements. Rather, end-of-life spaces dissolve into one another and flow from one moment to the next.

Turner's (1969) work on liminality identifies that transitions are fundamental acts towards shaping temporal and social experience. In the transition of life to death, it is important that family and friends are provided the space and amenities to follow along with a loved one's journey and take part in shaping that temporal experience. The degree to which social progress is marked within the managed environments of MAID will be determined whether death is empowered and not solely in the progress of legalization itself. Through allowing patients and their collectives the ability to adapt to their immediate space and create their own procession of celebrating life and death, like that of a funeral, a quality of death can be found that is not currently recognized in healthcare environments.

2.2.3 Phases of Liminality in the MAID Ritual

Transitions are marked by the liminal period in which stages of ritual occur (Turner, 1969). In this time, the individual or liminal entity enters a state of in-betweeness, where Turner (1969) states they are betwixt or between one realm or the next. Gennep's phases of liminality: (1) separation, (2) margin and (3) aggregation encompass the journey taken by a terminally ill patient in their transition between life and death. The first phase, 'separation', marks the point where the individual becomes detached from an initial fixed point in a social structure marked by social conditions (Turner, 1986). This is the phase where the patient's illness or disability is socially witnessed as a weakness and they no longer have the same status amongst those who are healthy and 'living'. The separation phase marks the first liminal point for the individual as they transition from a state of living to a state of dying. After separation occurs, the individual enters the marginal phase where the characteristics of the ritual subject are ambiguous (Turner, 1969). In this "liminal period" of the transition, the individual passes through a cultural realm that has

few or no attributes of the past or coming future (Turner, 1969). With MAID, this phase introduces the threshold of death where dying has become the individuals past state and what lies beyond is their future state. Finally, in the third phase of liminality, the ritual subject is in a relatively stable state, where the individual is expected to behave in accordance with customary norms (Turner, 1969). This third and final phase is what was previously mentioned as the future state, lying beyond the threshold of death. In accordance with customary norms, the state of 'beyond' has often been called the 'afterlife'; something awaiting individuals upon their death. The following section will further discuss these phases as they occur within the rituals of MAID and analyze how they can be incorporated into the practicum design.

2.2.3.1 Phase 1: Separation

In the ritual of death, the separation phase implies that a terminally ill patient has lost the social status they once maintained as a healthy fully functioning individual. Even though biology explains that dying occurs from the day of birth, it is not socially accepted as so until a significant health event occurs for an individual. In regard to MAID, this could come as a diagnosis of cancer which is the most common medical condition associated with MAID in Manitoba (Government of Canada, 2017). Individuals can experience a loss of their former identity, which may have been defined by their career. Where an individual might have once been 'the engineer', the label shifts, for example, to "the cancer patient".

Reverend Bodhi Be, an interfaith minister dealing with death on daily basis, explains that there is a misconception that dying is something that is happening to you when actually it is something you do (Bodhi, 2017). Yet, in following with contemporary norms of social status, it becomes apparent that at the liminal point of receiving a diagnosis and thus, transferring from a state of health into a state of dying, that an individual becomes 'separated'. This separation phase displays the inferiority society places on dying after an individual's 'coming out' or diagnosis of

illness. Awareness of such inferiority is discussed by Rev. Be (2017, 4:04) as he states that "we live in a culture that does not believe death has any value."

However, the cultural dilemma as stated by Rev. Be is nothing new, especially in the realm of healthcare design. In the transition between life, dying and death, the body's relationship is ambiguous enough, without even considering how terminally ill patients seek empowerment through their immediate built environment. Andrew Levitt (2007) in The Inner Studio discusses how those dying have been hidden away from everyday life and domestic settings, stowed away in clinical facilities, inherently implying a lack of social status. The design implications of this are what Levitt (2007) calls the 'shadow of society,' where everything built is embedded with an unconscious imprint of the designers and their shadows. Levitt's investigations on the human psyche introduce this shadow, moving beyond the physical being to discuss how the whole-self experiences the world (Fig. 1). The circle is used to represent the self being whole, incorporating aspects in the unconscious realm of the mind seen below the line: the body, dreams, and shadow. On the upper level of the circle, the ego represents the conscious aspect of the psyche (Levitt, 2007). Finally, the threshold of awareness is represented by a line from which the unconscious elements travel upward to consciousness through interaction with the natural world (Levitt, 2007).

It is the shadow aspect of the psyche that best interprets conflict between the body and the built environment, through society's lack of concern for those disabled and dying. Levitt (2007) brings attention to the fact that a portion of society has always had a physically challenged demographic, yet accessibility for these citizens through barrier-free design was not incorporated into legislation until the 1970' s. The issue took so long to address because society believed this demographic to be imperfect or substandard and finally, from a design point of view, they did not exist (Levitt, 2007). In regard to liminality, this explains how individuals

arrive at the first liminal point and become detached from society having been segregated through social norms. Issues like barrier-free design and accessibility have become a common language for designers. However, the premise of design typically begins with the consciousness of what a socially standard environment would be. Designers have often created interiors for physically challenged collectives but have not designed with them; considering the world they find to be normal. Those seeking MAID will have various states of physical decline and will, therefore, require their physical environment to enable them rather than further disable.

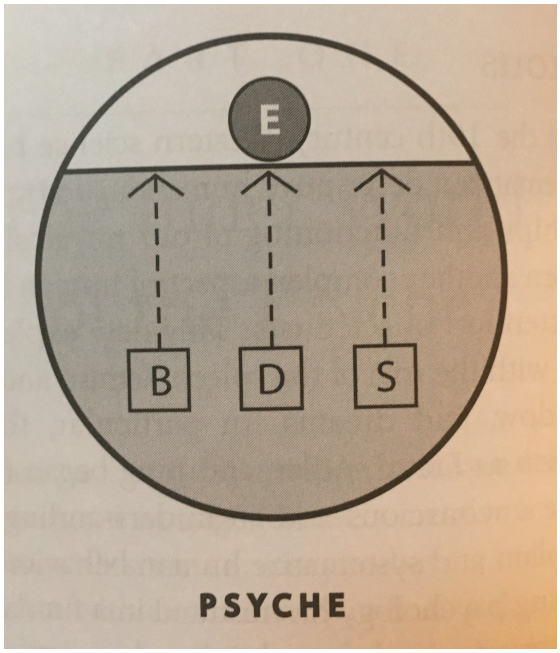


Figure 1 – Levitt's diagram of the human psyche.

Regarding physically challenged collectives, Rev. Be (2017) points out that the elderly are not culturally attractive because they no longer have the skills deemed important in a business society. This observance, however, only highlights the predominant capitalist society, as where other cultures such as North American Aboriginal collectives, mentioned later in the text, hold their elders in higher esteem. The symbolic circle used by Levitt to reflect the psyche also reflects how the segregation phase initiates liminal entities as unattractive beings.

Terminally ill individuals maintain a whole-self and therefore a 'whole circle' throughout all stages of the liminal ritual of death. However, after a diagnosis, the now terminally ill individual is viewed as a broken circle, being less than whole. Now standing outside the socially accepted norm, the terminally ill individual is difficult to relate to and thus forced into liminality.

Beyond the symbolism of the circle, the idea of the threshold is utilized in both Turners and Levitt's work. Turner's use of the threshold describes changes of social state, where Levitt's threshold is marked by a line between unconscious and conscious realms of the psyche. A MAID hospice allows these ambiguous thresholds to occur at the desire of the individual seeking empowerment in their death. It is here that architecture acts as a backdrop to these rituals, supporting practicality and safety, but also satisfying feelings of comfort and emotional sense of belonging for the terminally ill and their loved ones (Levitt, 2007). It is important to utilize these ideas of threshold and wholeness as the terminally ill patient transitions from the societal realm into a sanctuary where they will live out their final days.

Liminality's ambiguous attributes are expressed through a variety of societal symbols ritualizing socio-cultural transitions (Turner, 1969). As society evolves from the experiences of human nature and culture, traditions are being broken down and old symbolic structures have difficulty finding a place within new unprecedented rituals (Thordarson, 1986). Rapid change within Canada's death landscape has come from the acknowledgment of MAID as a legal end-of-life ritual. Increasing globalization matched by the plurality of cultures embedded in Canada offers a unique design challenge for a MAID environment. By way of rapid social change, there has been an observed breakdown in religious beliefs and an introduction of intercultural liminality (Thordarson, 1986). The belief that 'suicide is sin' surrounding 'old' religious doctrine is no longer monopolizing today's societal belief system. In the wake of MAID, this has been proven through its legalization. However, that does not dismiss that there was and, in some

communities still is, great difficulty merging the steadfast beliefs of religion with the ethics of human life. Due to this, traditional religious proceedings often associated with funerals and end-of-life are becoming reinvented in the rituals of MAID. The largest example of this reinvention is observed in the rationale for a MAID facility, through the dismissal of MAID practices in faith-based hospitals.

Nonetheless, end-of-life rituals and death are sacred experiences intertwined with spirituality. To provide for the plurality of cultures and faiths within the multicultural landscape of Manitoba or any part of the world where diversity and MAID intertwine, it is apparent that the facility must be non-denominational. To become a meaningful end-of-life environment the facility should embody death's variety of ritualistic forms by encompassing all types of spiritual, cultural and religious beliefs. The designed interior can offer individuals and their collectives a place that expresses their whole-self and allows them to conduct their ritual of MAID according to their judgement of what a dignified death is. This means allowing for diversified options of end-of-life experiences, whether they occur in the interior or exterior environments. No matter where these sacred experiences occur it is important that they are valued in design, in that where they occur becomes a sacred place. Therefore, not only should the immediate death experiences be emphasized, but also the after-death experiences, meaning that loved ones can return to a sacred place where they are commemorated through design. This will be discussed further in Section 2.2.6.

2.2.3.2 Phase 2: Margin

After the MAID patient is given a lethal drug through intravenous, it will be only moments until they will draw their last breath and pass on. It is at this point that the marginal phase of liminality within MAID will occur. This phase is in itself is a liminal point, where the individual stands at the threshold of life and death. Here, the liminal entity is no longer a part of

the society they once knew nor a part of its future.

Turner (1969, pg.96) reflects on the liminal phenomena as a blend of, “lowliness and sacredness, of homogeneity and comradeship.” In the marginal phase, there emerges a society unstructured from that of the typical hierarchical model that separates individuals in terms of ‘more or less’ (Turner,1969). This unstructured society is labelled by Turner (1969) as communitas, which denotes a communion of equal individuals who submit to the general authority of ritual elders. To further disarray the structure of this liminal period, MAID allows the liminal entity that same authority over the beginnings of their transition. It is after segregation passes to marginality that the ritual elders or collective are to fulfill and carry out the patient’s wishes regarding the ritual.

Use of the Latin term communitas was preferred by Turner (1969) over that of “community” because it distinguished the methods of social relationship from that of a common society. The liminal phase gives “recognition to an essential and generic human bond, without which there could be no society (Turner, 1969, pg.97).” Turner’s reflections on the importance of the communal entity in ritualistic transitions help inform the need for social space within a MAID environment. Communitas during at end-of-life provides equality in recognition of the imbalances which occur during life. Furthermore, Turner (1969, pg.97) states that “Liminality implies that the high could not be high unless the low existed, and he who is high must experience what it is to be low.” Therefore, MAID provides a unique opportunity to surround oneself in the journey of death and give purpose to life by reflecting on the sacredness of human imbalance in this end-of-life ritual.

At the marginal stage of the transition, it is important that the built environment be conducive to various ritual proceedings, which guide the liminal entity to pass into aggregation. Although communitas reflects a generic human bond it also translates over all socio-cultural spheres, thus presenting many ritualistic opportunities. Being, that the facility is to respect the multitude of spiritual beliefs and cultural rituals of Manitobans, it is imperative that the interior reflects that diversity by giving users control over their immediate built environment. The following sections outline some cultural rituals that emphasize this need for environmental control.

2.2.3.2.1 Pipe ceremony. Winnipeg is home to the largest Indigenous population of any major city in Canada ("Winnipeg's Indigenous", 2017). It is, therefore, appropriate to consider and explore first nations cultural rituals surrounding death. A large population of those indigenous peoples in Manitoba are Ojibway. The Ojibway believe that in order to understand death, first, you must embrace the circle of life (Anderson, n.d). They believe that people are spirits having a human experience. The circle of life exemplifies unity and equality between all people as they journey through life. The circle is also called the medicine wheel (Fig.2) and is separated into four equal parts of different colours, symbolizing seasonal changes, earthly elements, times of day and stages of life. For the Ojibway people, there are four stages in the journey of the human spirit that include birth, life, death, and afterlife. In this circle of life are three parts: spirit, mind, and body. The personification of these three divisions of the holistic self is similar to that



Figure 2 - Aboriginal medicine wheel

introduced by Levitt in his writings on the unconscious and conscious aspects of the psyche. Whether by a triad of the circle of life or the two levels of the human psyche the consensus becomes that all persons, especially liminal entities, experience their environments through the perspective of multiple facets.

In the conceptualization of the 'whole-self' or the Ojibway's circle of life, the afterlife phase is very sacred. The pipe ceremony is a symbolic death ritual of the Anishinaabe, including the Ojibway and several other indigenous peoples (Anderson, n.d). Anishnaabe refers to those who are on the 'right path' given to them by Manitou, the Great Spirit. The 'right path' references how an individual's life choices align with the teachings and beliefs of the culture. During the private pipe ceremony, sacred medicines such as sage and sweet grass are burned to purify the dying person and all those present (Anderson, n.d). Family members will also burn food and cloth offerings, with the potential to occur outside a hospital or fire pit at home (Anderson, n.d). While the burning component of the ceremony occurs, prayer also takes place and it is the combination of these two ritualistic elements that help ensure safe passage during the patient's journey.

It is within the separation phase of "liminality" that the patient would pray to the Creator and repent to solidify their relationship. Carrying through from the "separation phase" to the "liminal phase" all pray to the Creator for safe passage of the spirit into the sky world (Anderson, n.d). This ritual becomes important in order for the patient to pass through the threshold of death and complete their liminal transition. The many components of this ceremony, from the sacred fire, to value of privacy and nature, allow the pipe ritual to be an expressive example of how the built environment needs to accommodate cultural death traditions. The use of fire in this death ritual requires sufficient interior ventilation, as well as direct connections to the outdoors such as windows and doors that open up to an exterior ritual space. Finally, the importance of privacy

means creating intimate spaces both inside and out. Adaptable modes of privacy such as blinds or shades for interior ritual settings should be considered.

2.2.3.2.2 Opening a window. Earlier in this chapter (p. 51), George and Shirley Brickenden chose to label their joint death by MAID as "flying away." This is a common phrase provided by Danish people as they associate with their own death or the death of a loved one. It is this idea of the spirit flying away that lends to the practice of opening a window. This special tradition is carried out when a loved one near the end of life (Knapp, 2015) and is practiced throughout many countries. There is reason to believe that this act is linked to a deep-rooted respect and connection to nature that has developed this ritual, or it simply provides a sense of comfort (Knapp, 2015). The gesture of opening a window for "the soul" to pass through once a person has died is a simple act (Knapp, 2015) that is filled with immense spiritual intention.

Regarding the liminal phase, the window has an inherent symbolism of 'threshold' that relates directly to the threshold of death. Patterns of meaning become embodied in such symbols, forming the way people communicate and develop attitudes towards life (Thordarson, 1986) and in turn death. This symbolism of the window suggests that the threshold of death can be managed in the physical world and that the opening of a window has the ability to provide passage of the spirit or soul. This death ritual helps consummate the movement of an individual through the threshold of death, ensuring that the terminally ill patient can enter the afterlife and complete their aggregation phase. In fact, this ritual is often performed by hospice workers and nurses when a patient has recently died in order to 'let the spirit go free' (Roxby, 2012). However, regardless of beliefs in an afterlife, the opening of a window acts as a gesture of not only letting go but also letting in (Knapp, 2015). To open a window is to bring in the fresh air from outside and give promise to the days ahead (Knapp, 2015).

In the liminal phase of the terminally ill's transition, the built environment's response to

the death ritual of ‘flying away’ can be to provide operable windows. Provision of control can allow the collective of a patient peace of mind in that their loved one’s spirit can escape the threshold of death and finally be in a stable state of their transition. Finally, as a secondary effect to this death ritual operable windows adds to the effects of well-being as a way to circulate air and control temperatures as desired.

2.2.3.3 Phase 3: Aggregation

In the final phase of the transition, the liminal entity assumes aggregation and finds solidity in an afterlife of being. In Turner’s (1969, pg.95) terms the passage is consummated and the individual “is expected to behave in accordance with customary norms...” Depending on cultural conventions, religious or spiritual traditions, the afterlife can take many different shapes. Acts of cultural devoutness demonstrate what the Ojibway denoted as the ‘right path’. The expectation is that by following customary norms the deceased individual will enter a sacred space in the afterlife. For example, God’s Kingdom in accordance with Christianity, Valhalla in Nordic traditions. The Ojibway however, use the medicine wheel to demonstrate the infinite life of humanity and that the deceased will spiritually live forever in the natural world. These places are not physical proven, yet are manifested in faith and belief. In the afterlife, the now deceased individual is regarded as being in a stable state by their collective who remain alive, beyond the threshold of death. The final phase is ambiguous but none the less important because it marks the various beliefs of the individual and their collective.

The final phase of liminality marks an end to the transition of the terminally ill individual as they have experienced death. However, although the experience of death is over, for the individuals’ collective their experiences with grief remains. Dr. Kenneth Doka (2016), author of “Grief is a Journey” reveals that grief is not only an emotion but includes physical, behavioral, cognitive, social and spiritual reactions. Individual responses to death and grief are influenced by

religion or sense of spirituality (Doka, 2016). In this final phase of aggregation, the collective will firstly, care for the physical body and secondly, arrange a memorial. These next stages of the ritual will be conducted by the living collected to align with the beliefs and wishes of the deceased. It is through the laying to rest of an individual that the collective can help in their own aggregation of the experience of death. Experiences such as washing the body, putting soil on the grave and storytelling are a few examples that can help collectives find peace and deal with grief. Although the previously mentioned next stages of ritual may take place away from Communitas House that does not diminish the importance of the memorial value of the site itself. Karen Wilson Baptist (2013, 36), a researcher of memorial landscapes, believes that landscapes on which death of a loved one occurred can be a "redemptive medium for the bereaved." Baptist (2013, pg.36) states that between grief, death, and landscape there is a "performative relationship" and therefore commemoration may occur on that specific site. With this in mind, Communitas House's continues an active role in a collectives death journey far after their loved one passes on. Also, since MAID deaths are coordinated to when and where they occur, they are not spatially restricted and therefore there are a myriad of places in which they can occur on the site. For instance, a MAID patient may choose to die sitting by the fire watching the stars at night, alongside the Red River, sitting on their private patio, or within the comforts of their bed or living area. These sites now full of cultural meaning and symbolism (Baptist, 2013, pg.36) have created the opportunity for performative relationships between the bereaved and either the interior and or exterior site.

However, the performative aspect of these spaces does not occur until the bereaved return to visit the site. At this point, they become what Baptist refers to as "reenchanted" (2013, pg.36). To support these reenchanted landscapes Communitas House must not only allow the bereaved of MAID patients to return to the site so that they may commemorate their loved ones and deal

with their grief. Design plays a large role in commemoration, because the construction of a 'thing' such as a " tribute, symbol or topographical feature," can recall the memory of that absent person (Baptist, 2013, pg.36). One example is the 911 memorial, discussed later in Section 2.3, which has commemorated the deceased by inscribing their names in stone, thus reenchanting the geographical location where the deaths occurred. As mentioned previously the deaths occurring at Communitas House will vary spatially on site, however, they still remain within an overall geographical region. For some bereaved, they will be able to revisit the exact site if it occurred on a more public space of the site. However, for those deaths that occurred within suites or private patios of Communitas House, there will be a lack of accessibility for a casual revisiting of the memorial site. Taking this into account, the design of a memorial for Communitas House will not be about creating small tributes for each exact location where a death occurred, but rather focus on a focal element that can be revisited by many. For Communitas House this will confits of a memorial building within the exterior landscape (Chapter 6).

The incorporation of a memorial to the hospice site of offers a casual approach to how the design can benefit the bereaved after MAID occurs. However, another important component to Communitas House is a more constructed guidance of bereaved collectives in this stage of aggregation. As stated earlier by Doka, grief has many reactions, and these can take a toll on the human body. In fact, grief is dangerous to your health and can take on physical manifestations such as headaches, fatigue, chest pains, tightness in the throat or chest, shortness of breath and weakness, amongst many other symptoms (Doka, 2016). In order to guide those in grief, an environment providing the service for those requesting MAID should also facilitate healthcare services for family and friends. Clinical spaces for bereavement and grief counseling can provide users an environment where they can begin to alleviate the negative reactions and symptoms that follow medically assisted death of a loved one. Examples of these spaces will be provided as

therapy rooms in Chapter 6. In turn, the facility can offer facilitators who can provide clinical guidance and recommend strategies to maintain individual health for the physical manifestations of grief. Doka (2016) suggests that massage therapy, aromatherapy, meditation and the simple act of walking in a park or at the beach can help lessen grief's physical burdens. Thus the project site offers an abundance of forest trails and riverside walking experiences that provide this exposure health benefits and overall wellness.

2.3 Biophilic Design

2.3.1 Introduction to Biophilia and the Issues

Biophilia was a term conceived by E. O Wilson (1986) to explain human's innate tendency toward nature. Wilson (1986) believes that this is explained by human biology, accounting for how from birth, people learn to distinguish from the inanimate and are blindly drawn towards nature, focusing on life and lifelike processes within their environments. Stephen Kellert expanded on Wilson's theory of biophilia, developing his own theory that is relevant to design. This theory of biophilic design is utilized by Kellert to explain how elements of nature are necessary incorporations into our built environments. Kellert (2005) believes that interactions with nature are crucial to the well-being of individuals. In environments that concern themselves with terminal illness, creating spaces that promote well-being are important instruments toward finding peace and comfort at end-of-life. Therefore, Kellert's nature-based approach provides a design solution with the potential to strengthen overall wellbeing and enhance the quality of death necessary for individuals residing in a MAID hospice.

Even though humans benefit from direct contact with nature, it has been largely eliminated from the environments where people spend most of their time: inside buildings. Rev. Be (2017) states that somewhere along our evolutionary journey, humans decided themselves to be separate from nature and that this perception has been a detriment to the human psyche.

Modern buildings have an overabundance of steel, glass, and plastics, and simply lack any relationship to the natural environment. Kellert (2008) cautions the danger in the illusion that human progress and civilization is to be measured by our separation from, if not transcendence, from nature. Instead, Kellert (2008) advises that psychological and physical well-being are highly contingent on relationships with the natural world, stressing that they are not a luxury, but rather a necessity, for achieving satisfaction and quality of life in urban society.

According to Kellert (2008, pg.4), Biophilic design is a "new design paradigm," restorative environmental design offers a solution for how the modern built environment can reconcile and harmonize with nature. Through this paradigm, there can be long term support in restoring and enhancing a positive relationship between nature and architecture by what is called biophilic design (Kellert, 2008). The way Kellert's theory is constructed is through separation into two biophilic dimensions, each with six biophilic elements, related to around 70 biophilic design attributes (Table.1) (Kellert, 2008). The first basic dimension of biophilic design is the organic or naturalistic dimension. It is defined through the shapes and forms of any built environment directly, indirectly or symbolically relate to the inherent human connection to nature (Kellert, 2008). Place-based or vernacular dimension is defined as buildings and

landscapes of a local or geographical area that connect to their respective culture and ecology (Kellert, 2008).

Environmental Features	Natural Shapes and Forms	Natural Patterns and Processes
colour water air sunlight plants animals natural materials views and vistas facade greening geology and landscape habitats and ecosystems	botanical motifs tree and columnar supports animal (mainly vertebrate) motifs shells and spirals egg, oval and tubular forms arches, vaults, domes shapes resisting straight lines and right angles simulation of natural features biomorphy and biomimicry geomorphology and fractals hierarchically organized rations and scales	sensory variability information richness age, change and the patina of time growth and efflorescence central focal point bounded spaces patterned wholes linked series and chains integration of parts to wholes complementary contrasts dynamic balance and tension
Light and Space	Place- Based Relationships	Evolved Human-Nature Relationships
natural light filtered and diffused light light and shadow reflected light light pools warm light light as shape and form spaciousness spatial variability space as shape and form spatial harmony inside- outside space	geographic connection to place historic connection to place ecological connection to place cultural connection to place indigenous materials landscape orientation landscape features that define building form landscape ecology integration of culture and ecology spirit of place avoiding placelessness	prospect and refuge order and complexity curiosity and enticement change and metamorphosis security and protection mastery and control affection and attachment attraction and beauty exploration and discovery information and cognition fear and awe reverence and spirituality

Table 1 – Elements and attributes of biophilic design

Ultimately, accepting equality with nature means accepting nature's whole self, in the same way humans want to be regarded as 'whole', should they become terminally ill and seek MAID. The expression 'staying grounded' is quite fitting in this search for balance, especially in a MAID facility where death is embraced as a natural part of life. This expression suggests that if society is to be capable of accepting death, they must be grounded within nature. Similarly, in the previous chapter, the Ojibway believed that to understand death you must embrace life, as it is the very essence of the natural world. Thus, if 'staying grounded' within nature is realized and achieved, then there can be something very poetic in being able to choose one's own death. The design of interior spaces, in conjunction with how they influence social transactions within those

spaces, have the ability to give terminally ill individuals that recognition and acceptance of being whole at their end-of-life.

2.3.2 Dimensions of Well-being

Evidence shows that design has the capability to improve and contribute to patient experiences and their overall outcomes (de Swaan et al., 2006). Recent research, focusing on successfully designed environments through humanistic approaches, is supported by evidence-based design (EBD). Paimio Hospital designed in 1933 by Alvar Aalto demonstrates the foundations for the current field of EBD (Anderson, 2010). Aalto was the first designer to focus on creating a healing environment where human psychological and social needs were addressed (Anderson, 2010), by incorporating nature-based design details such as expansive views of nature and sun balconies ("Nomination," 2005). In the case of MAID, those with grievous and irremediable conditions are not seeking life-altering outcomes of perfect health. When the physical body is beyond saving and pain can only be managed, patients demand the chance to have their own end-of-life experience in an environment healing to the mind and soul. Therefore, Aalto's connection between nature and the psychological and social needs of patients is apt, in regard to the type of well-being trying to be achieved in an end-of-life facility.

Salingaros and Masden, (2008) who research the overlap between nature, neuroscience, and architecture regard the built environment as an externalization of humanity's intrinsic complexity and that this connection plays a role in influencing health and wellbeing. Biophilic design encompasses the social value of human's connection within nature and this can potentially elevate the quality in an end-of-life experience. Kellert's (2005, pg.6) theory of biophilic design supports this important connection by stating, "it confronts such basic considerations as how we think we fit into the natural world and how the relationship between nature and humanity reflects our basic conceptions of what is good, right, fulfilling and just."

Canadians, as a cultural entity are evolving in their views on human ethics and MAID, as 85% support the right to dignity and choice at the end of life ("Groundbreaking Poll," 2017).

In the same way nature can restore the built environment, the built environment can restore human experience. Healing, a term directly linked with healthcare, is no longer solely a 'physical' effect in relation to the wellness of a human being. Healing in its modern capacity incorporates the spiritual, emotional and mental components of human being. Where mind, body, and soul are concerned, it is a connection to nature that is at the basis of human serenity (Kellert, 2005). With respect to MAID, a healing environment consists of a space that eases the end-of-life transition and acknowledges the human entity as a vessel of the three components listed above.

Evidence-based research by Roger Ulrich concluded that poorly designed healthcare environments can considerably add to users' stress levels (Ulrich, 2008). For instance, if environments are noisy, deny privacy or hinder the presence of loved ones this can cause physiological symptoms such as anxiety or sadness and also psychological symptoms like increased heart rate or elevated blood pressure (Ulrich, 2008). Those who occupy healthcare environments will always have an underlying sense of stress because of the uncertain balance between life and death. With MAID, death is expected and therefore is less ambiguous, allowing stress from uncertain health statuses to be reduced. The built environment should not be the instigator of stress in any way and should always look to minimize it.

Salingaros and Masden (2008) recommend as much nature should be brought into the interior as possible and also that the design of the built environment should use geometric qualities found in nature. Much of the research behind these positive connections apply to the field of interior design, rather than architecture for two reasons (Augustin and Wise, 2000; Wise and Leigh Hazzard, 2002). Firstly, interiors are easier to manipulate and secondly, with

environments such as those for healthcare, any differences in human well-being and performance are immediate and significant (Salingaros and Masden, 2008). Ulrich, following in Aalto's footsteps conducted studies in both a lab and real environments, proved that introducing meaningful views of nature in a healthcare setting can alter well-being. A specific study to prove this was done by researching the brain's electrical activity. The findings revealed that within 3-5 minutes of being introduced to nature, there was significant physiological restoration indicated by dramatic changes to blood pressure and heart activity (Ulrich, 1983; Ulrich et al., 1991).

Another source of evidence-based inquiry is post-occupancy evaluations (POE's). These have been completed in healthcare facilities to measure how well the design requirements for enhanced well-being compare to actual building performance. Canada's largest healthcare facility POE's was undertaken for Bridgepoint Active Healthcare on their new Toronto Hospital (Alvaro, Kostovski, Wilkinson and Gardner, 2014). Findings of the study show an increased sense of well-being from both patients and staff within the Bridgepoint Hospital (Alvaro et al., 2014). Based on their findings, the researchers identified a need for meaningful views, access to natural light and physical connections through outdoor destinations (Alvaro and Kostovski, 2014).

Several of the previously mentioned elements, accounted for in this interior-exterior connection, are associated with Kellert's biophilic design attributes, includes: (1) daylight, (2) natural light, (3) views and vistas, (4) plants and (5) transitional spaces. Both the Bridgepoint POE and Ulrich's studies conclude that healthcare interiors must integrate elements of the natural world in order to promote enhanced well-being. In both cases, patients were allowed a direct connection to the exterior environment, whether visually or physically.

Daylight is an important consideration of the interior because it affects the body's melatonin levels, which influence energy and alertness (Ulrich, 2008). Natural light in an

appropriate dosage elicits emotional well-being and fosters restoration (Ulrich, 2008). Lighting quality can be administered through direct experiences to the outdoors or indirectly through windows. Windows have been said to reveal the spirit of place (Frumkin, 2008). They are considered by Kellert (2008) as a transitional attribute in biophilic design and an important passageway. They are similar to bridges or thresholds like doorways and hallways because they provide comfort from access from one space to another (Kellert, 2008). Windows have a dualistic nature, where they provide protection if closed but, if opened, promote restoration (Kaplan 1993, 2001). The ability to switch between these two demands of atmosphere can also influence instorative effects among users. Instorative meaning that due to a particular environment there can be improvements in psychological or physiological functioning (Steg, van den Berg and de Groot, 2012).

Colour is another environmental feature that should be an important consideration in the design of the interior. Natural colours can be sorted into two categories: bright and bold tones and earth tones. Inspiration for these colour types can be found in natural views and those plants within them which inherently symbolize sustenance and security. Kellert (2008) states that people are attracted to bright colourings like those from flowers, rainbows, and sunsets. This is because these colours elicit a sense of invigoration energy; rainbows assembling after a rainstorm reflect a refreshing of nature and newly bloomed flowers in spring reflect renewal of the earth. Earth tones, on the other hand, are soft in character and often produce a sense of calm and serenity to an interior atmosphere. An interior environment dealing with MAID would benefit from applying both of these colour groups. In spaces that seek to invoke a feeling of empowerment for patients, strong bold colours should be used. Other spaces wishing to focus on tranquility and spiritual healing should use earth tones.

2.3.3 Spiritually in Nature

End-of-life journeys are revered as sacred experiences and thus wrestle with spirituality within those environments where it occurs. Patients with a terminal illness who seek MAID know suffering and feel the bodily effects of dying. Yet, spiritual spaces have the capability to rejuvenate the soul as interestingly enough, Salingaros and Masden (2008) state that, "humans feel most alive in their spiritual moments". Humans' attachment to their universe is believed to be equivalent to their attachment to life itself (Salingaros and Masden, 2008). Therefore, sacred spaces are nourishing to whoever occupies them and Salingaros and Masden (2008) believe that this can be explained through the same process underlying of the biophilic dimension.

In spaces of dying, the duty of the built environment becomes to inspire and provide solace (Worpole, 2009). Death experiences are often contemplative because of the uncertainty of life. With MAID, there is decision and organization surrounding end-of-life, yet there is mystery as to what comes after. Mystery is a theological concept that is something sensed to be true and rational but cannot entirely be grasped (Salingaros and Masden, 2008). Therefore, as Salingaros and Masden (2008) state, mystery is not irrational, but inevitable. This holds true especially near end-of-life where the mystery of what lies beyond often eludes us. Reverence and Spirituality is one of Kellert's biophilic design attributes under the element of evolved human nature relationships. Kellert (2008) expresses that designs that connect relation to creation "provoke transcendence and enduring connection that defy the aloneness of a single person isolated in space and time." Through providing spaces for contemplation and reflection to occur, patients and their loved ones can embrace spiritual moments and a sense of mystery to see them through the journey of death.

2.3.3.1 Water. Water, among the most basic of our human needs, provides many services that enhance quality of life, one such example being that it offers a setting for contemplation and

spiritual restoration (Mador, 2008). It is apparent that like our earliest predecessors, humans still share the urgent and instinctive pull towards the water's edge (Simonds, 1961). This is evident by how cities are built upon shores and how real-estate along the water is valued high economically and emotionally. What influences the humanistic bond with water is its strong animistic traits such as motion, change, power and the sounds it composes (Mador, 2008).

Symbolically, water has a strong connection to spirituality in relation to death. An example of water as a spiritual symbol is referenced in Christianity, through the bodily immersion of water where a baptism symbolizes a progression of life, death, and rebirth (Mador, 2008). In Greek mythology, the river Styx symbolizes a boundary of life and death (Mador, 2008). Another example is Viking burials, where alongside their belongings, the dead would be placed on a boat upon a pyre that would be ignited from land by a flaming arrow. The river would then become a vessel for the cremated individual to enter into the afterlife of Valhalla.

In terms of the built environment, an influential example is seen within the 911 Memorial in New York City. Regarded as the largest man-made waterfall ("About the Memorial, n.d), the memorial design showcases a cascade of water that outlines the perimeter of what was once the twin trade towers. The design is described as a visible reminder of the lives taken during the terrorist attack ("About the Memorial, n.d). Surrounding the water is a bronze parapet and inscribed in it are the names of those that deceased during the tragedy ("About the Memorial, n.d). To stand at the edge of the parapet and see the waterfall float to an abyss is to give the visitor a feeling that what lies beyond is inaccessible ("About the Memorial," n.d). Here water is used to express feelings that coincide with death and trigger spiritual reflection for those who visit it. In this same way, a facility for MAID can provide such a venue to reflect and contemplate injustices of life or the finite nature of death. In conclusion, the built environment

can provide the spiritual guidance people seek through the incorporation of biophilic design elements such as water.

2.4 Hygge as a Design Concept

2.4.1 Introduction

Hygge, as mentioned in the introduction to Chapter 2, is meant to serve as a design concept for the project. The concept incorporates significant overlapping and unifying elements from the theories of liminality and biophilic design. These elements will be discussed in depth in this section of the chapter, but ultimately focus on the importance of quality of life and overall wellness that is found within the experiences shared with social collectives while also being in contact with direct, indirect and symbolic components of the natural world. As a design concept, Hygge truly reflects the essence of community, which is where the naming of the hospice itself derives from. At the forefront of end-of-life experiences within Communitas House, Hygge embraces the moment and those who share in it together.

2.4.2 Defining Hygge

Hygge pronounced “hoo-gah” is a Danish term, culturally codified to embrace atmosphere and experiences conducive to a sense of well-being. Meik Wiking (2016), Chief executive officer (CEO) and researcher at the Happiness Research Institute (HRI) describes *hygge* as a term used to express a ‘feeling’ rather than describe a ‘thing’. Therefore, defining hygge is a difficult task as there is a fluidity with feelings, being that they can take shape within many circumstances. The feeling of ‘happiness’ for example, coined within the name of the research institute itself, is often argued to be subjective, leaving little confidence in its measurability. Yet, the HRI maintains its focus on researching and measuring well-being and happiness, prioritizing the goal of supporting quality of life for citizens globally (Wiking 2016). The complexity of these humanistic elements requires focus on different dimensions of life, such

as cognitive, which focuses on life satisfaction; affective, focusing on the emotional dimension and finally; eudaimonic, which analyses meaning and purpose (HRI, n.d). These dimensions do not undermine the complexity or subjectivity of the pursuit of happiness and well-being but embrace them as a phenomenon of life's experiences (HRI, n/a). In relation to interpreting *hygge* and mapping its benefits, the term's defining framework is contained within these experiences through the importance of cultural rituals. Dying and death are important life experiences; phenomenon's bringing individuals together to form a collective, allowing for reflection, contemplation and growth. Although the term's origins are Danish, the 'feeling' of *hygge*, along with its embedded impacts of well-being, happiness and quality of life are understood all over the world. Despite any contextual diversity, the emotional spirit of the term endears three important characteristics that align with the practicum project: (1) social connections, (2) interior atmosphere and (3) nature.

Denmark and Canada share an extreme winter climate that plays a large role in contributing to the importance in quality of interior spaces. An example of the marriage between the interior and exterior is described by one individual, explaining *hygge* as something like "feeling good, drinking and spending 6-7 hours sitting around a table eating and drinking, with subdued light in a nice warm room, and it's cold outside..." (Levinsen, 2012, pg.85). As people spend a majority of their time indoors, interior elements are cultivated to form around the well-being of not only individuals but collective groups. The example above reinforces that the components of *hygge* are (1) interior atmosphere, (2) the natural environment and (3) social interactions. The following sections will analyze these three significant characteristics and demonstrate how they converge and take shape within the context of MAID.

2.4.3 Social Cognition

Social interactions are an important end-of-life experience as part of the death ritual, offering a collective embrace of the emotional and spiritual journey within human mortality. As a contemporary death practice, MAID offers a unique opportunity where death is scheduled and planned, allowing a collective group the chance to say last words and final goodbyes. In these last moments, meaningful and loving words celebrate and bridge the gap between life and death. Conversations about problems and dark days seemingly do not belong in the social context of hygge (Hansen, 1980), nor in the ritual of MAID wherein choosing the structure of one's own death, there is empowerment. This further suggests the socio-cognitive element shared between MAID and hygge, emphasizing that 'bad things cannot happen here now' (Hansen, 1980). This concept flips death from being a grievous and dark part of life to enlightenment; a sacred element of the journey, celebrated as someone finds wellbeing in the acceptance of death and a peaceful transition amongst loved ones.

Wiking (2016, pg.56) describes this impact of the collective by stating that hygge is "…about being with the people we love. A feeling of home. A feeling that we are safe and shielded from the world allowing us to let our guard down." Social relationships are a large part of the happiness individuals experience with hygge, as humans have a basic need to feel connected with others (Wiking, 2016). This instinctual element is a part of human biology and cannot be changed, therefore it provides a meaningful structure to be built off of and supported within the design of a MAID environment. The psyche, discussed earlier in the text symbolizing the holistic self, helps to illuminate the intrinsic connection between the individual and the collective. As the 'happiest country in the world,' Wiking (2016) contributes Denmark's success to its social support system. This idea demonstrates that a collective can provide positive experiences for the psyche by accepting the emotional and mental portions of the body. These

positive practices are essential for end-of-life rituals, as death is often experienced with feelings of sadness and insecurity. Such feelings occur through reflections on life's variables of time, purpose and meaning. Here, life is re-evaluated and the approach becomes that it must not be taken for granted, wasted, or uninhabited without ambition. These elements of the eudaimonic dimension are realized by the individual but supported by the collective.

Despite Denmark's claim to the happiness throne, 123 nations across different socio-cultural regions acknowledged the link between positive feelings and good social relationships in a World Happiness Report survey (Wiking, 2016). Therefore, Hygge may be a Danish principle, but it emphasizes the cognition of social influences that are globally valued. This social cognition component models the way that people mentally construct the situation, suggesting that in order to have hygge, time and place should be forgotten to allow for focus on the here and now (Levinsen, 2012) with those around you. Wiking refers to Canada's version of this as 'hominess.' The emphasis on this mediation of time within the death experience is supported by the following description of hygge: "…to be in a state of pleasant well-being and security with a relaxed frame of mind and an open enjoyment of the immediate situation in all its small pleasures (Hansen, 1980, pg.58)." Within the interior, intimately constructed environments can allow terminally ill patients and their loved ones the privacy to connect with one another and cherish the present moment.

Intimate environments can take shape surrounding the bed of a MAID patient in a private room, sitting around a communal table dining with a loved one for their last meal, or circled around a fire in the open midnight air. It is the proximity of these situations that allow the human body to react to the contact and embrace of others. A kiss to the cheek or holding someone's hand provides an instant wave of calmness and happiness (Wiking, 2016). These points of contact release the neuro-hormone 'oxytocin ', making us feel happy and reducing stress, fear,

and pain (Wiking, 2016). Oxytocin regulates social interaction and can provide us with that 'warm fuzzy feeling' (Badcock and Bleyer, 2017). In fact, psychologists Christopher Badcock and Jennifer Bleyer (2017) believe that oxytocin may be the secret ingredient to hygge in connection to the feeling of coziness and being trusted with others. Whether this phenomenon is accepted as hygge or a chemical reaction in the brain, it is evident that positive social connections and science go hand in hand. In a healthcare environment, both can explain how well-being can be supported through thoughtfully constructed environments encouraging intimacy. The calming feelings occurring from touch are wanted from both patient and their families, as MAID doctor, Ellen Wiebe points out there is usually a discussion of, "Who gets the hand to hold? (House, 2017, 19:49) " Wiebe states that it is almost like choreography to choose the last minute of life (House, 2017). Closely laid out furniture systems, couches or booth eating areas are examples of intimately grouping individuals as they provide for close visual and physical contact. It is this intimacy that allows oxytocin to flow through the body and helps to the connection with one another amidst end-of-life experiences. Hygge's magical ingredient, oxytocin, has also been linked to enhancing spirituality (Badcock and Bleyer, 2017), furthering the concept's befitting position surrounding the end-of-life experience with MAID. To be spiritual is to be grounded in the here and now in life (Bodhi, 2017), as dying is a part of that life experience.

Studies show that when individuals experience social isolation many of the same brain regions become active that are active in the experience of physical pain (Wiking, 2016; Levitt, 2007). It is imperative that in the ritualistic events leading up to and through the process of MAID, that interior spaces encourage communal activities between terminally ill patients and their loved ones. These relationships are considered the most important across all societies (Wiking, 2016), which may seem obvious, but it is crucial that the built environment

demonstrates this social connection between the inner self and the physical body. In the realm of healthcare, there is a need for connections between individuals that share similar hopes and concerns about their well-being (Lincourt, 2002). Therefore, not only is it important to consider the collective of loved ones, but also the collective of terminally ill patients who share comparable experiences in dying. Direct design implications that may influence these social transactions are communal or common areas or wide corridors, where patients can congregate to support one another (Lincourt, 2002).

2.4.4 Interior Atmosphere

In Wiking's (2016), *The Little Book of Hygge*, a hygge manifesto is compiled, naming the elements needed to achieve, or rather *feel it*: atmosphere, presence, pleasure, equality, gratitude, harmony, comfort, truce, togetherness and shelter. Many of these elements, if not all, described by Wiking reflect similar elements that can be achieved and enhanced within the built environment. Such elements as atmosphere, comfort and shelter are arguably the most evident in relation to designed spaces. Shelter describes one of the most basic needs for human survival. This demonstrates evidence to why the Danish believe that the warm, cozy interior becomes more *hyggeligt* (hyyge-like) the colder and more miserable it is outside (Wiking, 2016). The atmosphere again is an easy association with the interior because it describes the aura of space, that instant feeling that is given upon immersion in a built environment. Finally, comfort describes an instinctual human need to feel safe and belonging within one's own environment. The generalized definitions of these elements play into that instantaneous perception of parallel to the interior, but it is elements such as harmony, pleasure, presence, equality, and togetherness that make up the detailed components of a hygge environment. This is not to say that all things hygge are applicable to every situation. For instance, a cozy, dimly lit, open office environment might deter productivity and impede quality work. Yet in the case of an environment for MAID,

this same atmosphere may provide comfort and lend to spiritual moments. Hygge in healthcare encourages design elements that foster social connections, spirituality, living in the moment, and natural influences that all lead to well-being. Examples of such design elements could be contrasting between light and shadow to emphasize moments or application of psychologically impactful colours according to the spatial programme.

However, despite hygge's strong connections to well-being and quality of life, there is criticism and skepticism, as it is observed in North America widely as a 'trend.' One example might be the 'hygge parcel' where one Winnipeg company's recipe to hygge is a box filled with a candle, ceramic mug, air refresh spray, and a good smelling salve. This solution provides objects in order to make an environment feel more hygge but in a disjointed way, unaware of the larger influences of an interior environment.

Another, more well-known example to Winnipeg is the 'Communitas House' warming hut observed annually at The Forks (Fig.3). The hut is built as a section-cut interior of the symbolic Canadian cottage and every inch of the vignette is colored a fluorescent yellow. The design has been explained as "warm and inviting and sheltered from the wind ("Hygge House", 2013, para.2)." However, the openness of the hut, the abundance of objects and the colour itself are not at all reflective of hygge. Nonetheless, what can be said about the shelter is not that the furniture, objects or even atmosphere stand out, but rather that it is the people who inhabit the space that do. Bundled in winter gear, a variance of colorful bodies inhabit the hut and it is within that effect that hygge's social togetherness is grasped; a secondary element to the designs convoluted colourful intentions. Consequently, these examples display an attempt to fashion hygge to the everyday Canadian life, with the best intention of creating wellness, comfort, and togetherness for users. Whether misguided as springboard action from a trend or an attempted

understanding of hygge, the thought has been planted through these hygge elements and only add to quality of space and desire for well-being in the built environment.



Figure 3 - Communitas House warming hut

The symbolism of the traditional cabin or cottage, portrayed by the warming hut (Fig.3), plays a fitting role in the representation of hygge. Components of the cabin, such as a wood stove, wood-paneled surfaces and direct connection to the outdoors are all valued qualities of the hygge interior. Activated by basic senses, the experience of the cabin forces you to live more simply and slowly (Wiking, 2016). The combination and acknowledgement of these senses also describe the importance of phenomenology in design in how they pertain to social constructions of space and place. These social constructions become reality manifested through "fundamentally intersubjective experiences through places, objects and the signifier of things that are meaningful to us in any given moment" (Poldma and Vasilevich, 2013, pg. 104).

Wiking (2016) describes the smells, the sounds and the simplicity of the cabin experience, and these intersubjective experiences providing a closer connection to nature and each other. The key idea here is to account for these connections in design, focusing on the moments that occur in social experiences. Within lived spaces meaning is constructed moment to moment and is typically, "independent of design intention and dependant on intersubjective interactions, shaping the experiences of spaces and places in the moment that we navigate them" (Poldma and Vasilevich, 2013, pg.104). Therefore, it is not only the elements of nature, natural materials, and fire that helps to increase the sense of living in the present moment, but that they are incorporated in a shared experience and thus show an overlap between social cognition and atmosphere.

The rustic attributes of the previous elements also link back to our inherent desire for nature and biological tendencies to familiarize with symbols of perseverance. Pleasure is found in participating in experiences that are vital to human survival (Wiking, 2016). Therefore, gathering around a table with others to break bread and sip wine enhances the social atmosphere because the act of consuming sustenance activates a pleasurable nuance. Again, like oxytocin, this act of experiencing pleasure can be explained within the brain's activity. In the basal forebrain, the *nucleus accumbens* acts as a brain reward system, having a significant role in motivation, pleasure, and reinforcement (Wiking, 2016). When partaking in something, like the act of eating, a chemical substance is released and the signal substance dopamine is activated (Wiking, 2016). As dopamine is transferred from nerve fibers to receptors at different parts of the brain pleasure is experiences (Wiking, 2016).

Material value is important as it activates our emotions through the senses. Wiking (2016) describes the senses as the five dimensions of hygge, with the sixth sense being the 'inner feeling'. Juhani Pallasmaa (2012), in his research on architecture and the bodily senses of sight,

taste, touch, hearing, and smell, describes a need for a tactile environment to uplift the sensory desire of the human spirit. Again, this describes a phenomenological approach to design, where sensorial elements combine to reveal a significant spatial experience that occurs within time and place. Through more natural, tactile materials such as brick, stone, and wood the individual can center themselves in a historical context and more importantly in the present moment (Pallasmaa, 2012). Interior elements of hygge such as natural materials, comforting lighting and fireplace reinforce pleasure and enhance a sense of well-being.

2.4.4.1 Natural materials. Pleasure can be supported by the materiality of the built environment, where comfort plays its part in creating hygge. Fabrics that are cozy and provide elements of comfort, cushion and something to fall into, create a pleasurable experience and the feeling of wellness and security in the moments to come (Wiking, 2016). Design's conveyance of belonging and comfort through materiality can also be experienced through the sense of sight. In *Inner Studio*, Andrew Levitt (2007) expressed how the wood flooring of the Copenhagen airport welcomed him to Denmark, adding an element of surprise and comfort after a long flight. It is the textured feel of this material which makes us feel closer to nature (Wiking, 2016).

2.4.4.2 The Fireplace. A study done at the University of Aarhus reports that the majority of fireplace owners in Denmark argue hygge as the most important reason for having them (Wiking, 2016). Aside from it being the cheapest heating option (Wiking, 2016), the wood burning stove's effect of achieving hygge appears to confirm its importance as an interior element. In fact, fireplaces come in third on the list of things most associated with hygge, where they are succeeded by candles (Wiking, 2016). Fire is a strong symbol of survival in that it provides warmth and is associated with the cooking of food. It is also somewhere where time is spent with close ones to intensify feelings of togetherness (Wiking, 2016) in the moment.

2.4.4.3 Food. Food is considered the major component of ritual, especially during the traditional Christmas in Denmark (Wiking, 2016). Engaging with food is a social activity and sharing in a meal is not unique Denmark as is exemplified in many other cultural traditions. MAID is not a culturally celebrated tradition, but the experiences that occur before and during death are considered a ritual, which can be celebrated. Food becomes part of this ritual in the transitional period before death occurs. As a celebration of life in preparation for death, the gathering of a collective to share in a last meal may be an important part of this contemporary death ritual. Before George and Shirley Brickenden's assisted death, the couple indulged in a 'bon-voyage' dinner, surrounded by more than 20 family members at their daughter's apartment in Toronto (Grant, 2018). Another example of this ritualistic 'last meal' is witnessed through Switzerland's Dignitas, where the patients are encouraged to bring family and friends and even given advice on good restaurants for a final meal (Gentleman, 2009). Amongst others, Jeffery Spector, a patient of Dignitas with spinal cancer did just this, enjoying his last supper amongst family and friends in Zurich (Badshah, 2015). These several examples demonstrate the ritualistic component of food that is deeply ingrained in the concept of hygge. Indulgence and pleasure in sharing in a meal together with the ones you love creates an atmosphere of well-being. At the end-of-life, dying is active but living remains and that is something to be celebrated.

2.4.5 Nature

It is evident that the Danish conceive wood, amongst other natural materials as elements of hygge. The bringing in of nature to the interior is regarded as hygge and this can be anything from animal skins to leaves (Wiking, 2016). An interior is not just about the aesthetics but it is also about how things 'feel' (Wiking, 2016). Touch is a very important element of interior perspectives because it elevates the tactile nature of space. The feeling on a hand running across a stone fireplace, compared to touching a glass table is quite different. What can also be valued in

nature is the inherent decay of the built environment. This is something that can also be paralleled through MAID. Modern society has often discarded elements of nostalgia, such as wear and patina, in fear of what they resemble: death (Levitt, 2007). However, traces of age and patina of materiality can strengthen experiences of interiors, welcoming users through their embodiment of time (Pallasmaa, 2017). Interesting enough, Levitt (2007) believes that due to imperfections of the body, individuals are offered a unique perspective to understand the relationship of the built world to themselves. The nostalgic influence of the vintage is a valued component within the *hyggeligt* interiors (Wiking, 2016). It is accepted that objects hold more than just physical properties, but that they have emotional value and complete a narrative (Wiking 2016).

However, nature's inclusion in the hygge interior is just as important as how it is experienced outside. Therefore, a MAID environment requires the immediate connection to nature in order to achieve hygge and embrace a space of well-being. The following quote by Wiking describes how an environment of hygge can be created outside the context of walls, lending an interesting opportunity to achieving community well-being at end-of-life. Through the experience of nature, all the senses come together to embrace hygge and provide a quality of life, that in turn can provide quality of death.

> One summer I went camping with a group of friends along the Nissan River in Sweden. We were roasting chickens over the fire and they were slowly turning nice and golden. In the fire, you could hear the sizzling of the baking potatoes wrapped in foil. We had paddled a fair distance in the canoes that day, and now the darkness was falling. The fire lit up the trees surrounding our camp with warm colours but, despite the light from the fire, you could still see the stars through the treetops. As we waited for the golden chickens to be ready, we drank whiskey out of coffee mugs. We were silent, tired, happy and it was pure hygge. (Wiking, 2016)

Similarly, the same feelings were perceived on the site chosen for this practicum project. Up above the natural scape and high trees of the park the brightness of the stars is surprising amongst the urban glow. The sereneness of the park at night and the beauty of the lush greenery

during the day clarify the site's appropriateness to the project. The 'feeling' that hygge offers is capitalized by the simplicity and timelessness of nature. Combined with social cognition and interior elements it is evident that a project situated within nature could thrive from the implications of well-being and quality of life embedded in hygge. The evolving death rituals surrounding MAID demonstrate the need for a place to grow and embrace the many circumstances of individuals at the end of life.

2.5 Conclusion

Death is a universal concept, acknowledged in life's procession but is often misunderstood when conceptualizing it within built environments. Design wise, value is always placed on 'quality of life' but not often is value placed on 'quality of death'. MAID deals with the topic of death and design in a new way, where the living are given a chance to invest in their own 'quality of death' by choosing where and when they will experience end-of-life. A hospice for MAID provides a basis for how modern death rituals will unfold and for how design can support good experiences with deaths for terminally ill patients. The strongest component of these death rituals being that MAID is not a solitary ritual, but rather in one of solidarity, with a community of supportive individuals or *communitas*. Communitas House carries communities through the rituals of MAID and aims to act as a place of comfort and wellbeing in and through death.

The issues and concepts explored in this chapter help to establish a potential framework for what a hospice incorporating MAID can become. In supporting the goal to provide individuals with quality of end of life, Communitas House focuses on (1) psychological, (2) emotional, and (3) spiritual aspects of well-being, for terminally ill patients whose bodies can no longer be healed, only pain managed. However, physiological well-being is not dismissed where death occurs, as it manifests from grief, adding stress and anxiety to the experience of patients and their loved ones.

Therefore, all these types of well-being should be promoted for the collective community dealing with a death.

Liminality acknowledges the importance of social collectives in evolving end-of-life rituals such as MAID, where there is a deviation from traditional transitions between dying and death. The liminal transitions of separation, marginalization, and aggregation alter both real-life death experience's as well as those after death. By controlling the actual death experiences, a patient's family and friends are provided with an alternative way to deal with the psychological, emotional, and spiritual aspects of well-being. Cultural, spiritual or religious rituals important to the collective can have a chance to be embraced before the terminally ill individual dies. In turn, these new rituals may provide alternate ways of dealing with after-death experiences and memorial celebrations.

Where liminality explores the social collectives and community, biophilic design explores aspects of well-being through finding harmony with nature. The research on EBD by Ulrich and Aalto and current POE practices show the natural world's positive impacts on healthcare environments. EBD and POE research studies show how nature influences our biological systems positively through meaningful views, increased daylight into the interior and immediate connections to the exterior landscape. The main goal of EBD within healthcare settings is to increase recovery by reducing stress, pain, and depression. A MAID hospice shares these goals of reducing stress and depression ; however, it will never look to completely overcome pain and cure the body, rather simply manage comfort care until death occurs. In terms of MAID, care management means promoting a holistic vision towards well-being that incorporates emotional, spiritual, and psychological components.

It is the concept of hygge that merges both the ideas of biophilic design and liminality through the importance of social interactions and nature-based approaches. The connection between these theories and concept encourage a hybrid design for Communitas House. Hygge, as

a ‘feeling’ that embodies happiness, well-being and quality of life illuminates what could be a successful approach to end-of-life healthcare, especially that which incorporates MAID. This concept best embraces the communal spirit seen in MAID, where death experiences matter greatly and are carefully considered and organized in order to have the best end-of-life possible.

2.5.1 Summary of Hygge-based Design Strategies

The following list describes key design strategies that are important in establishing hygge within Communitas House:

- Provide a variety of sufficient spaces for intimate social gathering of personal communities
- Create inclusive and non-denominational environment for spiritual and cultural rituals
- Utilize nature-based approaches to promote all types of well-being
- Promote a sensory environment through materiality that reinforces comfort and familiarity of space
- A mixture of lighting that allows for functionality but also provides warmth and comfort
- A focus on ‘feeling’ of wellness, coziness and comfort throughout spatial assemblies
- Provide control within immediate environment
- Implementation of LEED design strategies to promote sustainable practices in line with promoting restorative environments

3.0 | Chapter 3 – Precedent Studies



Figure 4 – For Image 09080_149 refer to http://timothysoararchive.co.uk/project/12860

3.1 North London Hospice

Type: Healthcare

Design Team: Allford Hall Monaghan Morris (AHMM)

Client: North London Hospice Charity

Location: 110 Barrowell Green, London, UK

Completion: May 2012

Size: 8072 sq ft with exterior courtyards



Figure 5 – For image refer to http://timothysoararchive.co.uk/project/12860

3.1.1 Background

Located at in the borough of Enfield London, at 110 Barrowell Green, the North London Hospice (Fig 4-5) was completed in May 2012 by the architectural firm, Allford Hall Monaghan Morris (AHMM). The client, North London Hospice Charity (NLHC) had been providing the community with outpatient care and support services for over 20 years and increased demand in palliative care resulted in aspirations for a new facility. The goal of the project was to triple the number of patients, which would still only accommodate for just 38% of those diagnosed with terminal illness in the North London area. The new facility offers free of charge outpatient day services, encouraging individuals to drop in for chats, join in creative therapies, undergo treatments or simply just hang out to provide relief to carers (Swift, 2017).

The new facility is 8072 ft sq. with south and north facing, exterior courtyards. Due to NLHC's corner street location, there is an increase of awareness to the public (Swift, 2017). This awareness is an especially important strategy as it influences a social acknowledgement of the impact that design can have on well-being and quality of life for individuals seeking end-of-life healthcare. Its urban location and visual connection to the public are strong key influences for the design and site selection of Communitas House.

3.1.2 Concept

The intention of NLHC was to provide increased services to a wider community base with palliative care needs, through a beautiful, contemporary, non-clinical environment within urban London (Swift, 2017). Architectural Firm AHMM designed the facility to appear as an oversized house (Fig.4 -6) in order to enhance well-being for users through providing a domestic aesthetic (Swift, 2017). The client's commitment to a non-clinical design can be seen translated through a series of pitched roofs held above beautiful brick walls, with an abundance of exterior glazing to allow for ample daylight to the interior. By incorporating familiar, residential-like

design cues into the initial visual aesthetic of the hospice, traditional impressions of healthcare facilities as being cold and unapproachable can begin to break down. Once this initial impression is altered, the potential to reflect feelings of nurturing and comfort when entering the 'clinical' environment can lead to a sense of well-being.

NLHC was conceived to blur the boundaries between outside and in, through expansive glazing allowing light, airy spaces in the interior (Swift, 2017). This dissolving of boundaries allows for a strong connection to nature, both physically and visually (Swift, 2017). These strategies demonstrate that abundant glazing allows for the natural environment to contribute to and support users' experiences within the interior. Visual connections from the interior to the exterior landscape provide psychological and emotional breaks for patients, grieving family, friends and medical staff. Furthermore, the ability to merge those visual breaks with exit points into the exterior can provide users with further relief from any negative experiences in the interior.



Figure 6 - For image refer to http://timothysoararchive.co.uk/project/12860

3.1.3 Programme Characteristics

Located at a street corner, across from a large green space, North London Hospice is attractively accessible to pedestrians, bicyclists and vehicular traffic. This attention to site selection and inclusivity creates an appealing first impression towards the internal functions of the facility. Upon initial entrance (Fig.7) of the hospice, the drop-off area opens up to the meet and greet (Fig.8), an informal lounge replacing the more traditional 'institutional' reception area ("North London Hospice, 2015). Visitors can then proceed straight ahead to the adult daycare area, therapy areas, or hairdresser. Off to the right of the meet and greet is the café and dining areas (Fig.9-10,12). The water closets are conveniently accessible to the interior entrance and day care area (Fig.11). This ground floor is the most public of the three levels. The vertical spatial arrangement of programmatic elements allows for the first storey to function as the most social and loudest area of the hospice, while acoustics dim and privacy increases as the levels increase. Through locating these areas on the main floor there is accessibility of social and therapeutic services. Connecting all these ground floor spaces is a central exterior courtyard, physically and visibly accessible through full height windows (Fig. 10, 12).

.

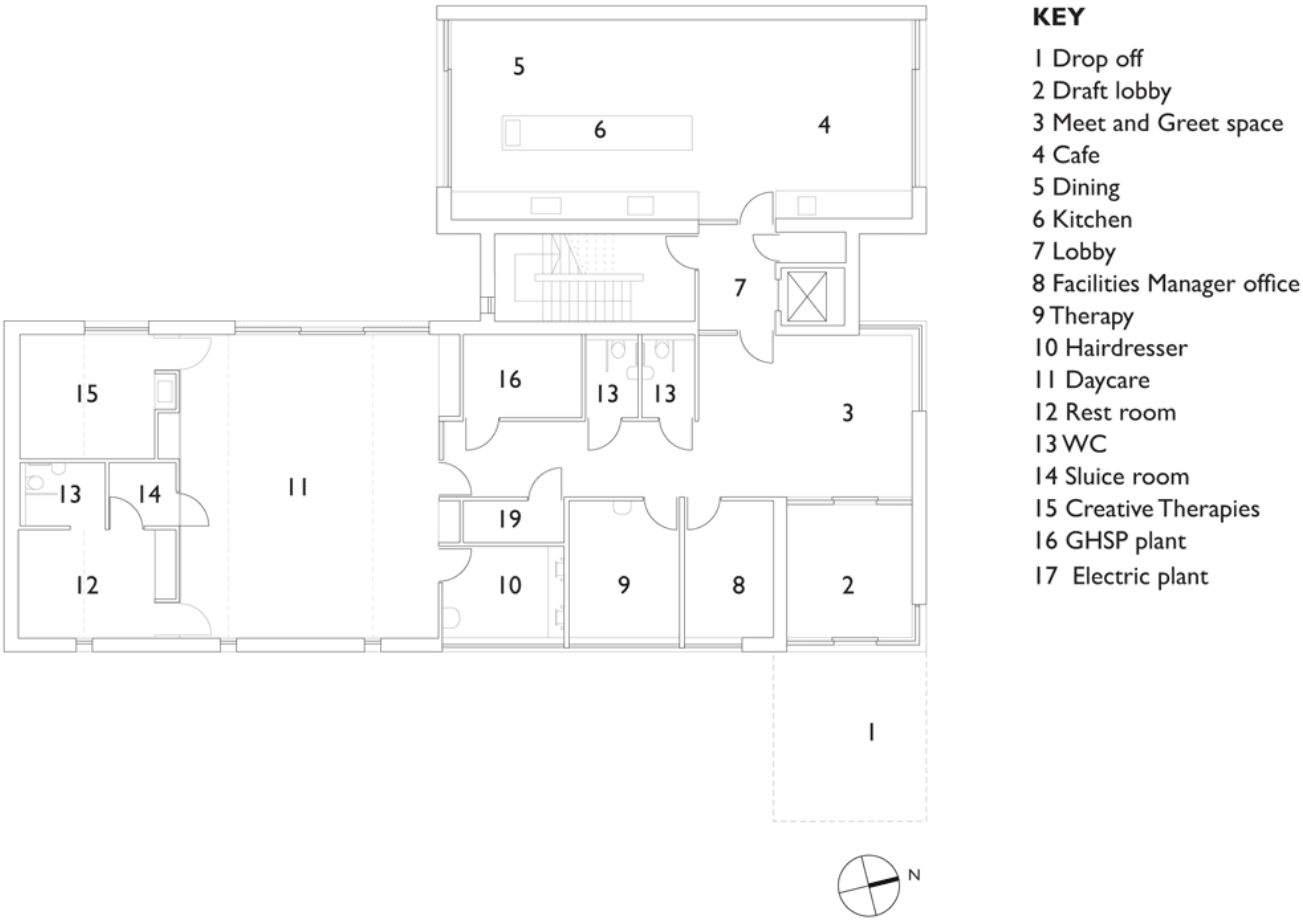


Figure 7 – Ground floor plan of North London Hospice © AHMM



Figure 8 - For image refer to http://timothysoararchive.co.uk/project/12860



Figure 9- For image 09080_133 refer to http://timothysoararchive.co.uk/project/12860



Figure 10 – For image 09080_135 refer to http://timothysoararchive.co.uk/project/12860



Figure 11 – For image 09080_128 refer to http://timothysoararchive.co.uk/project/12860



Figure 12 - For image 09080_168 refer to http://timothysoararchive.co.uk/project/12860

The second storey (Fig.13) is accessible by a centrally located set of stairs and elevator. The second storey provides more clinical areas, such as consultation, therapy, and physiotherapy. Also located here are a few administrative spaces such as a conference and meeting room. Support spaces such as the server room, utility, equipment storage, and cleaner room are located on this level. rather than taking up space on the most accessible ground level. Finally, the third storey (Fig.16) of the hospice is the most private and administrative of all the levels (Fig.14). Located on this level is the staff room (Fig.14-15), bookable office, team office, and water closets.

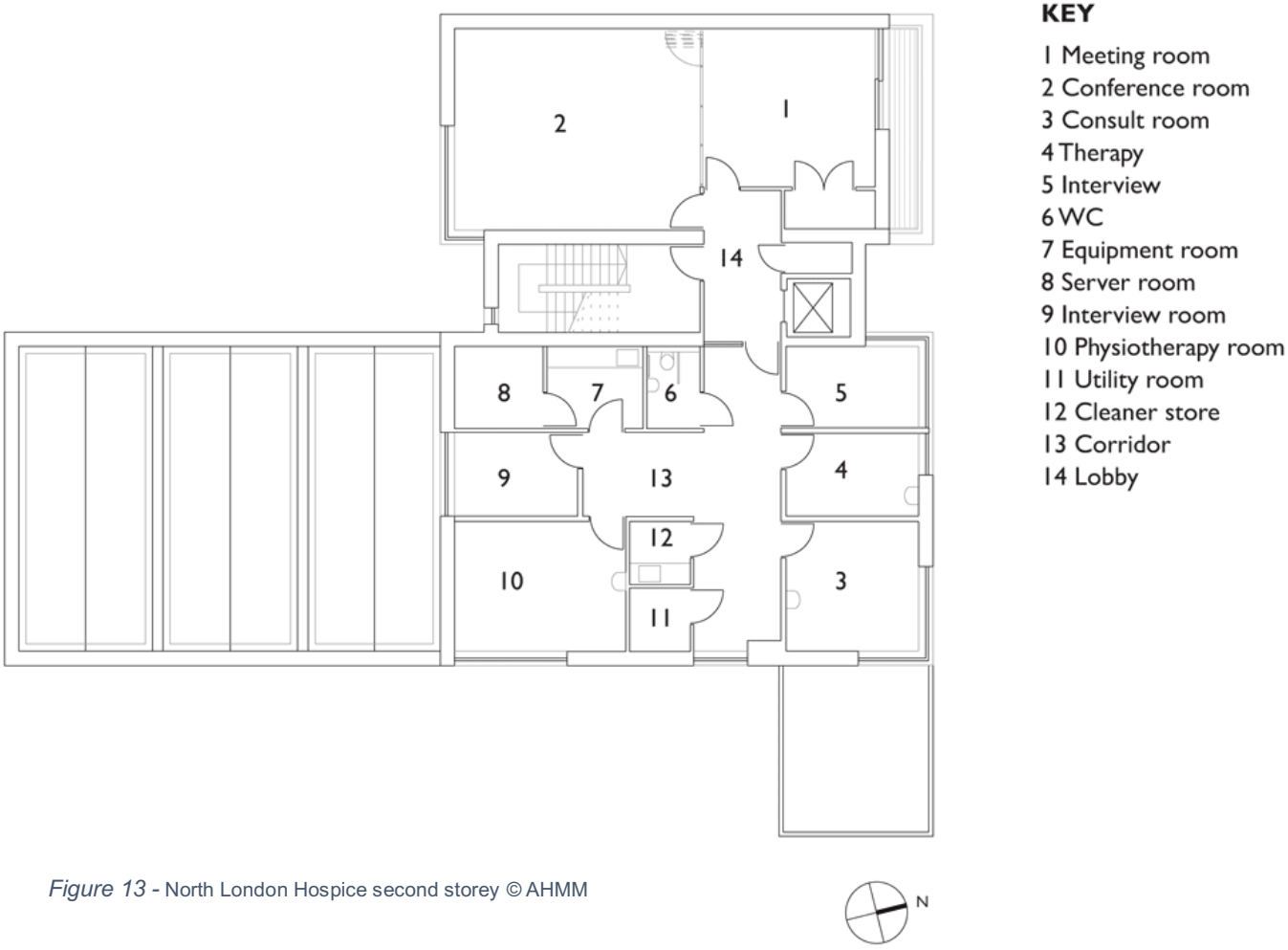


Figure 13 - North London Hospice second storey © AHMM



Figure 14 – For image 09080_137 refer to http://timothysoararchive.co.uk/project/12860



Figure 15 – For image 09080_140 refer to http://timothysoararchive.co.uk/project/12860

3.1.4 Atmospheric and Theoretical Characteristics

The aspiration of AHMM was to divert away from the clinical associations of a palliative care facility, allowing the opportunity for people to feel at home in the space ("North London Hospice," 2015). Monghan (2015, para.4), in an interview with the design blog, Dezeen, discussed how, "Brick, of course has strong associations with the idea of home." The marriage of brick between exterior and interior showcases a strong connection of the building to the existing community and its domestic architecture. While the exterior and structural use of brick (Fig. 4-6) may not universally applicable in regard to perceptions of the domestic setting, in the interior, brick evokes a sense of home in its association with the fireplace or hearth (Fig. 8-9, 11-12). Aesthetic and textural values of brick or stone thus become an important design application to healthcare facilities in order to reflect feelings of coziness, safety and comfort, identified in



Figure 16 - North London Hospice Third Storey © AHMM

conjunction with the domestic interior. These qualities are significant in embracing the concept of hygge as well as reflecting the benefits of including biophilic design principals in healthcare environments.

In order to balance and warm the cool qualities of the brick, wood was another key finishing material used in the design (Fig11). The natural materiality and contextually residential applications of brick and wood allude to a domestic residence of London. In turn, the use of wood dissolved the boundaries between external nature and physically constructed interior. A constant connection to physical nature and textural materials on vertical and horizontal planes can offer feelings of being in a space, supportive of the healing and comforting care of its patients, as well as connect to a sense of place.

Connections to nature are further enhanced through the abundant views to the exterior through large daylighting windows. Large windows and sufficient daylighting, matched with white painted ceilings and walls allow the hospice to feel open and light (Fig. 11, 14-15). Areas on the upper floors are provided with similar spatial experience through atmospheric volumes and skylights (Fig.14). Also, balconies enhance the views of the exterior courtyards and adjacent green spaces of Enfield (Fig.15). Visual and physically approachable connections to nature are programmed into prominent social spaces on the main level such as the meet and greet, café, and dining areas. The seamlessness of interior and exterior allow for a broader more holistic experience, in tune with the intentions of providing quality care for terminally ill patients.

3.1.5 Conclusion

In conclusion, the precedent of North London Hospice is a good example of a modern hospice responding to the goals of an increasing volume of patient care while not undermining the quality of that care. By designing a healthcare facility to have a non-clinical atmosphere, North London Hospice ‘flips the script’ on traditional healthcare strategies, envisioning a space

where patient experience is a core value. This precedent acknowledges that users' quality of life and well-being are important factors in design. By planning for a variety of connections to the outdoors there is a sense of control over and related nature-based experiences and essentially how users can experience their space. In turn, this control allows users to elevate their own quality of life and uphold their own degree of well-being while occupying the hospice.

Programmatic adjacencies and vertical connections allow for common activities, accessible programs and maintaining acoustics in accordance with privacy between patient-care and administration. The multi-level spatial planning of NLHC ensures acoustics and physical separation of community, therapeutics and administrative activities, showing respect for the different user experiences and drawing a line between personal healing and business transactions. This programmatic strategy, in conjunction with design strategies, depicts the non-clinical institution envisioned by NLHC for patients and families.

Materials, volumes, colour, daylight and consistent connection to nature offer up a facility that allows for an increased sense of home contrast to the typical healthcare setting. AHMM's concept of 'home' was predominant in the design, however, these design elements are also notable biophilic strategies used to promote physical, psychological, spiritual and emotional wellness. These design elements that reflect a residential setting, embracing a sense of coziness and comfort are also notable to the concept of hygge. Effectively, North London Hospice grasps that healthcare can strive to embrace the comforts that come from home, the sense of well-being promoted by nature and supportive of the experiences that enhance quality of life and death for terminally ill patients.

3.1.5.1 Relevance to Practicum Project:

The following list provides a succinct list of the key design strategies of NLHC that are relevant to the design of the practicum project:

- Functional and empathetic spatial programme with physical and acoustical separation between administration, therapies and public and private patient areas
- Use of natural materials and direct connection to the exterior
- Site location that allows for accessibility as well as awareness to the public, while having direct connection to natural landscape
- Sense of place created through initial exterior architecture and interior entrance
- Focus on creating a sense of home through familiar materials, furniture and lighting qualities

3.2 Bridgepoint Active Healthcare Hospital

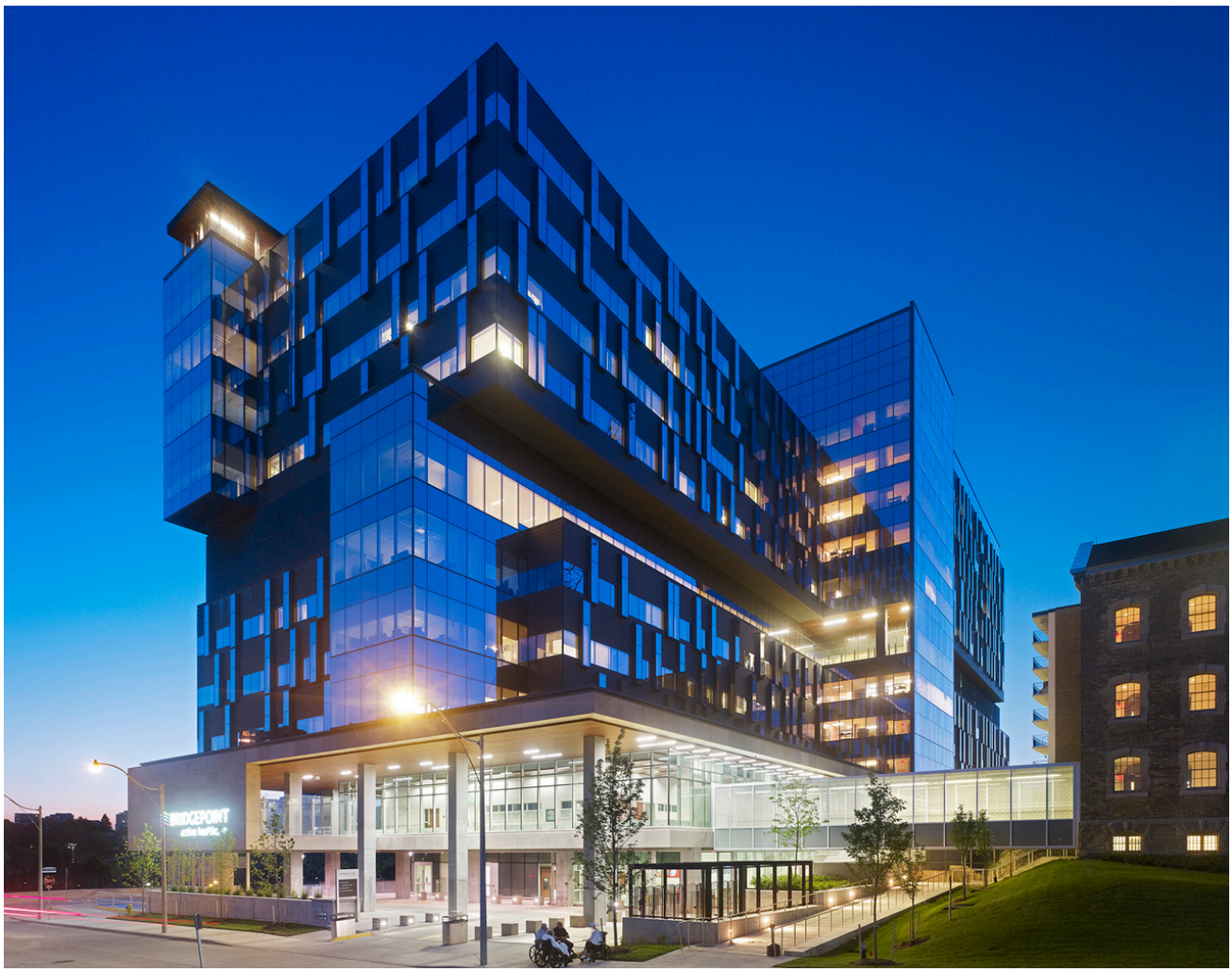


Figure 17 - Exterior of Bridgepoint Active Healthcare Hospital © Tom Arban

Type: Healthcare

Design Team: Stantec, KPMB, HDR and Diamond Schmitt Architects

Client: Bridgepoint Active Healthcare

Location: 114 St.Mattews Rd, Toronto, CA

Completion: 2013 with LEED Silver

Scale: 680,000 square feet, 480 in-patient capacity



Figure 18 - Hospital Entrance © Tom Arban

3.2.1 Background

Built in the 1960' s, the existing Bridgepoint hospital (Fig.17-18) was lacking the amenities to provide the transformative healthcare of today (Stantec, n.d). The goal for the new hospital was to set a standard for chronic disease management and rehabilitation to improve quality of life for people in Toronto with chronic illness (Stantec, n.d). Using nature-based design features, Bridgepoint augments traditional healthcare delivery models in order to provide uplifting patient experiences. Another intention of Bridgepoint, to further the healthcare standards, aimed to emphasize and promote community within the hospital by incorporating a campus model. The hospital incorporates a variety of institutional, educational and commercial based entities that hybridize the program in order to achieve successful patient care.

Bridgepoint Hospital is located on the eastern edge of Toronto's core where it is surrounded by a park, residential area, major highway and a historic jail (Stantec, n.d). The jail,

built much earlier in 1864, was original to the site and also part of the project, as it was to be renovated as an administration space for the hospital (Stantec, n.d). With this portion of the project, it would give the community a chance to access and engage with the history of the original site (Stantec, n.d).

3.2.2 Concept

The leaders of the hospital envisioned a new way to deliver healthcare that would, in turn, create a new kind of hospital ("Bridgepoint Active Healthcare," 2015). The Intent of the design was to blur the boundary between institutional and public access through a hybrid of civic and urban centres ("Bridgepoint Active Healthcare," 2015). The concept of hybrid space highlights a movement in healthcare design that moves beyond simply healing the body. For example, incorporation of food spots, spiritual areas, library space and hair salon emphasis the healing that can occur with self-care and nourishment of body, mind, and spirit (Fig.30). Stantec (n.d, para.2) refers to the hospital as a new "architecture of wellness." In order to achieve this Stantec (n.d) utilized nature as the design concept, for its therapeutic benefits and ability to heal. The result would allow for an inspirational setting to encourage patient recovery ("Bridgepoint Active Healthcare," 2015).

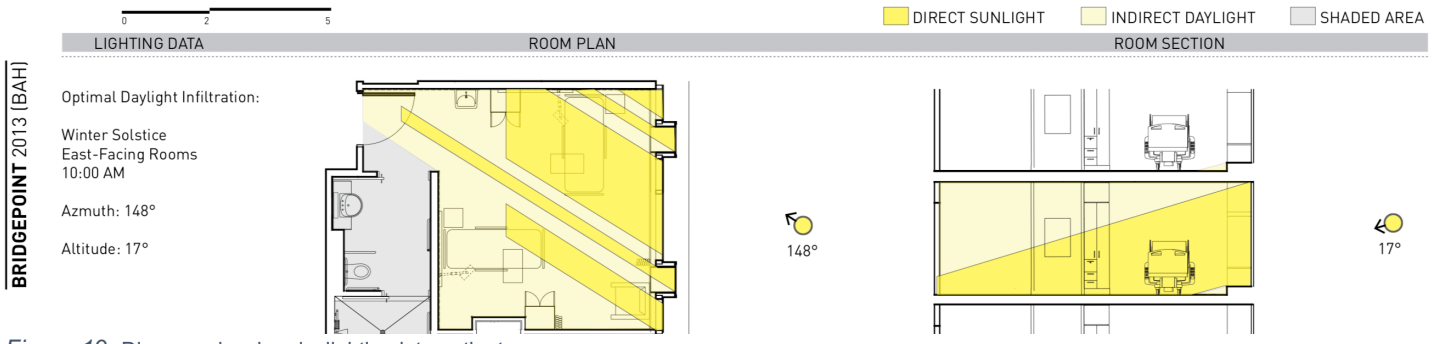


Figure 19- Diagram showing daylighting into patient room

Evidence of biophilic elements and attributes are evident through the design's response to how landscape, nature, and community can play a role in supporting health ("Bridgepoint Active Healthcare," 2015). Some of these elements are the use of natural light (Fig.19), access to nature

(Fig.20) and direct views of the surrounding park and city scenery (Fig.21-22). Designers realized that with a patient's lengthened stay it was beneficial to allow them connection with the outside world and the therapeutic benefits that nature can offer ("Bridgepoint Active Healthcare," 2015).

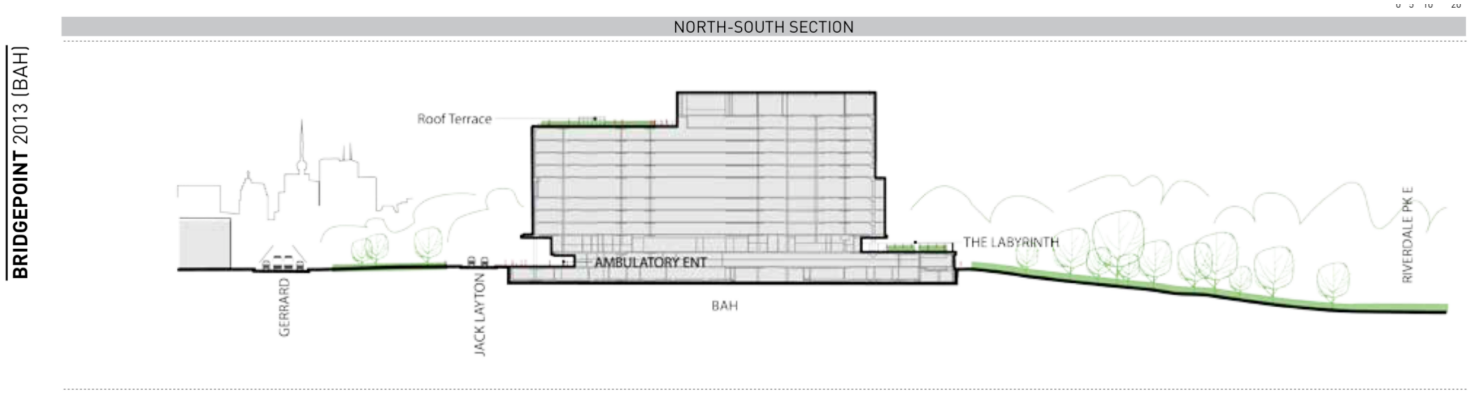


Figure 20 - Diagram showing adjacent green/ social spaces - South and North

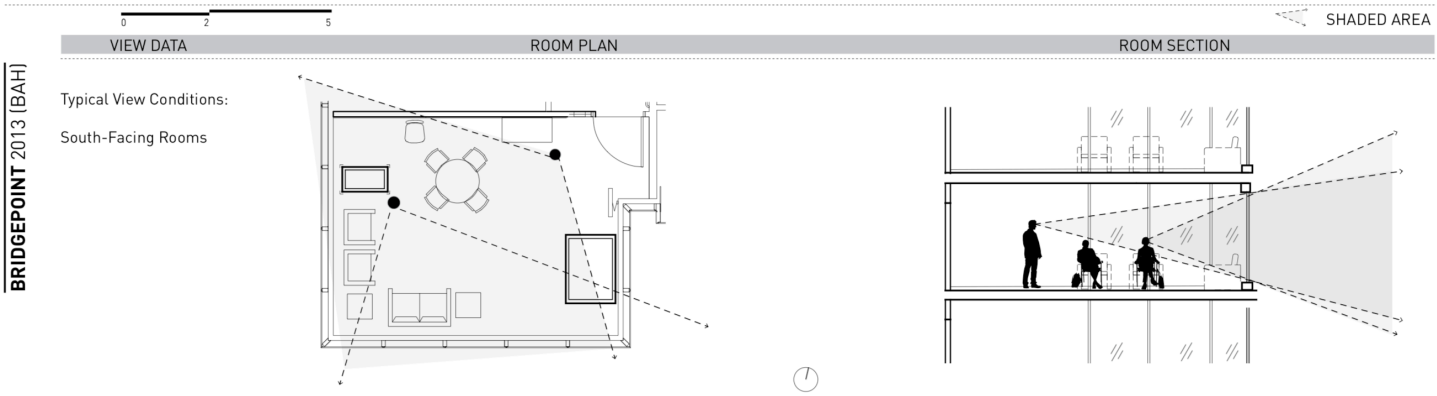


Figure 21 – Diagram showing meaningful views from interior patient lounge

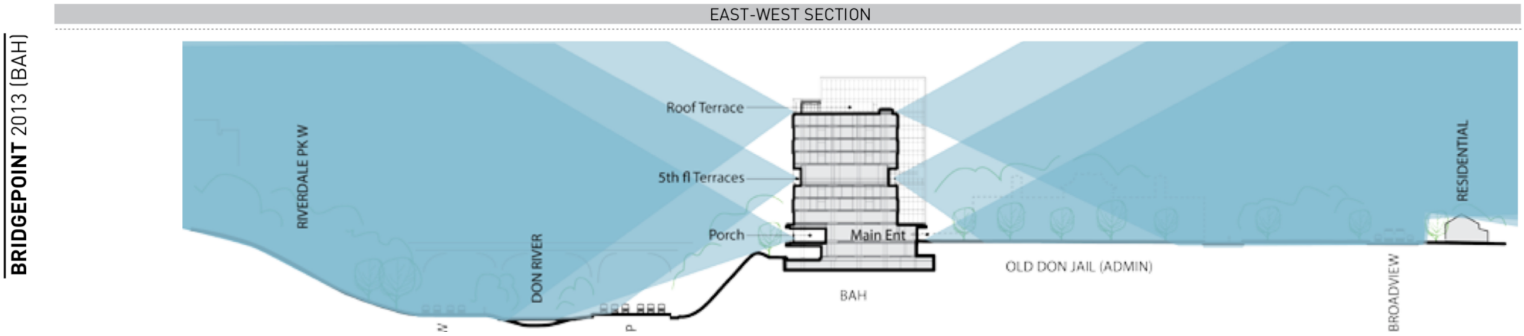


Figure 22 - Diagram showing meaningful views from outdoor social spaces- East and West

3.1.3 Programme Characteristics

The design implemented a vertical campus concept, by grouping patient units together with nursing stations, creating a 'neighborhood' effect ("Bridgepoint Active Healthcare," 2015). On every floor are centralized therapy spaces and adjacent common areas ("Bridgepoint Active Healthcare," 2015). Centralizing these activities allows patients and visitors to gather in a communal area (Fig.23), thus reinforcing the campus concept, as well as the integration of community within healthcare. The hospital has an abundance of windows that allow for every patient to have a view (Fig 24-25) ("Bridgepoint Active Healthcare," 2015) allowing connection to the world outside.

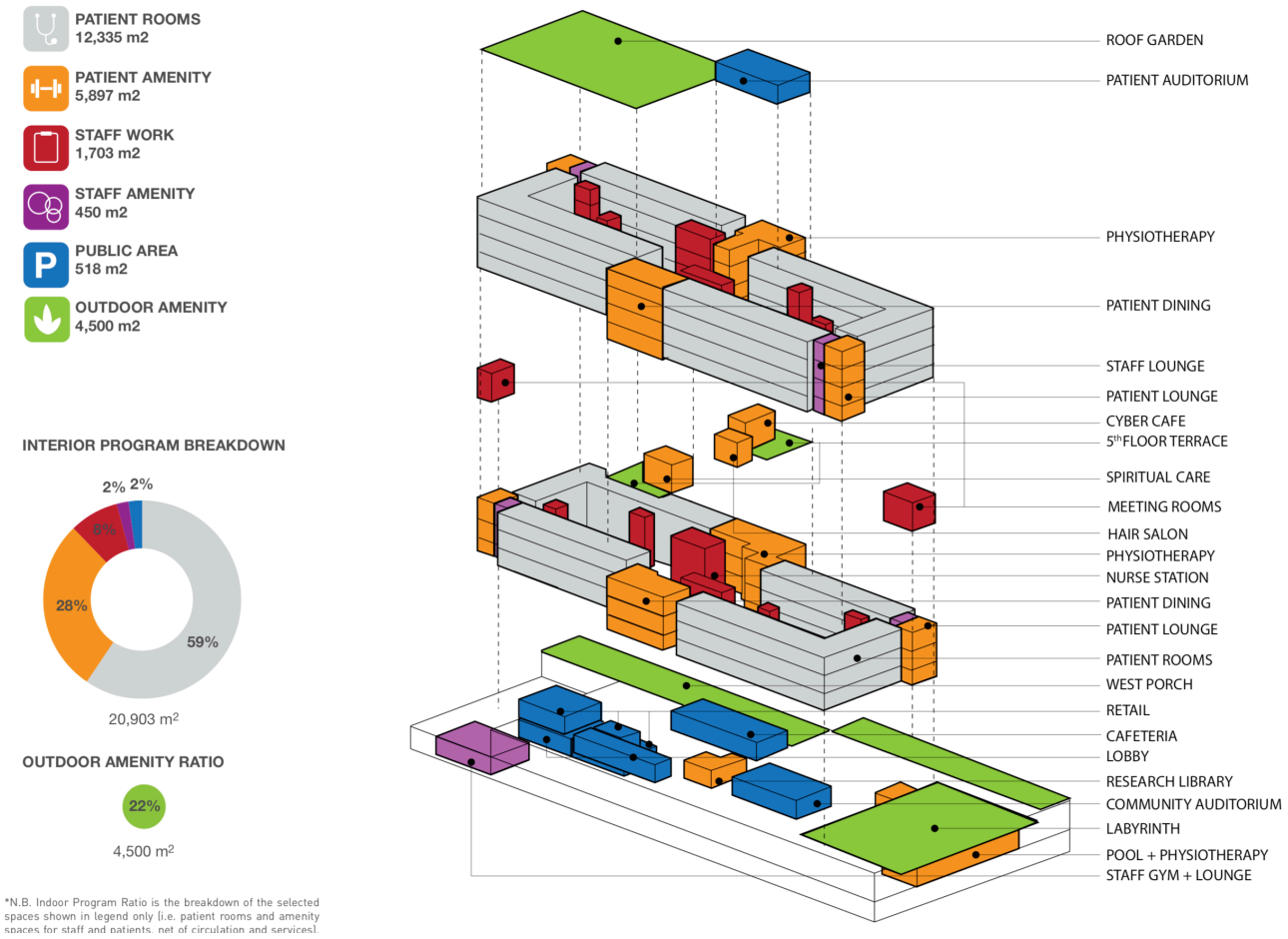


Figure 23 - Axonometric view of interior program elements at Bridgepoint Active Healthcare



Figure 24- Patient room with view © Tom Arban



Figure 25 - Corner patient room with view © Tom Arban



Figure 26 - Therapy pool © Tom Arban



Figure 27 - Labyrinth courtyard © Tom Arban

Aside from the clinical areas of the hospital, there are spaces that serve to educate and community. Interior spaces such as the café, library, and auditorium focus on other elements of wellness rather than the traditional 'medicinal' approach. These engage well-being through physical exercise (Fig.26), social transactions and nourishment of the body and mind. Exterior spaces such as the labyrinth courtyard (Fig.27) offer a space to meditation outside the more clinical environment of the interior. Plants, flowers, and seating also provide for a sense of wellness and chances to reflect alone or gather and socialize in a calm environment.

Patients

Perception of Improvement

Compared to one year ago, how would you rate...

1 Much worse	2 Somewhat worse	3 About the same	4 Somewhat better	5 Much better

	Site	Pretest		Postest	
		n	M	n	M
Overall Health	Bridgepoint	91	2.79_{a1}	100	2.85_{a1}
	West Park	55	2.82_{a1}	61	2.49_{a1}
Physical Health	Bridgepoint	91	2.54_{a1}	100	2.63_{a1}
	West Park	55	2.80_{a1}	61	2.44_{a1}
Mental Health	Bridgepoint	90	2.98_{a1}	98	$\mathbf{3.30_{b1*}}$
	West Park	55	3.15_{a1}	61	2.98_{a1*}
Social Health	Bridgepoint	91	3.65_{a1}	98	3.60_{a1}
	West Park	54	3.57_{a1}	61	3.77_{a1}
Financial Health	Bridgepoint	90	2.89_{a1}	99	2.87_{a1}
	West Park	55	2.73_{a1}	61	2.67_{a1}
TOTAL	Bridgepoint	90	2.96_{a1}	97	3.04_{a1}
	West Park	54	2.99_{a1}	61	2.87_{a1}

Note. Within rows, means with different subscript letters are significantly different at $p \leq .05$. Within columns, means with different subscript numbers are significantly different at $p \leq .05$. Post hoc paired comparisons based on Fisher's LSD. 1*, $p = .057$

Table 2- Table showing mental health was the largest to increase after the renovation of Bridgepoint

3.1.3 Atmospheric and Theoretical Characteristics

Pre and Post Renovation Evaluation of Bridgepoint revealed positive changes to typical user experience through documented impressions. Patient perception of mental health increased after the renovation of the facility (Table 2). Improvements were seen in the areas of wellness, safety, comfort, and cheerfulness (Table 3). Users also felt an increased sense of belonging within the facility and this extended to a larger context where they experienced a feeling a part of nature and the city itself.

Patient and Staff Impressions of the Hospital Design

			Bridgepoint		West Park	
			Pretest	Posttest	Pretest	Posttest
Wellness	Patient	*n*	94	109	64	66
		M	5.82$_{a1}$	**7.57**$_{b1}$	7.39$_{a2}$	7.17$_{a1}$
	Staff	*n*	122	194	139	183
		M	5.42$_{a1}$	**7.59**$_{b1}$	6.53$_{a2}$	6.33$_{a2}$
Part of the neighborhood	Patient	*n*	93	108	64	66
		M	5.17$_{a1}$	5.83$_{a1}$	5.88$_{a1}$	5.42$_{a1}$
	Staff	*n*	122	194	142	183
		M	6.42$_{a1}$	**7.20**$_{b1}$	**6.18**$_{a1}$	5.57$_{b2}$
Part of nature	Patient	*n*	93	108	64	66
		M	6.32$_{a1}$	**7.81**$_{b1}$	8.02$_{a2}$	7.82$_{a1}$
	Staff	*n*	122	194	142	182
		M	6.87$_{a1}$	**7.94**$_{b1}$	8.07$_{a2}$	7.64$_{a1}$
Part of city	Patient	*n*	93	109	63	66
		M	6.03$_{a1}$	**8.00**$_{b1}$	5.30$_{a2}$	5.77$_{a2}$
	Staff	*n*	122	194	141	183
		M	7.05$_{a1}$	**8.15**$_{b1}$	5.16$_{a2}$	4.90$_{a2}$
Safe	Patient	*n*	94	109	64	66
		M	8.03$_{a1}$	**9.21**$_{b1}$	8.84$_{a2}$	9.21$_{a1}$
	Staff	*n*	122	194	142	183
		M	7.08$_{a1}$	**7.89**$_{b1}$	7.11$_{a1}$	6.89$_{a2}$
Opportunities to visit	Patient	*n*	94	109	64	66
		M	7.22$_{a1}$	**8.68**$_{b1}$	8.17$_{a2}$	8.12$_{a1}$
	Staff	*n*	122	193	142	183
		M	**7.38**$_{a1}$	6.47$_{b1}$	7.16$_{a1}$	6.85$_{a1}$
Easy to find your way	Patient	*n*	93	109	64	66
		M	7.29$_{a1}$	7.68$_{a1}$	7.92$_{a1}$	7.98$_{a1}$
	Staff	*n*	122	194	141	183
		M	**7.11**$_{a1}$	6.36$_{b1}$	6.76$_{a1}$	6.30$_{a1}$
Comforting	Patient	*n*	94	109	64	66
		M	6.72$_{a1}$	**8.42**$_{b1}$	7.97$_{a2}$	7.62$_{a2}$
	Staff	*n*	122	194	141	184
		M	5.83$_{a1}$	**7.27**$_{b1}$	6.52$_{a2}$	6.37$_{a2}$
Cheerful	Patient	*n*	94	109	64	66
		M	6.33$_{a1}$	**7.94**$_{b1}$	7.66$_{a2}$	7.53$_{a1}$
	Staff	*n*	122	193	142	184
		M	5.74$_{a1}$	**7.17**$_{b1}$	6.39$_{a2}$	6.18$_{a2}$

Note. 1 to 10 scale, 1 = negative impression and 10 = positive impression. Within rows (i.e., pretest vs. posttest comparisons, separately for each site), means with different subscript letters are significantly different at $p \leq .05$. Within columns (i.e., Bridgepoint vs. West Park comparisons within the same period, separately for each user group), means with different subscript numbers are significantly different at $p \leq .05$. Post hoc paired comparisons based on Fisher's LSD.

Table 3 - Chart showing patient and staff impressions of Bridgepoint before and after the changes to design.

Although the architects do not say they incorporated biophilic design principals, it is very apparent that they play a large role in the design of the hospital. Biophilic design elements play an important role in the success of users' experiences and increased sense of mental health in the hospital. Some of these elements include: natural daylighting, courtyards, natural materials and interior connections to exterior views. Use of natural materials in the hospital's interior adds a warmth and welcoming spirit in contrast to its light white surfaces that are used to increase daylighting effects. The abundance of natural lighting and the wood finishes and helps to mitigate the coolness. In large double volume areas such as the entrance and stairways, the use of wood on the ceilings helps ground the user and not overwhelm them as they move between exterior- interior thresholds (Fig.18). Window blinds give users control over natural light and views. Existing brick (Fig.28) was incorporated into the new design connecting the user to nature and its inherent sense of time and endurance. The tactile nature from the patina of the exposed brick tells a story about the history of the hospital and allows users to make sense of their place in time.



Figure 28 - Seminar room © Tom Arban

A colour scheme of blue and green is seen in the furniture selections as well as tile work of the therapy pool (Fig.24-26). These colours reflect the elements of nature surrounding the hospital such as the park and sky. These cool colours enhance a sense of calm and peacefulness in the clinical areas of the hospital. The intent for nature to enhance well-being and encourage healing is evident through the use of materials spatial attributes. Also, the hybrid of healthcare and community plays out through centralized gathering spaces and exterior environments.



Figure 29 - Open staircase © Tom Arban

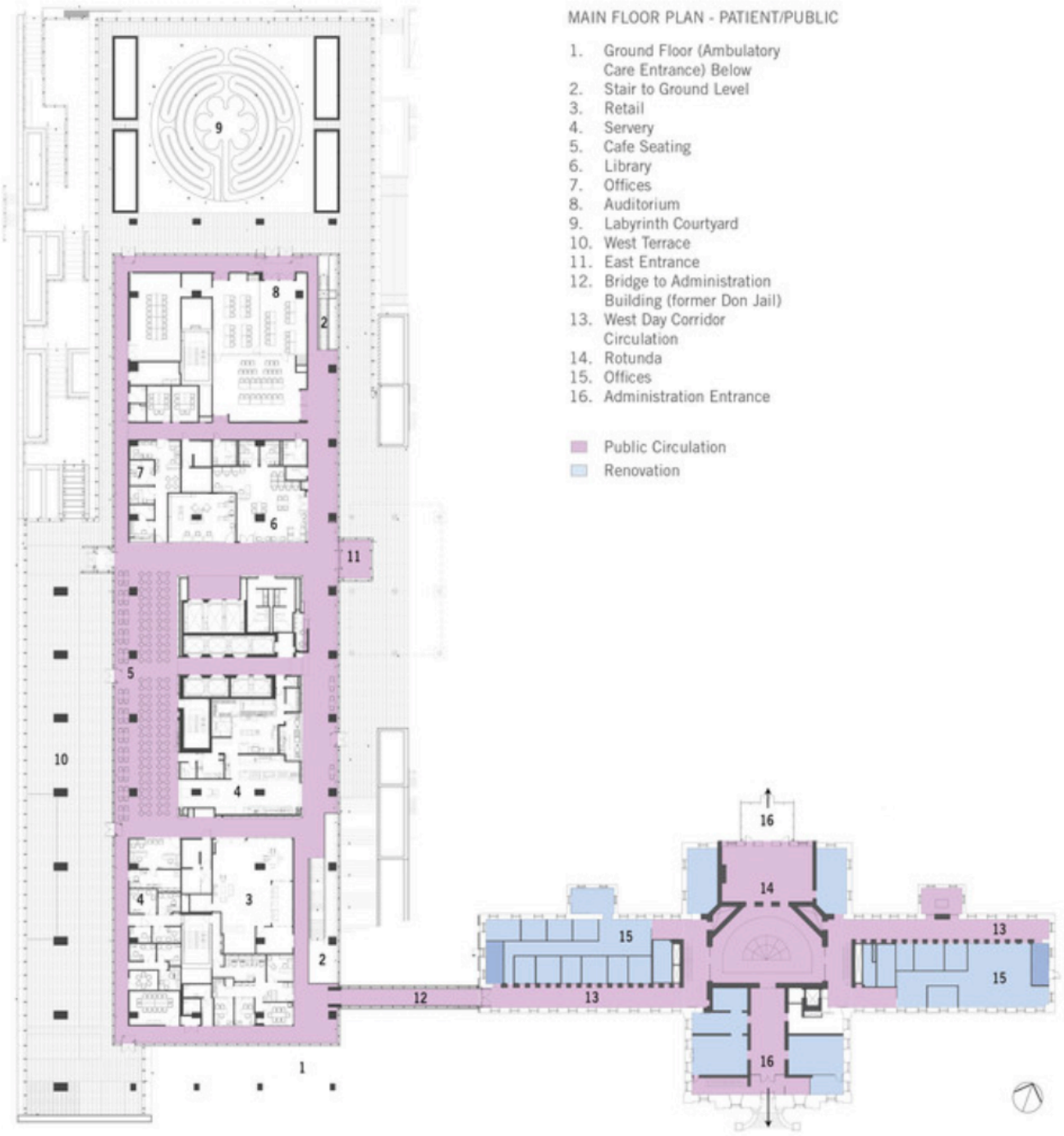


Figure 30 – Main floor plan

3.2.4 Conclusion

Bridgepoint's incorporation of natural elements into the design is reflective of the biophilic design principals that are a theoretical focus of the proposed practicum project. The hospitals POE demonstrates that inclusion of natural elements in a design can increase wellbeing, feelings of comfort and safety and overall generate better mental health among patients. Bridgepoint demonstrates that barriers between interior and exterior environments are unnecessary in order for healthcare to succeed and patients to heal. Immediate and indirect contact with nature provides for meaningful views, abundant natural daylight, and connection with the outside world. In turn, this allows patients to feel a part of a larger community that is the city. A sense of community can be experienced with the hospital itself through social spaces, which also introduce nature in some way. Some examples are the labyrinth and café on the outdoor terrace or the pool with its large windows. Overall, Bridgepoint exposes the achievements of nature that enhance wellness, which is essential to a hospice facility for MAID.

3.2.4.1 Relevance to Practicum Project:

The following list provides a succinct list of the key design strategies of NLHC that are relevant to the design of the practicum project:

- Access to meaningful views
- Access to nature
- User control over daylighting and views
- Urban location and park setting
- Use of existing materials with patina that reflects a sense of place and history in time
- labyrinth and exterior courtyards for social transactions and spiritual wellness
- Connectivity of materials between exterior and interior thresholds

- Spatial arrangements and materials that enhance a sense of belonging for users and comfort in the immediate environment

3.3 Sakura Suite – Deer Lodge



Figure 31 - Exterior entrance to Deer Lodge

Type: Healthcare

Design Team of Original Building: IKOY, Smith Carter

Client: Deer Lodge

Location: 2109 Portage Ave. Winnipeg, MB, Canada

Completion: 1987

Size: n/a

3.3.1 Background

Deer Lodge (Fig.31) was initially established as a care facility for World War I veterans. Over the years the lodge has required expansions and renovations but is still considered a veterans hospital to this day. Deer Lodge is a 430-bed facility, divided into departments such as

chronic adult care, veteran personal care, special care dementia, geriatric rehabilitation, neurodegenerative clinic, outpatient veteran post-trauma, movement disorder, and speech pathology. Among these units, the newest addition to the facility is the Sakura suite (Fig.32-33), specifically serving patients who are receiving a medically assisted death. The suite offers a designated space for patients who wish to end their lives, as well as the WRHA clinical team who will conduct the procedure. Currently, all the MAID patients have only resided in the suite for a day. Typically a patient would be transferred in the morning from home or hospital and then undergo the procedure in the afternoon.

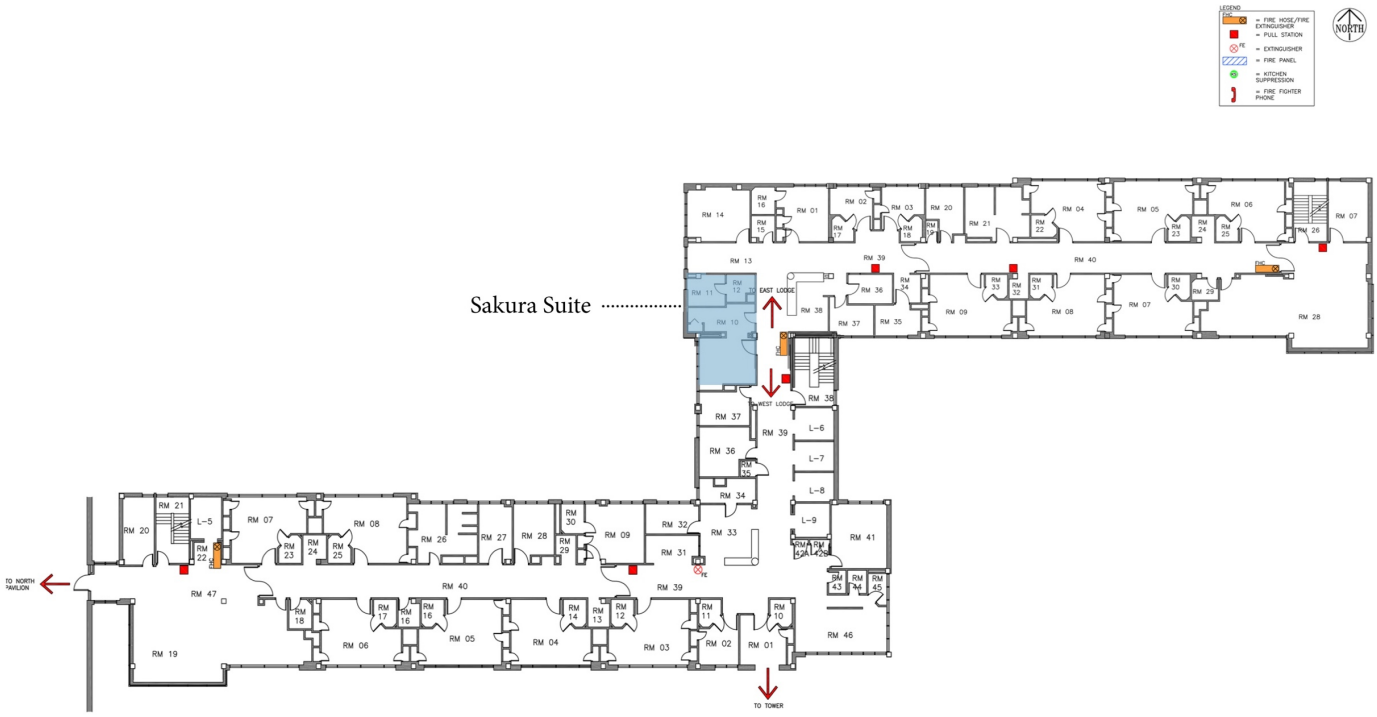


Figure 32 - Location of Sakura Suite in Rehabilitation wing of Second Floor. Floor Plan NTS

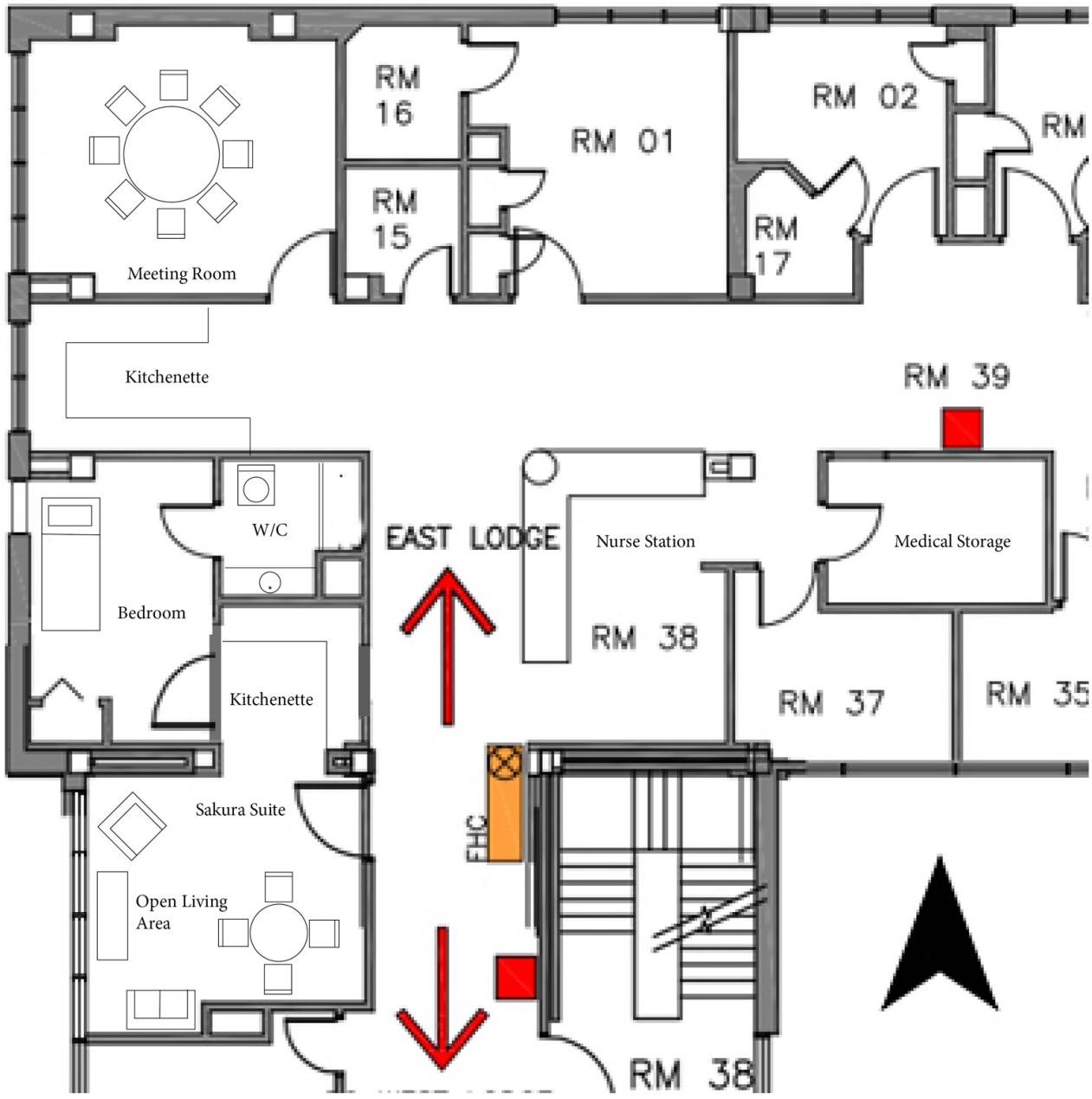


Figure 33 - Sakura Suite layout and adjacent rooms. Floor Plan NTS

3.3.2 Concept

Sakura, also known as ‘cherry blossom’ in Japanese, is the driving concept behind the MAID suite in Deer Lodge. Patients first experience with this design concept implementation is the name ‘Sakura’ on the exterior of the suite door (Fig.34), which is located on the second floor of the rehabilitation department of Deer Lodge. The suite itself has been converted into a larger room from two existing, typical patient rooms. Artwork of cherry blossoms (Fig.35) has been added to personalize the room and add to the general conceptual experience.



Figure 34 - Entry door to Sakura Suite



Figure 35 - Cherry blossom art work inside the Sakura Suite

The design itself shows limitations to the overall quality of experience individuals should experience as they acquire MAID. However, certain details although minimal, show acknowledgement towards the individual and communal needs of the experiences of MAID. Aesthetic and atmospheric needs through artwork have been considered. Functional needs are met through storage space, coat rack, and seating availability (Fig.36). Social needs are met through having a variety of options for sitting, from a more comfortable couch and chair to moveable side chairs.



Figure 36 - Communal area of Sakura Suite

3.3.3 Programme Characteristics

The suite itself is divided into two separate spaces: the living area and the bed area (Fig.36-32). When entering the suite users are greeted by a common area (Fig.36) that hosts table space, lounging space and kitchenette. In a separate room, physically divided by a door, are the bedroom and bathroom areas (Fig.38-41). The separation of areas are supportive of MAID because those who wish to take part in the death may enter the bedroom, while those who are not comfortable with participating can be visible closed off from it.



Figure 37 - Kitchenette in Sakura Suite



Figure 38- View of Sakura Suite bedroom showing patient bed, medical equipment and corner window



Figure 39- View of bed and closet area in patient bedroom



Figure 40 - Accessible washroom inside patient bedroom of Sakura Suite, showing tub assembly



Figure 11 - Accessible washroom inside patient bedroom, showing sink and medical waste storage

Functionality is the main prospect of the bedroom because while small, offers clear floor space for people to gather beside the MAID patient. This being said, the positioning of the bed in the corner is not ideal for 'gathering around', limiting family and friends from being able to support the patient from both sides (Fig.38-39). It appears that this placement of the bed was influenced by the positioning of the window and although small lets in daylight and connection to nature. However, the window does not truly support meaningful views because of the patient's positioning. Rather the window is more ideal for a few standing members of the patients collective. Also, although the window is operable and therefore has the potential to support spiritual needs and physical ones, it is not accessible due to the placement of the bed.
Overall the simplicity and clinical vibrancy of the Sakura suite bedroom does not sufficiently support the emotional and spiritual needs of MAID. The singular window in the bedroom does elevate these needs slightly, but the size and positioning of it are not preferable.



Figure 42 - Common area showing sitting areas, cabinet, TV, corner coffee cart and view to the outside

Inside the bedroom is access to the washroom (Fig.40-41). Although accessible to the MAID patient, it limits users outside of the bedroom who are not directly participating in the death. Other washrooms can be accessed in the corridor outside of the suite, but this is not ideal in creating an overall experience of the death ritual separate from that of the hospital.

Outside of the bedroom the open concept living area is small but does support the gathering of people. Furniture selected is both comfortable and flexible so that it can be adapted to how a specific collective wants or needs to gather together. The recliner couch and chair (Fig.43) were also considered for their ability to transform into sleeping areas should the patients family need to stay overnight.

The table sitting area supports the WRHA staff who may be preparing documents or the medicine, as well as the patients who may wish to gather around, talk, eat or watch television. Across from the table is a cabinet that hosts the TV. Relocated from another area of the Lodge, the cabinet acts as a storage unit for snacks or users personal belongings. In the corner is another refreshment surface in way of a coffee cart.

Outside of the Sakura Suite, there are other auxiliary spaces that can support the patients and family's end-of-life experience. Several of these have a direct and meaningful view to the outdoors, as well as breakout space for gathering or pause and reflection. The closest of these spaces are the sitting and alternate kitchenette areas adjacent to the suite (Fig.47). On the same second level of the suite, outside of the rehabilitation wing, is Chad's Place: a seating area that reflects a pub -type atmosphere (Fig.45-46). This is one example of a break out space that can facilitate the gathering of people in an informal way with views to the exterior site. On the main level is there is a gift shop, donor wall ,and food vendor and café space (Fig.48) that opens up into an exterior courtyard (Fig.49-50). The courtyard houses several small gardens that are tended by residents, a fountain and green space (Fig.49-50).



Figure 43 - Reclining chair in common area of Sakura Suite



Figure 44 - Sitting area located on same floor of Sakura Suite



Figure 45 - Bar of Chad's Place



Figure 46 - Seating area of Chad's Place



Figure 47 - Communal kitchenette located outside of Sakura Suite



Figure 48 - Deer Lodge café sitting area



Figure 49- Green space and fountain in exterior courtyard



Figure 50 - Exterior courtyard to the cafe area, featuring resident gardens



Figure 51 - View of bath that MAID patients can use before procedure



Figure 52 - View from bath

Another auxiliary space for the MAID experience is the bath area of the rehabilitation floor (Fig.51-52). In one case so far a patient requested to have a final bubble bath and so this area was made available for them to use as per their request. This example shows that while the suite is the main area for MAID, it is important to consider the adjacent spaces that have an effect on the overall experience of the user and how they can tie into patients final wishes. Ultimately, it is the accumulation of these spaces that complete the end-of-life narrative for the MAID patient and their collective.

Aside from the patient and their immediate collective, there is also the program of the staff and MAID clinical team to consider. The staff does function within the interior or the suite, but there are procedures that can be done in adjacent spaces so that there remains a more holistic, less clinical ambiance within the Sakura suite. Alternative spaces, like the meeting room (Fig.53) and medical supply room (Fig.54) offer areas for the staff to consult with one another and prepare the drugs and forms away from primary users of the suite. This behind the scenes work can be helpful for the staff to focus on best healthcare practices while allowing the MAID collective to have privacy in their own end-of-life rituals. These spaces also offer a retreat for staff as they deal with shifting mindsets between clinical work and MAID work.



Figure 53 - Meeting room close to Sakura Suite. Used by staff and WRHA MAID clinical team to meet and prepare



Figure 54 - Medical supply room that can be used for preparation of drugs for MAID team

3.3.4 Atmospheric and Theoretical Characteristics

Patients first experience with Deer Lodge is walking into the double height atrium on the main level and although outdated, is welcoming with a light and airy quality. However, the users next experience before arriving in the suite is coming off the elevator to face a white clinical wall, littered with posters. Since this wall is an important focal point leading up to the coming experiences, it has the potential to overwhelm users and give a sense of unease as they further their way to the suite.

The suites positioning right in the middle of a healthcare area the lodge leaves no physical or acoustical separation between clinic and MAID area. Therefore, the overall atmosphere reflected upon the Sakura Suite experience is one that is cold and clinical. Not only

does this affect the overall experience for MAID users, but is also hard for Lodge staff to switch between two mindsets, programmatically speaking, between rehab and MAID.

Inside the suite, minimal aesthetic revisions have been undertaken for the renovation of the suite. However, the attempt to create an overall concept of the cherry blossom has meant bringing artwork into the rooms, adding a symbolic connection to the natural environment. Furthermore, both main rooms of the living space and bedroom have windows allowing for views to the exterior site. The windows allow natural light into the space and a connection to nature on the site, however, their higher positioning on the wall eliminates accessibility to meaningful views (Fig.42)

It is the suite's overall layout that emits a basic sense of hominess to the space. This feeling is unsupported by the choice in paint colour, flooring and general materiality of the design, which resembles a hospital room. However, the suite differs from the adjacent lodge rooms in that it mimics a residential living space with kitchenette, sitting area, and a small dining table. Small details like the coffee cart, coat rack and wood cabinet are moveable features that were not integrated into the design and reflect pieces that would be found in a home. The input of these features and their lack of integration into the design of the space is due to the scope of the renovation. Despite this, the small details add rather than detract, to the suite's overall attempt to create hominess and appear separate from the rest of Deer Lodge.

Theoretically speaking the design's feeling of comfort and coziness that is reflected in hygge is contained within the open living area of the suite, only through the inclusion of soft seating and intimate floor plan. The overall layout supports the liminal transition of the death ritual but both accounting for social gathering but respecting individuals inclusion or exclusion from the actual death. Biophilic elements that are found in the space are the artwork, symbolic of nature and the windows, providing sufficient natural light and views.

3.3.4 Conclusion

Deer Lodge's Sakura Suite was selected as a precedent for the practicum project because it is the only designed interior specific to MAID in Winnipeg. This precedent is an example of how there is an urgent need for increased quality design for MAID environments. As the only designated interior environment, it limits and control and end-of-life experiences that terminal patients should be provided when they choose or require having a medically assisted death at a healthcare facility.

The precedent is a prime example of how there is difficultly renovating existing spaces within a larger institutional setting. Merging two existing rehabilitation rooms into the current Sakura Suite highlights the mindset of MAID as healthcare experience equal to that of the existing, adjacent medical areas of the lodge. Lack of separation between the MAID suite and the rest of the rehabilitation area creates psychological tension for Deer Lodge Staff, the WRHA clinical team and the MAID patients and their families. Therefore, this precedent helps to support the need for a MAID environment independent of a conventional healthcare institution, where MAID can occur as a death ritual rather than a death procedure.

The healthcare portion of MAID will always remain, due to the involvement of lethal drugs that are administered by a physician or registered nurse practitioner. Having the Sakura Suite in the Deer Lodge makes practical sense in lieu of this, however, it does not address the emotional, psychological and spiritual wellbeing that design should support in death space. Unintentionally, it is the auxiliary spaces of Deer Lodge that have the potential to lend to some of these components of wellbeing. These spaces are the exterior courtyards, garden area, café space, and break out areas.

In conclusion, there are two major take-ways from Sakura Suite that can aid in the design of Communitas House: (1) the use of supportive spaces to enhance the rituals of MAID, (2)

variations in types of gathering spaces, (3) and the suite layout. Supportive space, like those of the exterior courtyards and café area, allow users options of spatial narratives. When users need to pause and reflect, consult, retreat or engage they are able to do so with spatial opportunities differing in programme and atmosphere. In some cases, supportive spaces can act as both individual private spaces and environments to gather. This diversity in programming provides comfort to users in that they can have control over their own spatial narrative. In turn, users also are provided a sense of security in knowing that the design is supportive of their desired experiences. The Sakura Suite acts similarly, providing an open layout with an option to close off the actual death space or open it up for inclusion. Providing sufficient space to gather, with the ability to stay overnight is a strong component of the suite because it allows family and friends to take part and support their loved one through the entire end-of-life ritual. The kitchen area, multiple seating options, and furniture selections have added to the overall goals of the suite. Overall, the suite and the adjacent lodge area provides an emerging, basic model from which Communitas House can learn from and build off of.

3.3.4.1 Relevance to Practicum Project:

The following list provides a succinct list of the key design strategies of NLHC that are relevant to the design of the practicum project:

- Inclusion of kitchenette area and small dining table inside private suite
- Ability to have a spatial retreat inside private suite
- Use of artwork
- Adjacent support space for MAID clinical team for meetings and preparations for medical and document procedure

- Labelling rooms like “Sakura Suite” to enhance a residential feel and lessen the clinical atmosphere
- Variations of supportive spaces outside, but in close proximity of private suites

3.4 Dignitas House



Figure 55 - Front of the Dignitas House

Type: Residential

Design Team: n/a

Client: Dignitas

Location: Pfäffikon, Switzerland

Completion: n/a

Scale: n/a

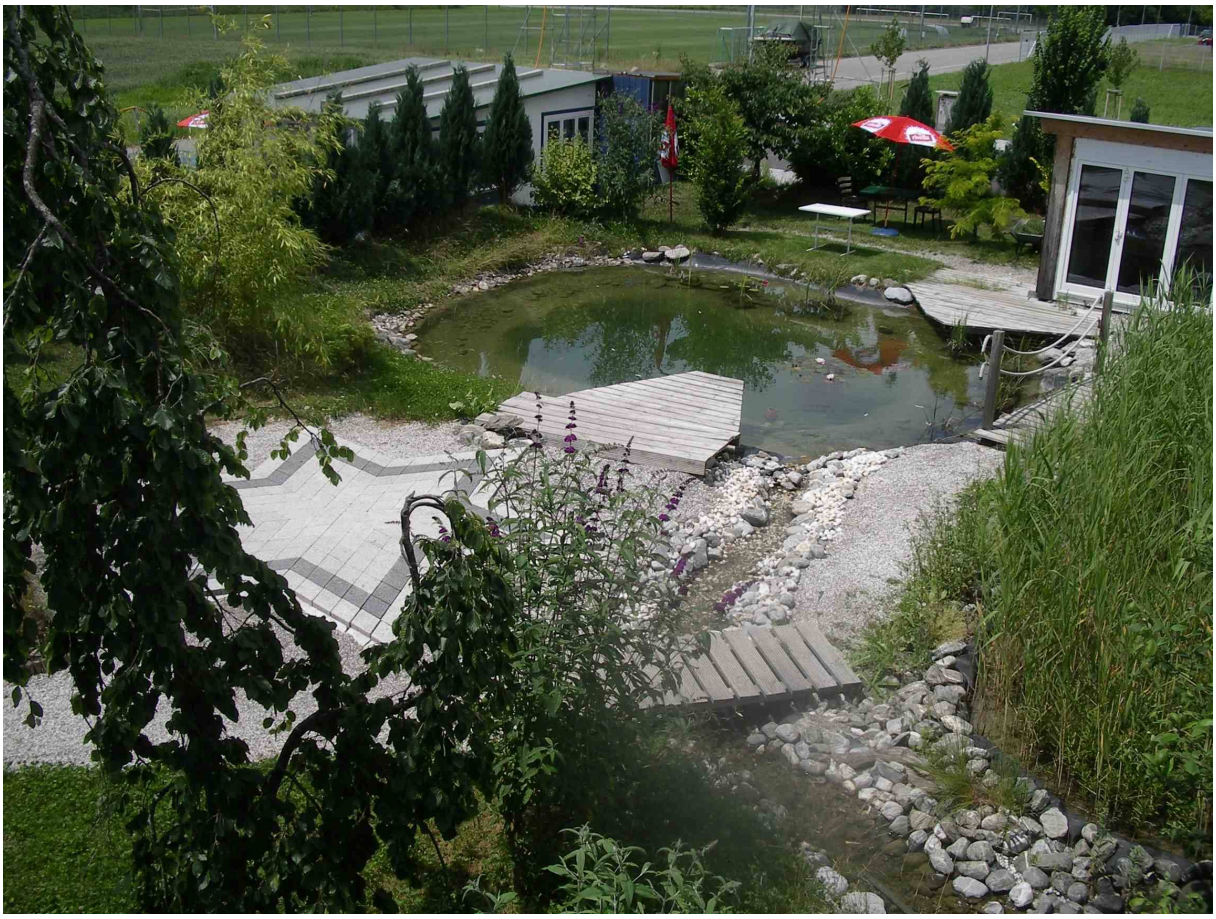


Figure 56- Rest area and pond in front of the house

3.4.1 Background

Dignitas itself is a right-to-die organization founded in 1998 by lawyer Ludwig A. Minelli, at Forch, near Zurich, Switzerland ("Brochure of DIGNITAS", n.d). The Dignitas House (Fig.55) in Pfäffikon, is the most well-known sanctuary for those wishing to be assisted in ending their own lives due to pain and suffering from terminal illnesses. Dignitas is in association with Swiss laws, which states, "Whoever, from selfish motives, induces another person to commit suicide or aids him in it, shall be confined in the penitentiary for not over five years, or in the prison, provided that the suicide has either been completed or attempted " ("Legal Basis," n.d). Essentially anyone who assisted in death without 'selfish motives,' such as financial gain, are not penalized by the law. Since many countries still do not legally allow

assisted death or the laws are too strict, Dignitas House has been a refuge for many global travellers.

Switzerland has often been criticized, in regard to assisted death, for being host to 'suicide tourism.' Although meant to be a negative labelling for the Dignitas organization, in a sense the house itself is what some might say a 'popular destination'. However, Dignitas' importance as a destination does not come from typical five-star ratings associated with spa retreats or luxury hotels. Rather, Dignitas' value comes from its historical value of providing dignity and empowerment for those seeking comfort from pain and suffering, thus solidifying its popularity amongst many. The travels of Dignitas' guests should not be labelled with the trivial definition of a 'trip, often associated with tourism', but more aptly be described as a 'pilgrimage'. Those travelling far to seek assisted death are voyageurs seeking a destination of moral and spiritual significance, in line with their beliefs and faith.

As a destination for many seeking a dignified death, Dignitas House has set a precedent and contributed to the evolution of MAID. The importance of Dignitas is evident and not to be dismissed, however, its lack of contemporary legal MAID protocols, supportive elements, and impact of design influences should be considered in regard to the best potential outcome for a MAID environment.

3.4.2 Concept

The Dignitas House is known as the "anonymous blue metal building" on the middle of an industrial estate in the suburbs of Pfäffikon (Jones, 2016, sec.2, para.7). The architecture of the building itself is unalluring and reflects a more clinical vibrancy to the House. Softening, and helping to alleviate the hard, cold surfaces of the building are the flower garden, pond, and abundancy of trees (Fig.56). The interior is laid out like an apartment with kitchenette, living, and

dining area (Fig. 57-59), providing a homely feel (Jones, 2016), in turn contradicting the anonymity of what the façade represents.



Figure 57 - Living area in Dignitas House



Figure 58 - Kitchenette in Dignitas House



Figure 59 - Smedley, wife and others sitting at kitchen table in Dignitas House

3.4.3 Programme Characteristics

The following is a list of activities comprised in Dignitas:

- Counselling in regard to all end-of-life issues
- Cooperation with physicians, clinics and other associations
- Carrying out Patient's Instructions and patient's rights with regard to doctors and clinics
- Suicide- and suicide-attempt prevention
- Support in conflicts with the authorities, with the management of nursing homes and with doctors not chosen by the patient
- Further legal developments in regard to questions about "the last issues"
- Accompaniment of dying patients and assistance with a self-determined end of life.

("Brochure of DIGNITAS", n.d).

In the documentary, *Terry Pratchett: Choosing to Die* (2011), the final journey of Peter Smedley is followed while he undergoes assisted suicide at Dignitas. The documentary allows for an in-depth look at the interior environment where many ill patients experience their last moments of life. In the documentary, the different areas of the House have multiple functions, atypical of a

normal residence. The kitchen table (Fig.59) is the first example as it is observed to function as three things: (1) dining table, (2) office desk and (3) clinical station. The second example is the couch and bed as they function as clinical spaces. The following documentation of Smedley's experience at Dignitas will help to elaborate on these different functions.

The tables first function is a dining space, where people are meant to gather, eat drink and converse. When Smedley first enters Dignitas, his wife and he enjoy coffee while sitting at the table (Fig.59). Next, the table transitions to a clinical office, as the Dignitas representative explains that Smedley will be asked several times if he is certain he wishes to go through with the assisted suicide. Smedley, stating he is quite sure, asks for the first medication, which is to coat the stomach and allow for the lethal dosage to work. Transitioning from clinic to dining again, Smedley takes this medicine at the table and while waiting for it to activate, enjoys some chocolates with his wife and chats some more.

The next experience Smedley encounters is the couch (Fig.60), in the living area. After the 30-minute wait is completed, the Dignitas representative guides Smedley to the couch, where a glass containing the lethal dosage sits upon a table next to it. Smedley's first experience with the couch is simply as a lounging place, a seat to sit upon with his wife by his side, comforting him. The couch then transitions to a clinical setting once more, when the representative asks once more if Smedley is sure he wishes to go through with the assisted suicide. Upon his agreeance, Smedley takes the cup and drinks, eating chocolate soon after to kill the bad taste in his mouth. The couch then transitions back to a lounge space, a place to rest. Smedley says his thanks to everyone before falling into a deep sleep, where eventually his breathing stops and in turn his heart. The couch and living area, once a place where all participants gathered to be at ease, now becomes a place of mourning; a death space. In other circumstance, with those not as mobile as Smedley, would have occupied the bed (Fig.57) and carried out the assisted suicide by IV drip. Either way, the spaces

reflect multiple functions that are not common to the rituals carried out daily in a typical home setting. So, although the interior appears as a home in its layout, with its furniture and décor, it is in fact, a foreign place. Nonetheless the functions that occur within are comforting and put its guest at ease, similarly to home, because the relief they are seeking can be provided there. In the end, all functions merge together to create a unique death experience, where ultimately the patient has a say in the their own death.



Figure 60 - Smedley and his wife sit on couch with Dignitas representative beside

3.4.4 Atmospheric and Theoretical Characteristics

Dignitas House demonstrates the most basic idea of what a space for assisted death should be: a home. Beyond those spatial elements of a house, such as the kitchen, dining and living area, the interior invites guests to engage with the familiar elements that are typically found in a house: art on the walls, plants in the corner and on the window sill, area rug, and side tables. Although not fully developed, there is a sense of hygge within Dignitas in its connection

to an atmosphere of hominess. The dining and living area act to gather people together to partake in pre-death rituals and after death rituals of grievance. After Smedley was declared dead, the Dignitas representative told his wife, "Now you are allowed to cry…everything you kept inside until now, let it out " (*Terry Pratchet,* 2011, 55:06). Grieving can be done in the comfort of social settings, but also alone in the solitude of nature.

A connection to the outdoors create pause and breath for the family and friends of the Dignitas patient. The pond, flower garden, and exterior landscape are in fact biophilic elements that influence the experiences of those at Dignitas. After Smedley's death, documentarian Terry Pratchett steps outside into the crisp winter air, stating, " In this time, in this place, there is something good about the snow, yea it's the right kind of snow. (55:15)" There is something about nature that solidifies our connections to death and makes sense of the experiences of the deceased. Pratchett was able to find meaning in the landscape around him and was overcome with joy. Ideas of winter being cold and not the most suitable of conditions were overshadowed by its beauty as a natural element; symbolizing life in the midst of death.

3.4.5 Conclusion

Dignitas House, as the most well-known and popular destination for assisted death, offers a unique perspective on the lengths individuals will go to seek relief from pain and suffering. At a time when things are unfamiliar, elements of home and nature provide reassurance to experiences of the moment, to those leading up to death, as well as those after. Out of necessity, the space itself was born and its interior shows the most basic idea of what a space for death should be, which is something comforting that resembles the everyday familiar. Our deepest connections to nature allow us to understand the world when situations are difficult, by reinforcing what we have already seen and know. A tree, is a tree, is a tree. When Pratchett referred to the snow as 'good' it was to validate the experience he has just been a part of, which

he referred to as a “happy event ” (Pratchett, 2011, 56:27). The snow was not ‘bad’ snow, because the experience was not bad. Therefore, nature acts as an element of reflection on our experiences and thus can support individuals as they deal with death.

4.0 | Chapter 4 – Programming

4.1 Client Profile

In the initial stages of the project, the federal government of Canada will provide funding. Facilities operation funding will be provided on a provincial level by the Winnipeg Regional Health Authority (WRHA). Further financial support will be provided from private donations. Operations of the facility will be carried out by the Manitoban MAID Clinical Team. This provincial clinical team is the only authorized group in providing MAID within regional health care facilities.

4.1.1 Client Needs and Future Goals

Communitas House will be divided into four separate areas: (1) clinical, (2) residence, (3) educational and (4) administrative. These four areas will accommodate for what the procedures already established with the WRHA MAID Clinical Team, as well as those that are necessary to accommodate for the best care of terminally ill patients and the advancement of healthcare standards for MAID.

4.1.1.1 Clinical

The clinical portion of Communitas House will be for outpatient MAID care. Patients who may want to die at home, another facility or anywhere else they wish can come in for preparation that comes before a medically assisted death in Manitoba. These preparations are consults and their two separate Independent Physician Reviews. The reviews will be completed by a team comprised of a physician, nurse and social worker in the assessment room. For patients who are not mobile or admitted into an alternative healthcare facility, the WRHA MAID clinical team can come where they reside. Essentially there are flexible options for anyone seeking out MAID, but the outpatient clinic offers a concrete, reliable space for individuals who need support and assistance throughout the process. Those patients who have already moved into the residential

suites of the hospice will acquire their Independent Physician Reviews within their private suites. This location will be more accessible for patients, especially those with limited mobility.

Another programmatic element to the clinical portion of Communitas House is the therapy rooms. These rooms will function for grief and bereavement counselling sessions where they can be either individual or family based. Mainly in this side of hospice, the rooms will focus on assisting the families and friends of the loved ones that have passed on via MAID, whether at Communitas House or elsewhere. In the case of therapy sessions for residents of Communitas House, these can occur directly in a patients private suite.

Lastly, the clinical area of Communitas House will act as a touchdown area for all clinical staff. A small meeting area will allow the MAID clinical team and any other support staff groups to meet up to prepare for medical assessments, consultations or the medically assisted death itself.

4.1.1.2 Residence

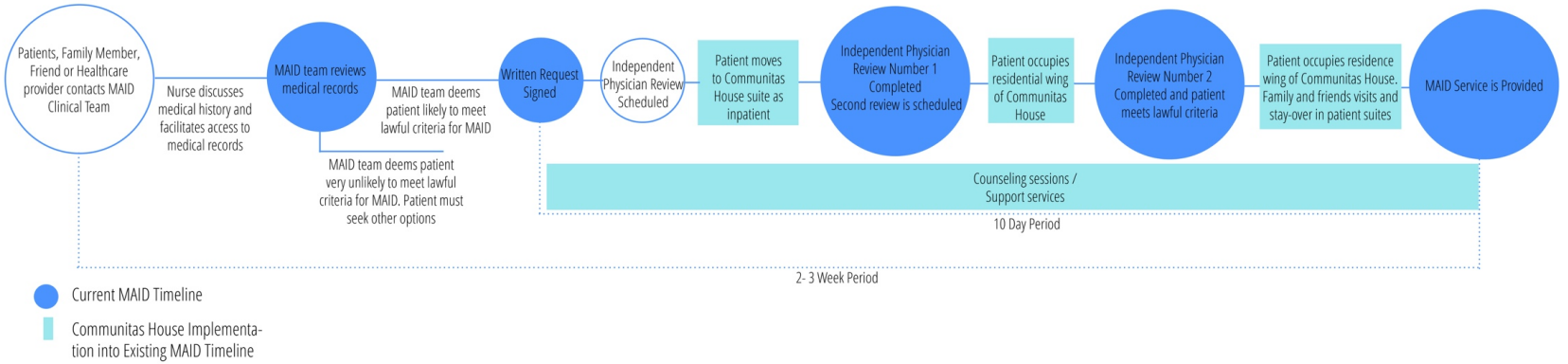
The medical procedure for MAID will be carried out in suites that will accommodate patients and their families. Currently, statistics show that from 2016 to October 2018 there have been 203 medically assisted deaths in Manitoba (Fig.62) and of these, 70% have been within Winnipeg. In 2016 MAID deaths in Manitoba totalled 24, where between January and October 2018 alone there were 114. Over those two years, there has been an exponential growth of medically assisted deaths at an increase of almost 3.8%. Within Winnipeg, the most recent stats show 76 deaths in ten months, therefore averaging around eight a month.

In order to sufficiently programme for the number of suites needed for the MAID facility, weekly numbers of MAID deaths were calculated. The projected rate of weekly deaths occurring from MAID in 2018 is two. However, since the number of MAID deaths is still growing and there is no estimated year for a plateau it is important to accommodate for future increase. Also factored into the equation was an overlap of stay for the residential programme of

the practicum project. Therefore, four patient, in different suites can occupy Communitas House at one time.

Terminally ill individuals will move into the Communitas House suites just before their first Independent Physician Review is scheduled, when the MAID Clinical Team has deemed the patient's criteria lawfully viable for MAID (Fig.61). At this point, up to four individuals can now be in-patients of Communitas House during their assessment period. If the assessments prove viability for MAID, individuals will continue to be inpatients of Communitas House and the procedure can be scheduled. Figure 61 also notes other alternative timelines for residential occupation, as some patients may acquire assessments ahead of time and organize for their death at a later date. Many patients do not have a certain date in mind but desire the assurance that they are approved and can go ahead with it at a later date.

The written request for MAID must be signed prior to or after the medical assessments take place. The timing for signing may depend on the availability of the two required independent witnesses. There must be 10 clear days between when the written request is signed and the actual procedure date. Therefore, if the request was signed on October 1st, the earliest the patient could receive MAID is October 12th. Therefore, the patient will likely reside at Communitas House for an estimated 2 weeks after starting this process, unless they decide to wait until a later date. The stats (Fig.64) show that roughly 32% of patients act within the 10 day period in 2018, up from 22% in 2017, suggesting a future increase in MAID patients who will act within that 10 day period. However, this timeline will vary patient to patient and can be influenced by their immediate collective. For example, should a patient receive the go-ahead for MAID, but their family is travelling from afar and has not arrived yet, it could be a few extra days stay.



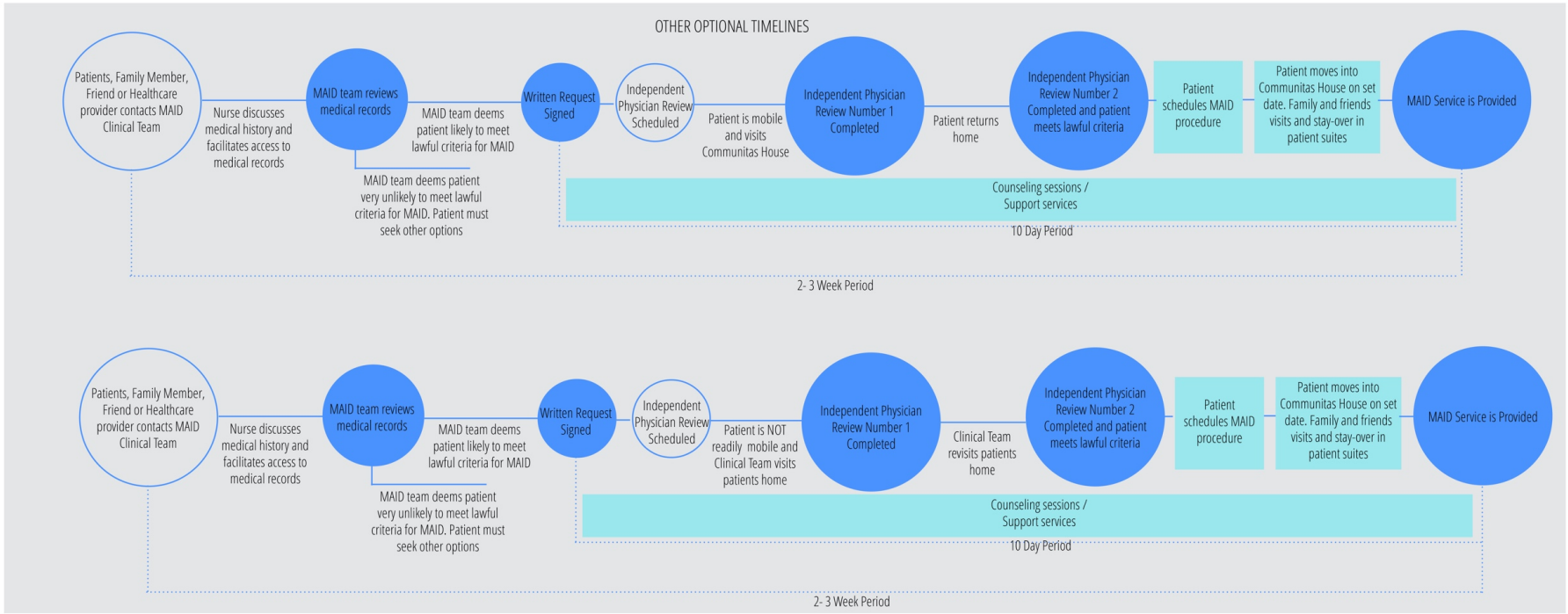


Figure 61 – Timeline showing how MAID currently proceeds in Manitoba, along with integration of proposed timeline for Communitas House

Within the 2-week period, visitors may come and go, as well as stay over with the patients in their suites. Interior and exterior areas for sharing food, lounging, spirituality, and wellness will supplement the residents stay at Communitas House. The patient's suite is one of a few optional spaces where the actual procedure occurs, and final moments can be experienced. For example, MAID can occur inside the spiritual area, out by the river or outside in the open air.

Although it appears reasonable that MAID deaths will increase in the years to come, the infancy of legalization leaves little support to growth statistics for the clinic. However, the scale of the site will allow for future expansion, should the program need to accommodate more patients. For the time being, there are circumstances where the duration or amount of patient care will be flexible, especially since there may not always be four persons staying at the facility consistently. Some examples of this include:

- The patient is mobile and visits Communitas House for assessments but does not become an in-patient until MAID is scheduled.
- The patient is not mobile but has someone bringing them to assessments until becoming an in-patient after MAID is scheduled.
- The patient wishes to receive assessments at home until MAID is scheduled.

*Note: See Figures 62-64 for more statistical information and calculations.

4.1.1.3 Administrative

The WRHA will require office space for facility operations and general administrative duties. This portion of the facility will overlap slightly with all divisions of the program and will be the core of Communitas House. Examples of this would be the intake of patients, scheduling of assessments (Fig.61), the organization of seminars and conferences, and security for the residence suites.

4.1.1.4 Educational

The goal would be for Communitas House to also act as a central base for education and development of MAID. A seminar and conferences area would allow health care providers the ability to congregate, learn and share on current knowledge with MAID. On a smaller scale, the seminar area can serve the Manitoba MAID Clinical Team when there is a need for group discussions and general meetings.

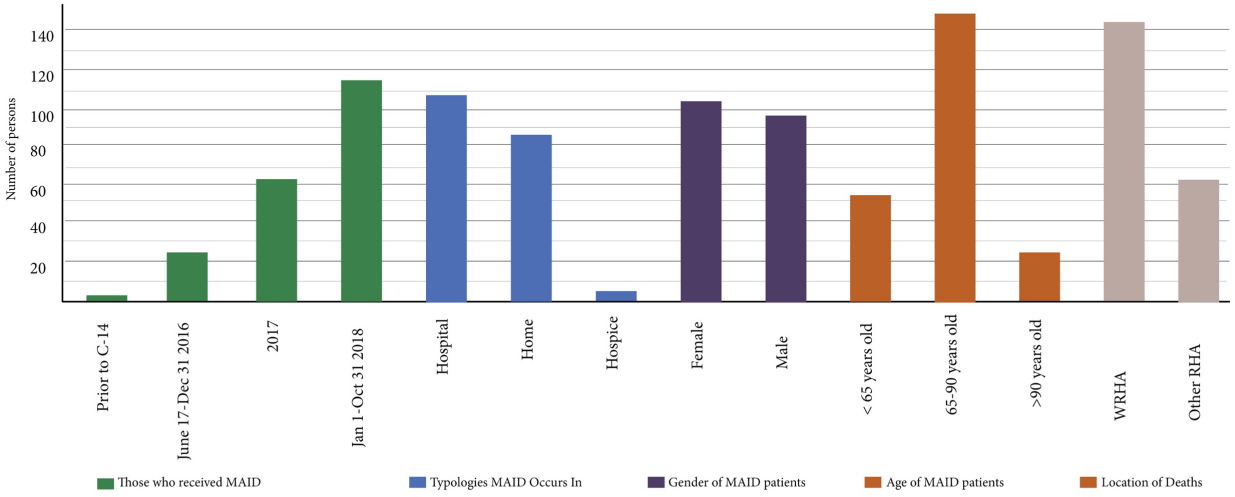


Figure 62 - Chart showing numbers of persons receiving MAID services in Manitoba, where it occurred, genders and ages.

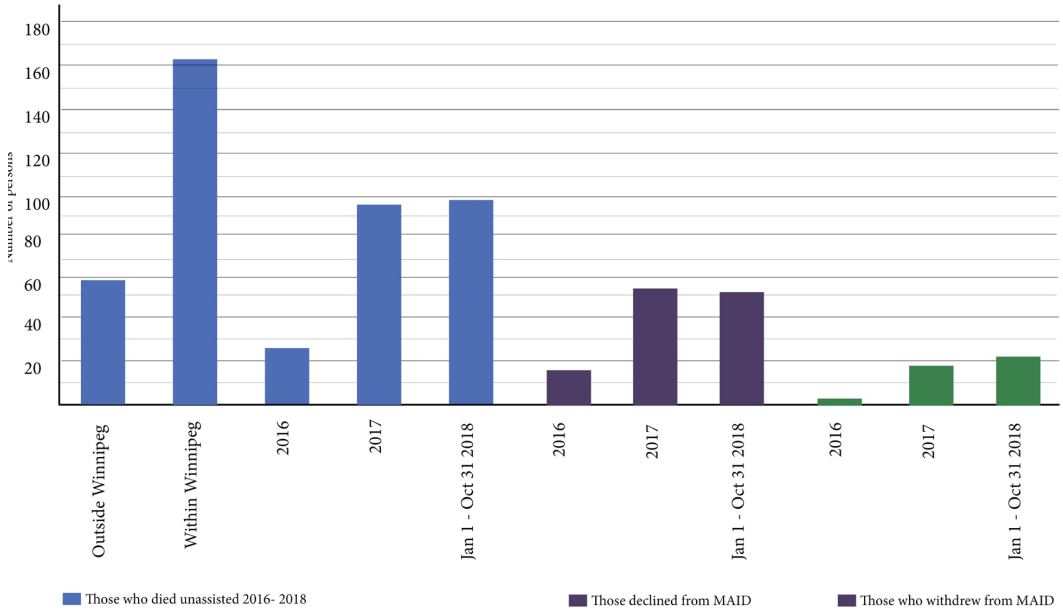


Figure 63 -Chart showing unassisted deaths and declines for MAID

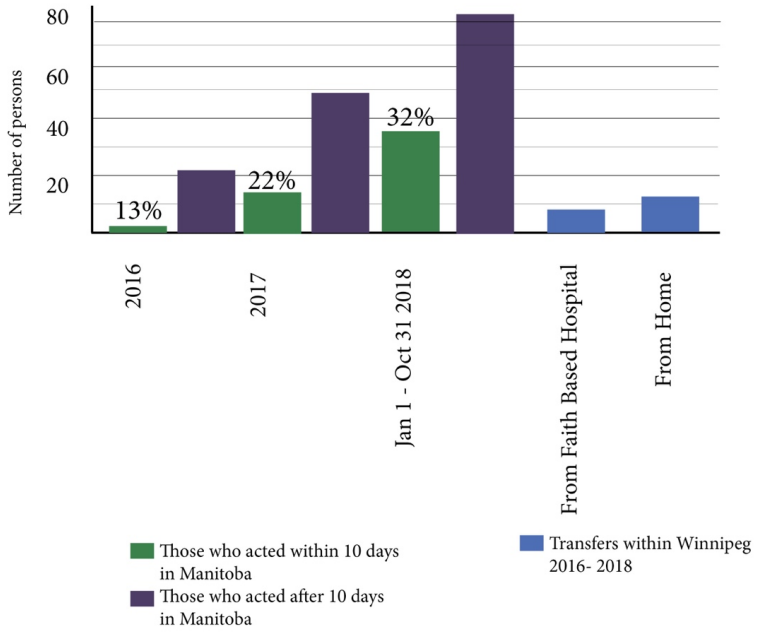


Figure 64 - Chart showing transfers within Winnipeg, MB and MAID patients who acted within 10 days

4.2 Users

The most primary users of Communitas House will be MAID patients and their supporting collective of family and friends. While the previous section outlines how client protocols affect the experiences of primary users, it is important to consider rituals that are more meaningful experiences for those partaking in MAID. By examining existing experiences of Canadian MAID deaths, end-of-life journeys and rituals can be explored and further implemented into the programmatic, spatial and atmospheric design considerations of Communitas House. The following two stories exemplify a variety of differing end-of-life experiences, which correspond with rendered perspectives in the following design chapter.



Figure 65 - Storm (left) and Dave Miller (right).

4.2.1 Storm Miller

In the documentary "Letting Her Go" (2018) from the MAID based series "Good Goodbye," Dave Miller recounts the assisted death of his wife Storm Miller (Fig.65). In the summer of 2011 Storm encountered her first diagnosis of cancer, which was located in her breast. After multiple chemotherapy treatments and surgeries came another diagnosis in 2016: stomach cancer and this time terminal ("Letting Her Go," 2018).

The prognosis led to a hastily planned wedding for her daughter Millie. Right after the wedding, Dave Miller informed both his daughters that Storm was ready to give up her life, now that there was no reason for her to carry on suffering. Upon returning home from the wedding, Dave and Storm Miller sat down and discussed going through with MAID. Dave took control of organizing of Storm's death, starting with picking dates according to the availability of their daughters. Storm wanted it to be at the crack of dawn, but Dave convinced her to wait until at least 11 AM, as it was a better time for everyone to get ready and come over ("Letting Her Go," 2018).

In organizing his wife's assisted death, part of Dave's job was to arrange with the funeral home a time to pickup of Storm's body ("Letting Her Go," 2018). Since the time was set for MAID, a pick up time could be accurately arranged for. However, interestingly enough Dave found an issue with specifying an exact time, wondering "how long do you leave a body there…," eventually settling on a half hour after the procedure ("Letting Her Go," 2018, sec.3, para.5). This thought process shows the intricacy of evolving MAID experiences, where end-of-life rituals are not quite common practices.

The next important task for Dave was deciding whom to inform about their plans and whom to invite to share in the final days of Storm's life. It was easy for Dave to know that his daughters and their significant others and the Miller's grandchildren would participate in these last ten days. However Dave struggled with other invitations stating, "That's pretty hard picking who's going to be on the inner circle and who is going to be outside and then you are going to have to deal with the kickback afterwards ("Letting Her Go", 2018, sec.3, para.7)." Others, such as close neighbors were informed about the death but only invited to come afterwards. Storm's participation in MAID was not to be of knowledge to anyone, however, friends were notified via Facebook about her terminal cancer ("Letting Her Go," 2018).



Figure 66 – Storm hugs an old friend at her home in Comox, B.C.

After the legal waiting period passed and final hugs (Fig.58) and goodbyes were shared, the day came for Storm to die. Dave let his wife know it was time to move into the sunroom, and those chosen to participate in the death followed. Dave gave his wife a hug and a bouquet of roses (Fig.66-67) before she plopped down on a comfy chair. Dave sat at Storm's left side along with his daughter Millie. Everyone in the room was advised to sit down by the doctor as he hooked up Storm's power port for the injections and asked her to give final consent ("Letting Her Go," 2018).

Dave recounts that the experience happened too quickly and in seconds Storm became unconscious. Dave told a story about how his wife and he first met, to fill what Dave considered the 'awkward waiting period', between the time of injection and the moment her heart would stop

beating, where the doctor would announce Storm as deceased. Reflecting nearly a year later on Storm's death, Dave does not regret inviting family and filling their home in Storm's last days. However, Dave felt he lost some privacy with Storm and wishes he could have spent more time letting her how he felt, but acknowledges it was not about it him…it was about her ("Letting Her Go," 2018).



Figure 67 - Dave holding his wife Storm with her bouquet of roses

In the narrative of Storm Miller's death, there are several key ideas about how MAID, as a ritual, can unfold in Communitas House. (1) Firstly, is the location in which the death occurred: the comfy chair in the sunroom of the Miller's home. The chosen site reflects a need for the security of the familiar and the comforting embrace of cozy furniture. The sunroom itself reflects the desired connection to nature, while also allowing Storm to find a sense of place at end-of-life, by having a view of her home property. (2) Secondly, is the collective who is chosen to witness the death. According to Dave, this was only decided moments before entering the sunroom. This last minute curation of the death suggests a need for flexibility in seating arrangements. (3) Thirdly, is the position of the collective in regards to the MAID patient. It was advised by the doctor to take a seat. There is no direct reasoning for this in documentary, however, it is suspected that by sitting down there becomes a casualness to the room. Also by the horizontal balance between patient and collective, there becomes a more democratic atmosphere in the patients final moments. (4) Finally, there are the choices and thus curated experiences of the death that reflect liminal rituals. The first denotes Storm's separation phase, where Dave notified friends via Facebook about his wife's fatal cancer prognosis. From this moment, Storm's supportive, outer circle collective in knowing she was dying became aware of her separation from typical societal hierarchy. Secondly, the 'awkward waiting period,' as referred to by Dave Miller, between unconsciousness and death, embodies the marginal phase of liminality, where the liminal entity stands at the threshold of life and death. The ritual Dave chose to embed in this phase was the act of storytelling, to bring life to his wife and their relationship as it died away. Thirdly, Dave's decision to arrange the funeral home to pick up her body 30 minutes after the injection, left time for those outside the sunroom to come and visit Storm's body before it was taken away. This final part of the ritual, which would be accompanied assumedly by a funeral, demonstrates the ritual of the aggregation phase in which Storm will once again find solidity, only this time in the afterlife.

Not only does the well-recollected narrative of Storm's death help to express a ritualistic example of MAID, but it is in the missing details of the story, where design implications can be acknowledged to assemble an end-of-life space (Fig.67). These design implications can be investigated through questions, such as: where were the flowers right before Storm held them when she died? Were the flowers waiting in a vase? Did the flowers go back in that vase or stay with her when the Herse came to pick her body up? Although a vase is a simple decorative detail, it is still important to the storyline and thus a design consideration in Communitas House. A decorative object such as a vase symbolizes a familiar expression of home while containing in itself the larger symbolic element of the flowers. The roses symbolize Dave's love towards Storm while being yellow acknowledge the sickness and his will for her to feel 'better' in death.



Figure 68 - Esther Supernault

4.2.2 Esther Supernault

On *APTN Investigates-Dying with Dignity*, Esther Supernault's (Fig.68) end-of-life journey is followed by her niece, video journalist Tina House (House, 2017). Supernault, a 66-year-old author, mother and grandmother suffered through cancer for 17 years. When doctors informed her of her imminent death, Supernault came to the decision to die with dignity and invoke

the MAID service.

In Supernault's last 48 hours, friends and family gathered to share stories and good memories (Fig.69). The interview itself does not follow the actual moments leading up to and after Supernault's MAID death. However, it is evident that Supernault was surrounded by many supporters, some of these recognized in the interview: husband Cliff, sister, sister in law, children grandchildren, and of course niece Tina House.



Figure 69 - Family and friends of Supernault gather to share stories and good memories

Supernault's aboriginal heritage has played a large role in her acceptance and experiences with her end-of-life journey. To help illuminate the experiences of death within the Aboriginal culture, the House interview Elder Seis'lom of Lil'wat nation in British Columbia. Seis'lom states that historically there have been ceremonies done for people at the end of their lives (refer also to previous section 2.2.5.1 *pipe ceremony*). Death amongst Aboriginal people was a sacred right for the person dying, family and the entire community. Seis'lom has heard, in regard to ending someone's life, that people have died in sweat lodges or even been brought to the mountain to

practice their death rite. The changes in death rites are noticed by Seis'lom as he acknowledges that it wasn't part of the Aboriginal culture. Nonetheless, Seis'lom believes that Aboriginals must reflect back on what is remembered and cherish the sacredness right of death.

In the interview, Supernault shares her beliefs of the afterlife in stating that our spirits are eternal and thus by dying she will carry on to enjoy something else. Supernault approached her liminal separation differently than most, as when she was first diagnosed she began researching and exploring cancer, finally talking openly about it in her book, *Blue Diamond Journey*. In her journey of separation, Supernault turned to traditional herbal remedies, rather than chemotherapy, which she considers the reason for her many years of life. However, as 'her time' came, Supernault looked forward to one such experiences in journey after death stating, " Now when it's my time I dream of a white horse. A beautiful white horse, so white he is luminous. He has this long silky mane and he is standing about a foot or so from me, his reigns dangling, waiting for me. So, in two days when I invoke the MAID service I am going to get on that horse and ride (House, 2017, 2:09)." Husband Cliff shares Supernault's spirituality, explaining in the interview that in the Aboriginal world the Great Spirit is here to protect us and he knows our destiny, just like Supernault does as well as she invokes her right to a good death. These spiritual beliefs help lay out Supernault's liminal aggregation phase. In support of this, the interview also follows husband Cliff Supernault as he pays his respects to Supernault by placing flowers in the water (Fig.70). This cultural ritual is done to help the spirit to go and be free within the arms of the creator.



Figure 70 - Cliff Supernault places flowers in the water to guide his wife to the creator

The narrative of Supernault's journey describes one surrounded by a large supporting collective, filled with storytelling, cultural importance, and strong spirituality. The previous elements describe key ideas that can be included to support users of Communitas House. (1) Firstly, the importance of orally sharing stories and memories with the soon to be deceased indicates a specific spatial arrangement. Having comfortable and abundant seating, where family and friends can face each other when speaking is a necessary spatial element in order to carry out this ritual. Back in Figure 69, The photo demonstrates this layout, as Supernault's collective has arranged themselves in a semi-circle to share their stories. (2) Secondly, the large supportive collective of Supernault demonstrates a need for spaces in Communitas House that can adapt to smaller or larger groupings of people, but that still remains intimate and feels safe. Figure . in Chapter 6, provides a version of how this could look in Communitas House. (3) Finally, there are the cultural and spiritual elements of Supernault's deaths that bring focus to the incorporation of natural elements. The sweat lodge and mountain setting described earlier by Seis'lom elude to a

strong connection to nature within Aboriginal cultural and spiritual beliefs. By having exterior spaces and landscapes that support these end-of-life, threshold experiences, Communitas House can embrace the diversity of death rituals. Figure. Also in Chapter 6, Figures 166 and 167 capture the essence of how a death ritual, embedded in nature could look. Furthermore, Cliff Supernault deals with the liminal aggregation phase of his wife's death by throwing flower petals into the water. This ritual is believed to allow Supernault to cross over into the afterlife, where the Great Spirit will look over her. Discussed earlier in section 2.3.3.1 of Chapter 2, water contains symbolic and spiritual importance for death rites and therefore, should be incorporated into ritualistic spaces of Communitas House. In Figure 167 an exterior pond allows those left behind, to help the newly deceased into a state of stability in the afterlife, thus completing aggregation.

4.2.3 Primary Users

MAID patients
Visitors
- Family
- Friends

Medical Staff - MAID Clinical Team
-Nurses
- Physicians
-Social Workers

Administration Staff
- Human Resources
- Patient Administration
- Facilities Manager
- Accounting

Food Services
- Head Chef
- Cooks
- Busser/ Cleaning Staff

4.2.4 Secondary Users

Medical Staff
- Therapist/ Grief Counselor
- Pharmacist
- Spiritual Leader
- Healthcare aides

- Volunteers
- Death coaches / death doulas

4.2.5 Tertiary Users

Maintenance
- Groundskeeper
- Janitorial Staff / Caretaker
- Mechanical Technician
- Living Wall Technician
-Laundry

4.3 User Profile Chart

Age	Behavioral Needs	Psychological Needs	Spatial Needs
Typically 65 -90 (Fig.62)	Occupy the hospice for a duration of anywhere from 2-3 weeks, 24h a day. Prior to this they may occupy the facility on a casual basis to find information, undergo assessments and consultations. Throughout the stay patients will interact with medical staff and personal visitors, who will follow them on their journey during this transitional period. They also may interact with other patients during their journey. Daily activities will include	Sense of well-being will be an important element, allowing the patient to feel at ease in their transition between life and death. Spaces invoking meditative and spiritual qualities give opportunity for reflection upon life at present and eminent death.	-Comfortable and private space to go ahead with procedure. This will occur in a suite. - Space to reflect. This may include exterior landscaped areas, spiritual environments and wellness areas - Space to lounge and experience family rituals. This may occur within the private suites or other areas in the facility, such as dining area, reading area, common space or the exterior grounds - Accessibility everywhere - W/C
Visitors (All) All ages	Will accompany a loved one to the facility to undergo the procedure. They may visit prior to this visit on a casual basis to attend consultations or gather information.	- Sense of well-being - Comfort and support - de-compression	- Comfortable and private spaces to be with terminally ill loved ones - decompression spaces or spaces to let grief out - supportive spaces to cope with grief and the process - Dining facilities -W/C - quarters to rest and stay over -lounging and social spaces -spiritual spaces
Nursing Staff			
Age	Behavioral Needs	Psychological Needs	Spatial Needs

22-65	Will work full time shifts between 8-12 hours, occurring during daytime or nighttime, as patients need available care 24/7. Nurses will be the main point of contact for patients during their residence and thus will move between private quarters, public space and nursing station on a daily basis.	Private staff areas allow medical staff to decompress from the emotional impact of caring for the dying. Due to the close and constant care of patients and nursing staff relationships may form and cause psychological impacts when the patient passes. This impact requires meditative and spiritual spaces for staff as well as patient.	Accessibility in circulation to and from patient's private quarters will allow ease in care. Staff room and private staff washrooms will be separate from public, patient areas. A small touch down residency space for nurses may be valuable in case of overnight stays. This space should have secure lockers for personal items as well.
Physicians 30-65	Physicians will meet with patients to provide information, consultations and assessments, as well as aid in medical procedure. Therefore their typical daily shift will vary. Physicians will also need to interact with the rest of MAID Clinical Team.	Private staff areas allow medical staff to decompress from the emotional impact of caring for the dying. Due to the close and constant care of patients and nursing staff relationships may form and cause psychological impacts when the patient passes. This impact requires meditative and spiritual spaces for staff as well as patient.	Accessibility in circulation to and from private quarters will allow ease in care. Staff room and private staff washrooms will be separate from public, patient areas. Physicians will require office space to carry out private consultations and an exam room for assessments.
Social Worker 25-65	Typical daily shifts will include 8h, 5 days a week.	Private staff areas allow medical staff to decompress from the emotional impact of caring for the dying. Due to the close and constant care of patients and nursing staff relationships may form and cause psychological impacts when the patient passes. This impact requires meditative and spiritual spaces for staff as well as patient.	Staff room and private staff washrooms will be separate from public, patient areas. Will require office space to carry out private consultations and an exam room for assessments. Storage for files and reports.

Administration Staff 20 -65	Typical daily shifts will include 8h, 5 days a week. Will maintain the operations for the facility, dealing with the behind the scenes work ie: paper work, financials etc	Private staff areas allow medical staff to decompress from the emotional impact of caring for the dying. Due to the close and constant care of patients and nursing staff relationships may form and cause psychological impacts when the patient passes. This impact requires meditative and spiritual spaces for staff as well as patient.	Staff room and private staff washrooms will be separate from public, patient areas. Will require office space.
Food Services 18-65	Typical daily shifts will include 8h, 5 days a week. Will organize food options, preparations, cooking and service of food to all staff, patients and visitors of the facility.	- Space to decompress after interactions with patients and grieving families - relaxation spaces for work breaks	- Food Storage -Food Preparation areas -Food Cook areas -Food Service areas -Dining areas - W/C - Accessibility to garbage, recycling and composting - Staff Room - Delivery area for food

Table 4. User Profile Chart

4.4 Functional + Aesthetic Requirements

Space	Description	FFE	Area (sq ft)	Desired Atmosphere
Entrance Area				
Vestibule	Initial Entrance space. Transition between outside climate and interior climate conditions.	- Accessible Doors and operational buttons	180	- accessible
Lobby	Open area at entrance to allow for a welcoming area into the hospice and to support flow of people in and out.	-Architectural feature that intrigues and welcomes visitors	600	-Welcoming -Relaxed -Supportive -Open and inviting
Meet & Greet	Informal reception area for incoming MAID patients, potential patients and visitors.	-soft seating via couches and chairs - storage -desk and chair -TV screen - Wayfinding sign/directional map	300	- Welcoming/Inviting - Comfortable - Relaxed - Supportive -Informal - Organized -sanitary
Reception	Space for visitors to register in and be directed to the appropriate wing.	-reception desk -computer -storage	220	-Informal -Relaxed -Supportive -Inviting
Outpatient Clinic				
Consultation Room	Potential MAID patients will be provided information by medical staff and sign documents. Arrangement of date and time of MAID to be discussed between physician and patient	- soft seating via chairs and couches -desk and chair -storage	200	- comfortable - relaxed -organized -professional -sanitary
Assessment Room	This room will be utilized by the patient and assessment team made up of a Physician, Nurse, Social Worker. Two of these assessments will occur. Patients may also be accompanied by a family member/proxy	- examination table -privacy curtain -storage -desk -chair - medical equipment - W/C	260	-sanitary -organized -relaxed
Therapy Office x2	Potential MAID patients will be assessed to comply with government laws of MAID. Family and Friends can also partake with therapy for grief counseling.	- soft seating via chairs and couches -desk and chair -storage	(250 ea) 500	- comfortable - relaxed -organized -professional -sanitary

Flex Office	May serve as a larger gathering space for therapy or consultation sessions between the family and patient	- soft seating via chairs and couches -desk and chair -storage	150	- comfortable - relaxed -organized -professional -sanitary
Meeting Room	Small meeting room for MAID clinical team to gather in preparation for MAID services. Also can be used as meeting space between other staff members to discuss or prepare work.	-task chairs -conference desk - storage	260	-organized -professional -comfortable
Pharmacy Storage	Storage for drugs and medical accessories	-storage	120	-sanitary -accessible
Nurse Touchdown Station	Care-givers can have a small office area to see over medical records and other patient related issues.	-task chairs -desk -storage	230	organized -professional -comfortable
Public WC x 2	Accessible gender-neutral washrooms for patients, visitors and staff	- toilets, sink, hand dryers, accessibility equipment, mirrors	60 x 2 = 120	-sanitary -accessible
Utilities				
Mechanical	----		80	-sanitary -accessible
Janitorial	-----		50	-sanitary -accessible
Storage	----		100	-sanitary -accessible
Residence				
Patients Suites x 4	This area is where patients will experience their transition between life and death as a physician or nurse carried out MAID. Family and friends of patients will also partake in this end of life ritual. There will also be space for relatives to stay the night should there stay extend over a day period.	- hospital bed - end tables -soft seating - table - pull out sofas - lounger -storage	550 x 4 = 2200	-calming -peaceful -sanitary -organized - light and airy
Suite WC x 4	Patients, family and friends will use this washroom. It must be compliant with	-toilet -shower -sink	150 x 4 = 600	

	accessible standards for patients.			
Laundry Room	In house laundry services		200	-sanitary -organized
Communal Space /Lounge	Area for staff and patients, family and friends to partake in socializing or solitary decompression.	-soft seating -coffee table -end tables -storage	600	-calming - sanitary -serene
Spiritual Space	Non-denominational space to have gatherings or services before or after MAID.	-seating	800	-intimate -uplifting -calming -peaceful -sanitary
Pharmacy Storage	Medical storage area for medicines needed for MAID procedure as well as anything prescribed by physicians for comfort care of terminally ill patients.	-storage -counterspace -coolers	100	-sanitary -organized
Break Out Areas	More intimate lounging areas for smaller groups or individuals.	-soft seating -side tables	800	- relaxed -comfortable - inviting
Sharing Food	An cozy dining experience for patients, their families and friends.	-group tables with a mixture of soft seating, benches and chairs	720	- relaxed -comfortable - inviting -sanitary
Private Sharing Food	An intimate dining experience for patients, their families and friends.	-large communal table with soft seating	250	- relaxed -comfortable - inviting
Open Kitchen	Informal kitchen prep area where food workers will interact with patients, families and friends. Also includes café seating	- stools -island -storage/millwork -fridge, oven, stove, microwave, DW	360	- sanitary -organized -open and inviting
Pantry	Informal food storage area for kitchen purposes	-storage	100	-organized - well-lit for accessibility -sanitary
Public WC x 2	Accessible gender-neutral washrooms for patients, visitors and staff	- toilets, sink, hand dryers, accessibility equipment, mirrors, baby changetable	60 x 2 =120	-sanitary -accessible
Garbage Room			200	
Equipment Storage		- storage racks	200	-organized -sanitary
Seminar Area				

Seminar Room	Here health professionals may gather for meetings towards development and education of MAID- MAID Clinical Team.	-conference table -chairs -storage -tv, screen, digital AV equipment - whiteboard -pin up board	3000	-professional - relaxed -informal
Washrooms	Access to washrooms for seminar attendees, female, male and universal	-toilets, urinals and sinks	500	-sanitary
Administration Area				
Conference Room	Meetings will occur here as the MAID Clinical Team will participate in monitoring and provision of MAID. Other meetings may include those for financial reasons and general administration?	-conference table -chairs -storage -tv, screen, digital AV equipment	300	-professional - relaxed -formal
Staff Room	Area for staff to relax and decompress.	- soft seating -chairs - tv -storage -kitchenette	300	-decompression space -relaxed -serene -informal
Staff Rest Area	Area for staff to rest during work hours or overnight	-beds -tables -storage	100	- relaxed -calming
Administrative Office	Private office area from that of the clinical part of the facility. This private office area will be occupied by: Human Resources, Clinical Director, Executive Director, Facilities Manager, Community Engagement Officer, Nurses, Physicians, and Social Workers.	- desks x 12 -task chairs 12	1,000	-professional -organized -serene
Staff WC	Access to private washrooms with inclusion of female, male and universal closets	-toilets, urinals and sinks	500	-sanitary
Misc.				
Circulation	30% of area		Est 1600	
Walls/Partitions	7.5% of area		Est 450	
Transition Spaces			Total (18572)	

Table 5. Spatial requirement chart

4.5 Spatial Analysis

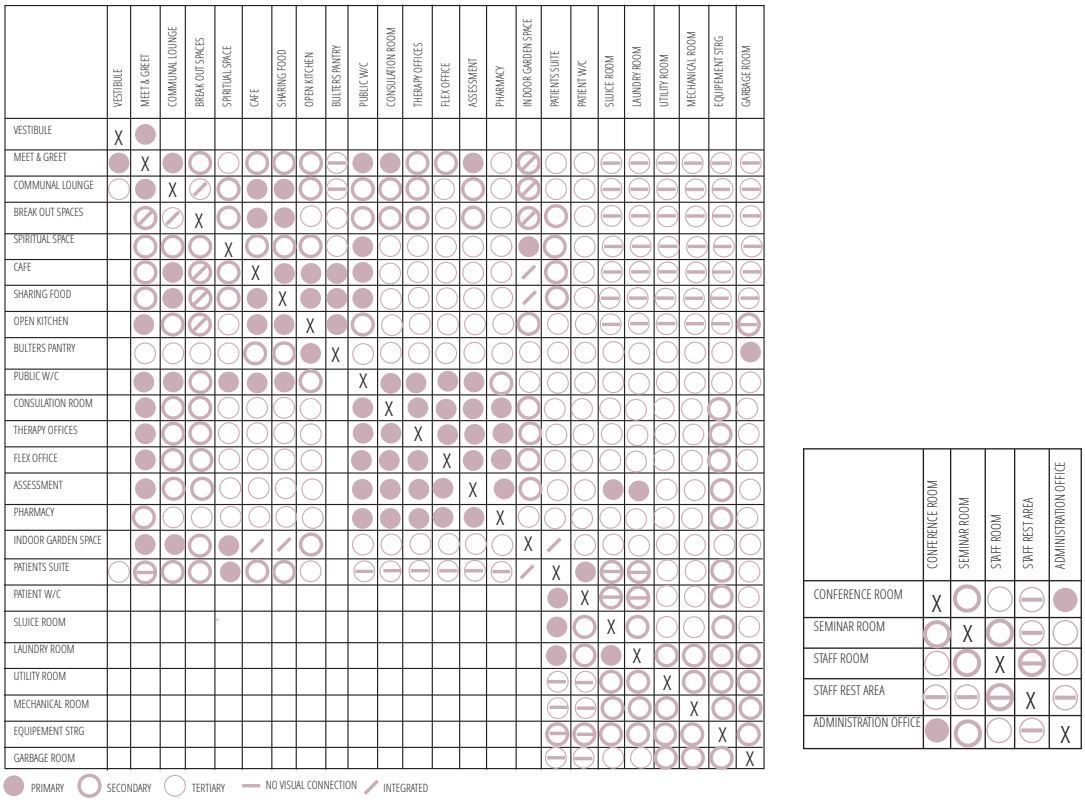


Table 6 - Spatial adjacencies

5.0 | Chapter 5 – Location Analysis

5.1 Project Overview

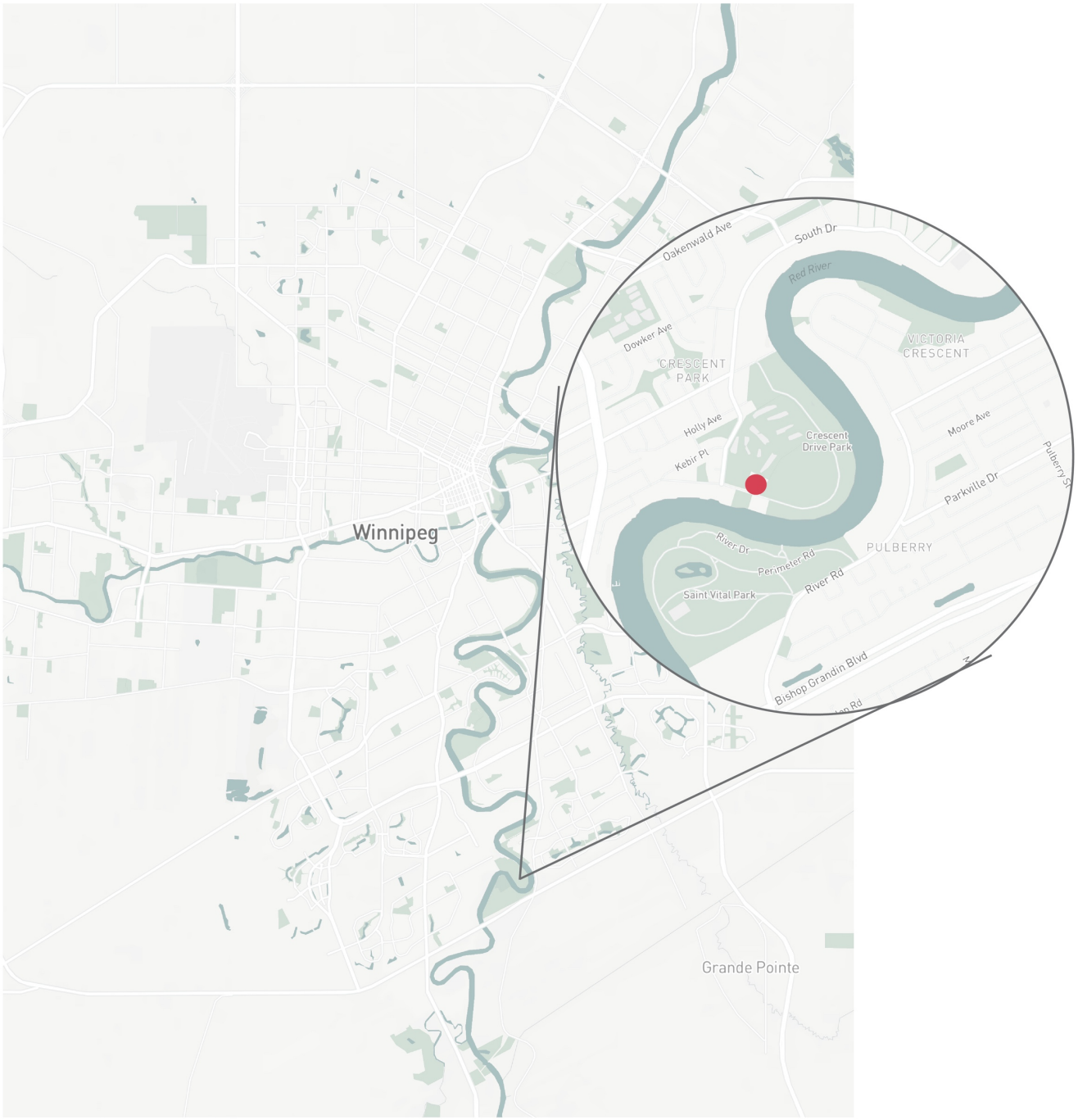


Figure 11 - Map showing Crescent Park location within Winnipeg, MB and close up of park within surrounding neighborhoods. Building site is highlighted in red.

Winnipeg's populous density influences the number of MAID deaths that occur in the province under WRHA. While some of Winnipeg's largest healthcare facilities such as St. Boniface remain intolerant to MAID it is important that terminally ill patients are allowed access to the care they need. However, the rest of the urban population and that extending into the rural domains, appear to show continued support for this monumental movement in healthcare and human rights activism. Winnipeg has dominated the media in cases resulting from a religious bias towards MAID, both the urban and its nationally central position in Canada's landscape will help to evolve MAID and hopes to show how it will evolve in the realm of Canadian healthcare

The site is located in Winnipeg's Crescent Drive Park (Fig.71), which is made up of 25.68 hectares of park area ("Crescent Drive Park," n.d). This location, while offering a modest central location, embraces the qualities of a rural area being as it is imbedded within a natural setting of forested park area with close proximity to a river. A balancing between public accessibility and visual privacy was a necessary site selection criterion. Since Crescent Drive Park offered this, along with an already existing building site, it was the most suitable selection for development of Communitas House. However, this existing site hosted several buildings unsuitable to the project and not ideal for the surrounding community, therefore requiring demolition in order to attain clear building space to host a new building. A clear site meant that there was sufficient space to host the new building with minimal demolition to the natural landscape.

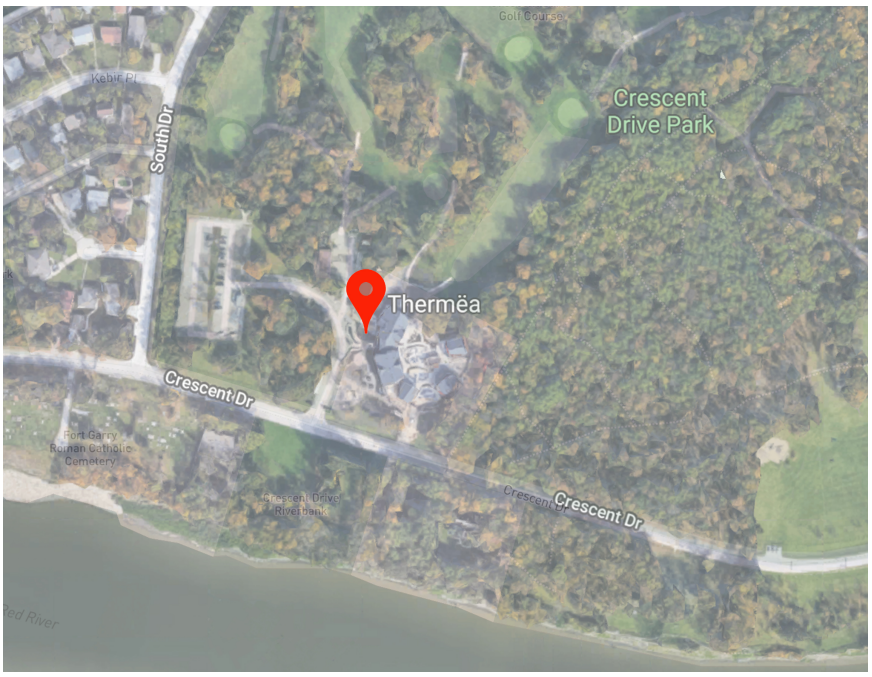


Figure 71b - Map showing project site with existing Thermea buildings

In order to attain the site as well as maintain empathy to the programmatic elements of the practicum project, the existing Thermea spa (Fig.71b, 83) would have to be demolished. The clear site could not contain both building programmes and function in unison. It also appeared that Communitas House would serve the community atmosphere better than the current spa. Although relaxing and a positive benefit for users of the spa itself, the local community has become bombarded with an influx of visitors. The increase to traffic and overflow of parking onto the main Crescent Drive takes away from the enjoyment of the park area and quiet residential streets, as they now have become what you first experience entering the park itself.

The host building selected was the Lakeview Resort and Spa (Fig.94) as its architecture complimented that of Crescent Park Drive. Constructed with natural materials and an abundance of large windows, not only could it be embraced by the site, but the interior would have a meaningful view of the park area. The adaptive reuse of the resort became Communitas House, offering a vision and programme better suited to the serene, natural landscape that residents have grown to enjoy about the site. The hospice does not intend on overwhelm the natural landscape or hinder access to the park entrance. Therefore, the hospice site has included parking closer to the building itself, with overflow parking on the existing parking lot. Furthermore, landscaping was done to create privacy between both building and street.

The following chapter further analyzes the site of Crescent Drive Park and the Hecla Resort and Spa that will be transferred to the site, hosted on the clear space of the demolished Thermea Spa.

5.1.1 Building Type

- Healthcare
- Adaptive reuse

5.1.2 Users

- WRHA Clinical team
- MAID patients
- Family and Friends of MAID patients

5.1.3 Site

Location

- 775 Crescent Park Dr.
Winnipeg MB

Current Building Location

- Hecla Resort and Spa
Hecla Island, MB

Square Footage

- 70,000

Architects

- Gustavo Da Roza Architecture and
- Smith Carter Architects and Engineers Incorporated

5.2 Site Analysis

Communitas House proposed the design reuse of the resort and spa buildings previously located on Hecla Island, MB. For the purpose of the project the resort building has been used as an architectural model to be built in Crescent Park within Winnipeg, MB (Fig. 71,85) because (1) it provides sufficient interior space for the hospice programme, (2) the architectural 'wings' of the building allow for physical and acoustical separation between the separate areas of the hospice, (3) the resorts architecture is similar to that of Thermea spa and therefore will cause minimal visual disruption, and (4) the exterior resort architecture reflects biophilic properties that would engage with the existing site. It is the intention that the Scandinavian inspired building will harmonize within the natural greenery, forested area and riverside location of the park. This particular coupling addresses the need for an urban location and provided a building capable of integrating within its natural surroundings. Through utilizing an urban location, the hospice will not only provide accessibility of services but also aims to elevate the social and political consciousness of MAID. The original building is 70,000 square feet spread over two above-ground levels. The scope of the design work will include new floor plans for an 18,500-square-foot renovation, with a concentration on the interior spaces considered to be most influential to

the project's intent. The facility will highlight multiple end-of-life spaces inside and within the exterior, a communal dining area and break off areas, spiritual space, clinical offices, and educational seminar space.

5.2.1 Site History

Originally, a part of the Rural Municipality of Fort Garry (incorporated in 1912), Crescent Park (Fig. 72-83) legally joined as a part of the City of Winnipeg on January 1, 1972. Today, Crescent Park is a mainly residential neighborhood located in the southern portion of Winnipeg. Its major development began after World War II, although there are a handful of homes dating to the 1910s and 1920s. Several parks, schools, and a community club are part of this neighborhood. (History of Crescent Park, nd.) The specific site chosen within this neighborhood is currently home to Thermea by Nordik Spa and adjacent to Crescent Drive Golf Course (Fig.72-73,84-85).



Figure 72 - Golf course with path (A)



Figure 73- Golf course (B)



Figure 74 - Crescent Park Drive (C)



Figure 75 - Forest path (D)

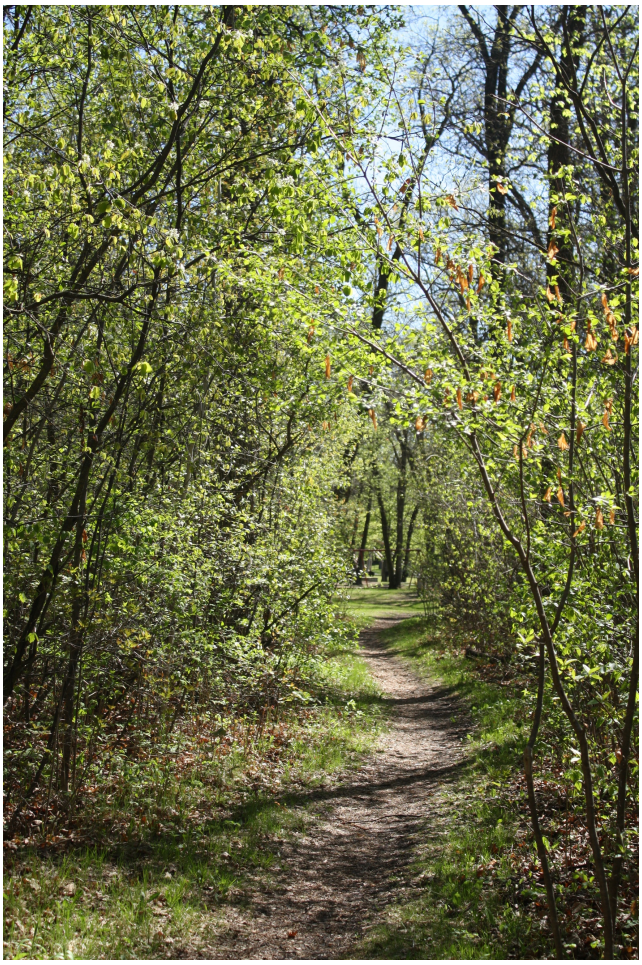


Figure 76 - Forest path 2 (E)



Figure 77 -Playground *(F)*



Figure 78 - Fallen tree with moss (G)



Figure 79- Foliage (H)



Figure 80 - Bench by river *(I)*



Figure 81 - Picnic area (J)



Figure 82 - View of river (K)



Figure 83 -Entrance to site (L)

5.2.2 Surroundings



Figure 84 - Map showing site adjacencies

Adjacencies (Fig.84)

-Crescent Drive Park
- Picnic Shelter
- Washrooms
- Parking lot
- Toboggan Slide
- Play Structure
- BBQ pits

-Red River
-Residential Housing

Zoning

- PR2 Parks and Recreation – Active Neighborhood/Community

- Property Description: Spa / Crescent Drive Golf Course

This district is intended for sites that include community recreation facilities and parks that are accessed by a mix of pedestrian and vehicular traffic. These sites may provide active programs and activities, including community centres, hockey pens, arenas, indoor soccer, wading pools, spray parks, skateboard parks and athletic fields.

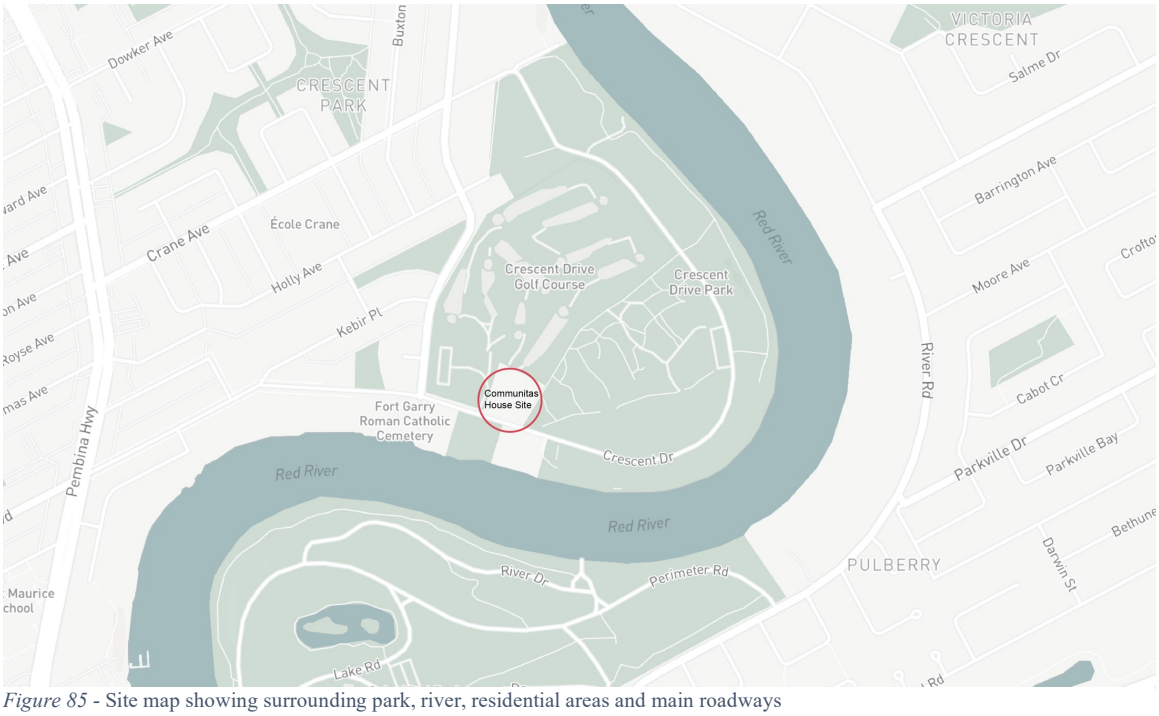


Figure 85 - Site map showing surrounding park, river, residential areas and main roadways

Parking facilities ranging from 10 to 100 stalls may be associated with these uses. These parks and facilities typically occur along collector streets.

5.2.2.1 Climate

Wind Patterns

- Mean annual wind speed around 17.8 km/hr
- Average maximum wind gust reach around 129 km/h
- Average maximum hourly speed of 89 km/h
- Prevailing wind direction is primarily from South and secondarily from North and Northwest in winter and spring months (Fig.86)

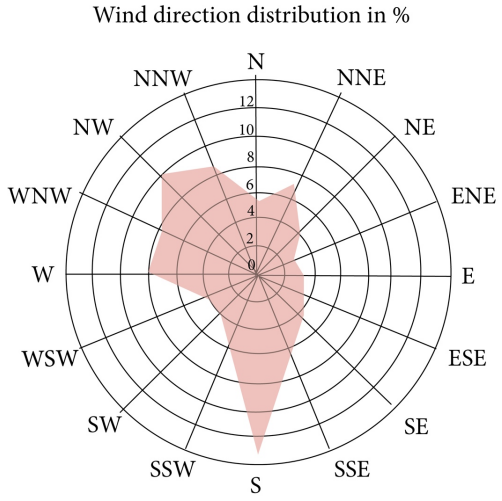


Figure 86 - Windrose showing wind direction and distribution for Winnipeg, MB

- Large amounts of tree coverage protect the site from higher hourly wind and gust speeds

Temperatures (Fig. 87)

- Average January temperature -13 °C
- Average July temperature 26 °C
- Winter season averages 132 days annually
- Garden and patio areas will only be functional throughout summer and spring months, April- September.

Rainfall (Fig.87)

- Water collection strategies can be designed for when higher precipitation occurs between May -September

- Colder months of precipitation deal with issues of freezing and therefore play into safety of the site

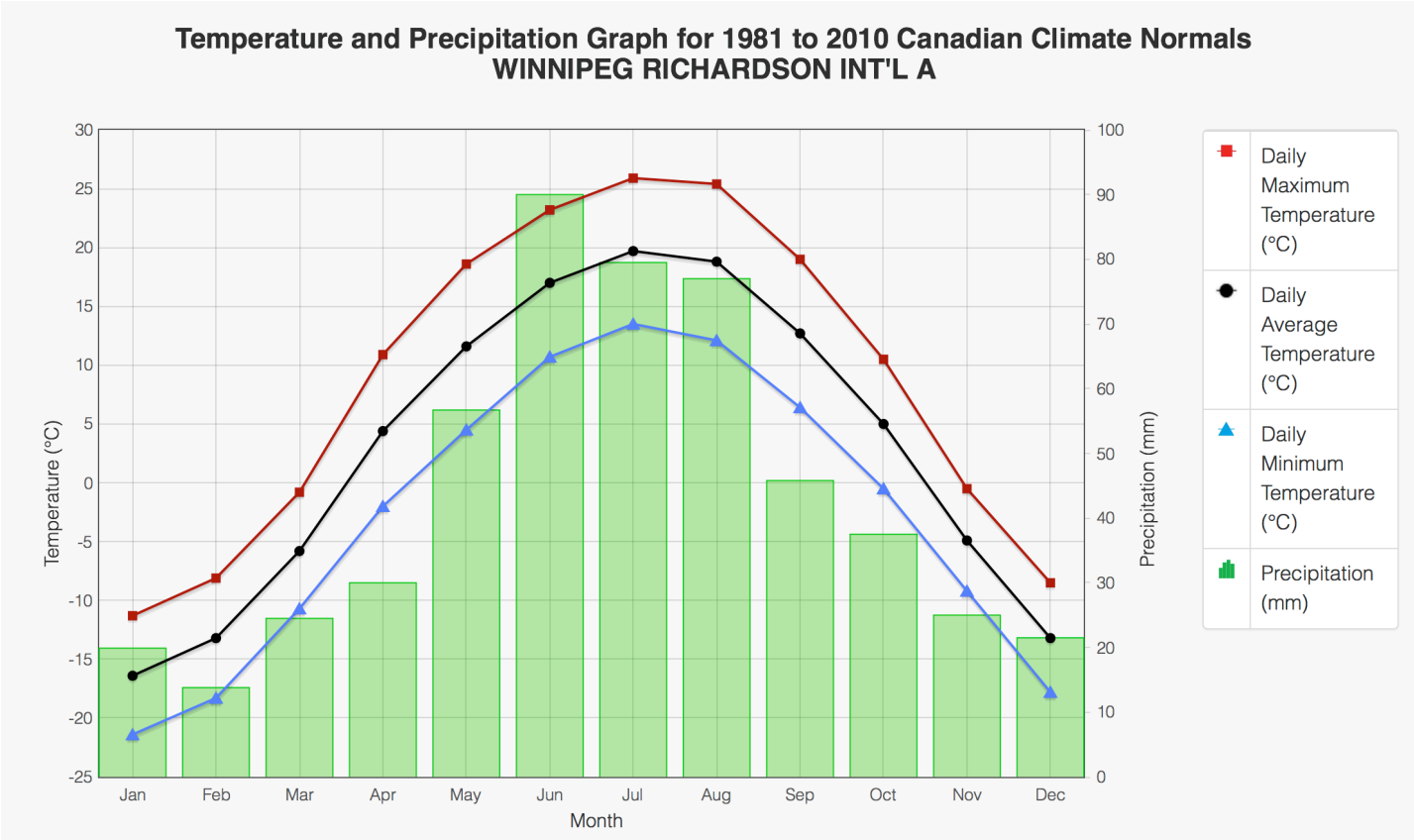


Figure 87 - Graph showing historic temperature and precipitation for Winnipeg, MB.

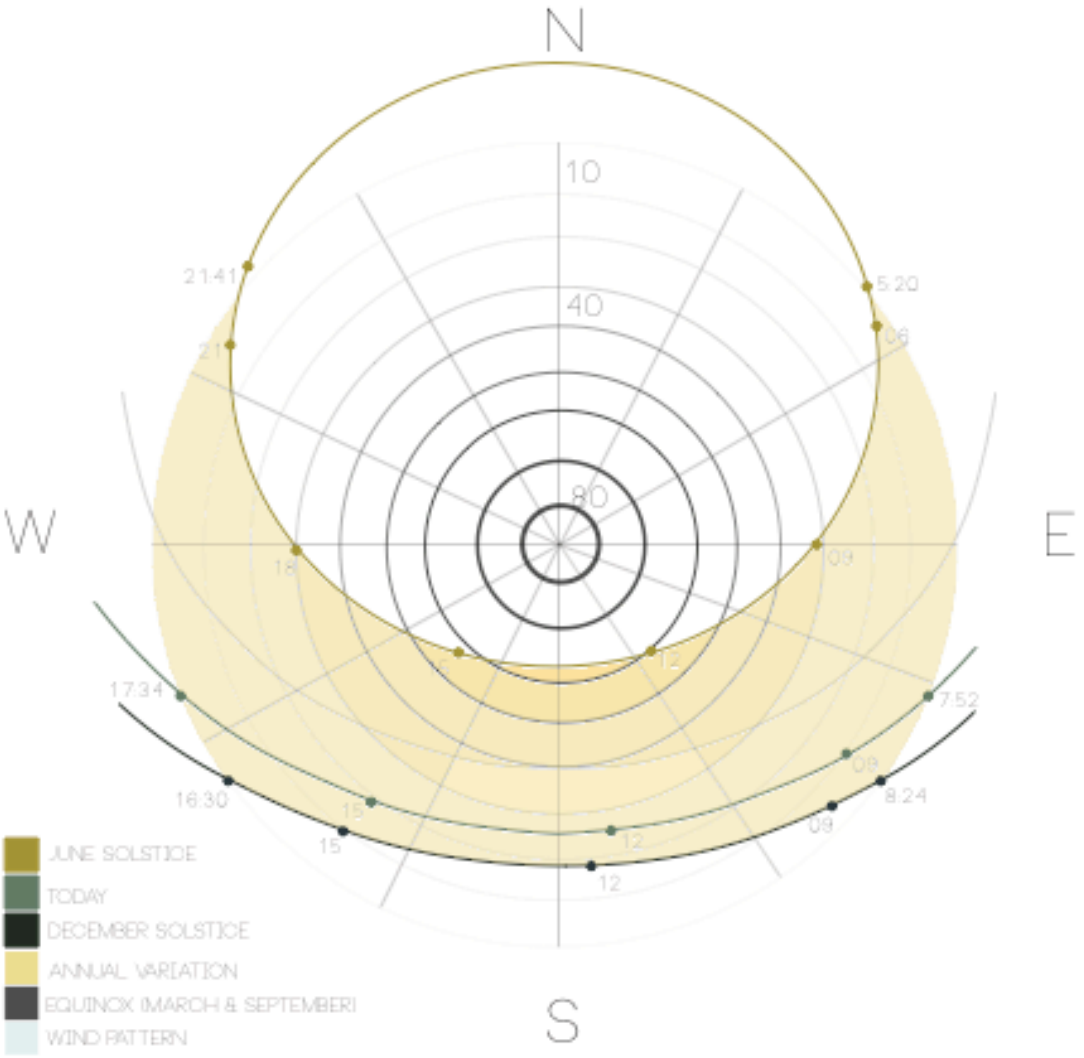


Figure 88 Sun path diagram

Sun Path (Fig.88)

- Winnipeg's skies are among the clearest in Canada, seeing a great deal of sunny weather all year round (Fig.79)

- The longest part of the building will be located facing south to allow for maximum daylighting during the day

Pedestrian & Vehicular Access (Fig.89)

- Easily Accessible

- 3 minute walking distance from Winnipeg Transit Authority (WTA)

bus route 94

- 15 minute walking distance from WTA bus routes 60, 160, 162, 163, 170, 183, 185, S430

- Located near Pembina Highway , a main Street.

- 25-30 minute drive from Winnipeg James Armstrong Richardson International Airport, w/ option of taxi or TappCar , Parking available



Figure 89 - Map showing Winnipeg transit stops

5.2.3 Neighborhood Demographic

Of Winnipeg's 237 neighborhoods, Crescent Drive Park covers 1.8 square kilometers; just 0.5% of the city area. The site holds a population of around 2,600, split evenly between male persons. This demographic is only 2.5% of Winnipeg's 663,617 persons. The population density is a low 1,443.4 per km square, as over half of this neighborhood is park and recreational area. Figures 90-91 show that this neighborhood is comprised mostly of employed individuals ranging from young adults to middle ages persons, with the largest population between 20-29 years.

Despite the high employment rate, a third of the neighborhood consists of non-labour force persons, probably contributing to the largest personal income percentage (Fig. 91,93) being from incomes of >$5,000- $9,999.

Most of the population in Crescent Drive Park uses a vehicle as their mode of transportation (Fig.92). Almost a quarter of the neighborhood utilizes public transportation and another 10% walk or bike. This may reflect the higher percentage being younger or the large percentage of non-labour individuals. Either way, this shows that the neighborhood is accessible to public transport with many bus routes and multiple stops, this being important to the site selection.

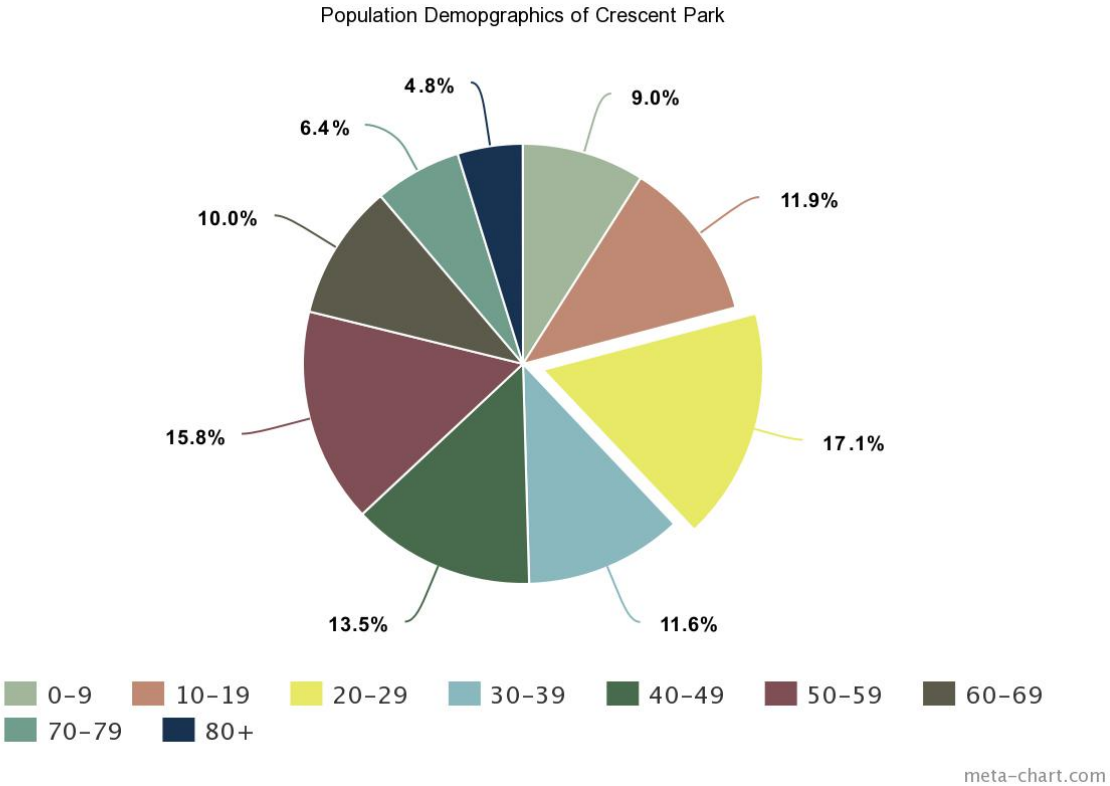


Figure 90 - Chart showing population demographic of Crescent Drive Park

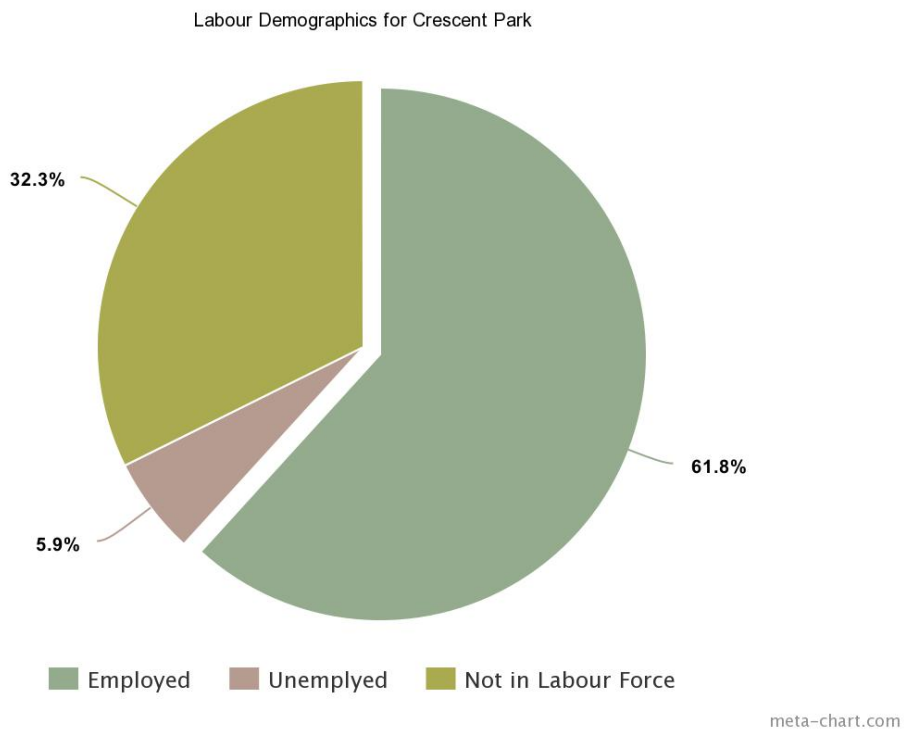


Figure 91 - Chart showing labour force demographic of Crescent Drive Park

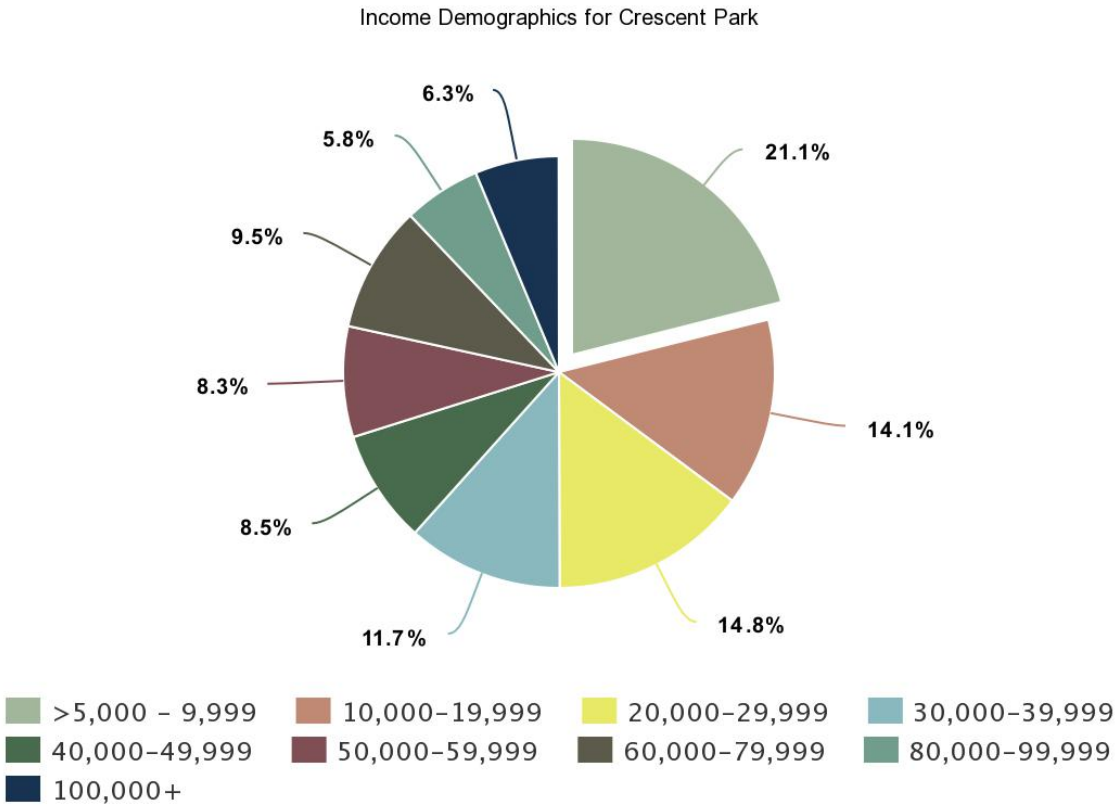


Figure 92 - Chart showing income demographics for Crescent Drive Park

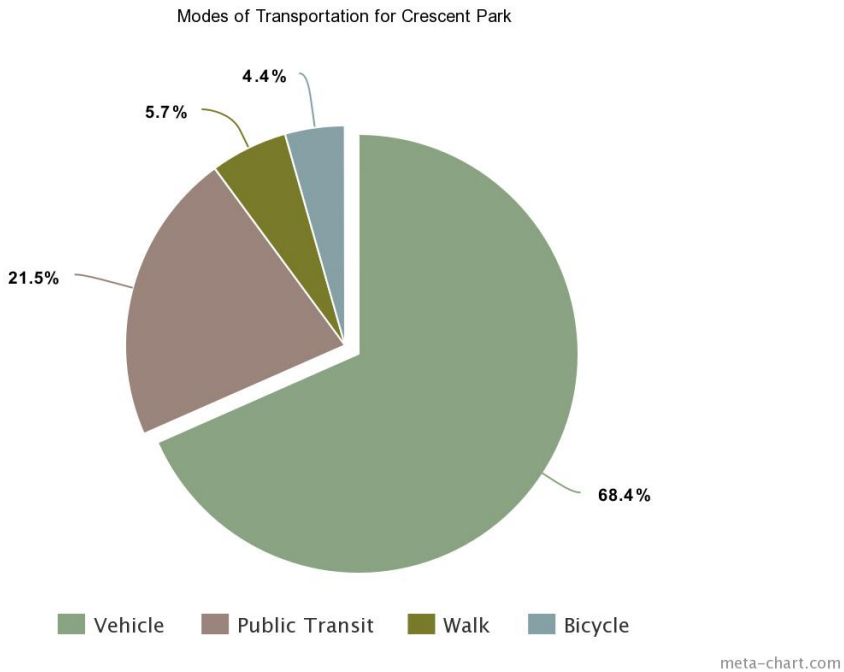


Figure 93 - Chart showing modes of transportation for Crescent Drive Park

5.2.4 Site Opportunities & Constraints

Opportunities

Designing the building in the park will offer the convenience of urban amenities and transportation while optimizing privacy through integration into the forested park area. Location directly off of Crescent Park Drive (Fig.89) allows for ease of emergency vehicle access. Pathways (refer back to Fig.75-76,84) within the park forest offer a chance for family, friends, and staff to decompress outside of the interior environment. This has the potential to alleviate negative health effects caused by any stress surrounding end-of-life care and death.

Constraints

Vehicular traffic going in and coming from the Park are problems acoustically and for privacy. Site location is not directly along the river and is not a possibility

without disrupting the park itself and existing vehicular pathways. However, the river is still in close proximity and able to be accessed by foot at multiple locations.

5.3 Building Analysis

5.3.1Building History and Reasoning for Design Re-use

5.3.1.1 Design Re-use

The resort itself was built in 1976 by Venture Manitoba Tours a Crown corporation and originally named *Gull Harbor Resort and Conference Centre*. The resort (Fig. 94-100) was designed by Gustavo Da Roza in 1977, where its style influenced by a prior trip to Scandinavia. It was designed to be responsive to the environment and Icelandic architecture of original settlers. Although the building was designed for its original site, it is the resort's site responsiveness and Scandinavian style that ultimately led it to be selected as the design model to be built on the Crescent Drive Park site. The park site demonstrates similar attributes to that of Hecla Island, for which Da Roza's intended the building complimenting a particular natural landscape. These similar attributes are (1) the forest park area, (2) large expansive greenspace, and (3) the proximity to a body of water. Da Roza's inspiration of local culture, which resulted in the Scandinavian style architecture of the building, ideally complements the concept of hygge applied to the design of Communitas House.

Despite the building and Hecla site being similar to Crescent Drive Park, and therefore ideal for the project, its rural location made it unsuitable. Inaccessibility to the island and distance away from Winnipeg are not comparable to the practicum project programmatic requirements. Due to the majority of MAID deaths occurring within Winnipeg and its central location hosting accessibility to many amenities and ease of

transportation, the practicum site had to be in this urban setting. Therefore, it was inevitable that the design of the Hecla resort building be built on the Winnipeg, Crescent Drive site.

5.3.1.2 History

The two storey complex had four wings of guestrooms and four suites that sprawled from a central lodge. Use of wood and shingles on huge roofs (Fig.94-95) and absence of windows on north speak to winter climate, spacious windows open to gardens and water on sunny sides. Inside there is an indoor pool and gym, a beautiful lounge and dining room that share an open limestone fireplace. The cabin wings have steeply sloped wooden roofs with no overhangs to block the sun. (Gustavo Uriel Da Roza, nd.)



Figure 94 - Exterior entrance of Lakeview Resort and Spa



Figure 95 - Existing architecture of Lakeview Resort and Spa



Figure 26 - Back Exterior of Lakeview Resort and Spa, showing patio deck and large expanse of windows

In 2004, the Manitoba Government announced plans for “new development opportunities” (The Globe and Mail, 2004). Interestingly enough, owner Ian Rabb had a business solution of creating an addiction treatment centre in order to capitalize on the 20$ billion industry which is Health and wellness tourism or medical tourism. However, Rabb’s plan was never realized. In 2005 Manitoba sold the property to the Paleha group and the resort was renovated (Fig. 97-100) to include a luxury spa, water park, and gourmet restaurant. This version of the resort reopened for business in 2008 as the *Radisson Hecla Oasis*, but after struggling to make profit Paleha shut it down in 2010 (Chapin. A, 2014).

Finally, in 2012, *Lakeview Management* bought the resort naming it *Lakeview Resort and Spa* (Cash, 2012). The resort maintains the renovation and design that was created for the *Radisson Hecla Oasis.* De Roza’s original architecture still remains, with some demolition to several wings for guest rooms. In the interior, designers expanded on De Roza’s appreciation for the surrounding landscape by incorporating natural materials, colours and site materials.



Figure 97 - Lakeview Resort and Spa lobby



Figure 98 - View towards sitting area in lobby



Figure 99 - Corridor between lobby and restaurant



Figure 100 - lobby sitting area to the right of entrance

5.3.2 Features

Structural

- Concrete columns

- Steel Frame

Building Envelope

- Large and abundant amount of window openings

- Interior separated into separate wings

- Multiple points of egress

- Double height atrium within entrance

- Scandinavian inspired architecture with stone and timber claddings

Non-Structural

- Culture Stone (Fig.94-95,98)

- Timber posts and beams (Fig.94)

- Concrete flooring (Fig.97-100)

-Wood and stone siding (Fig.94)

Circulation

- Several stairwells located within the interior, corresponding with each separate wing

- Elevator

- A ramp within the entrance leads to another wing of the building providing adequate accessibility (Fig.97)

Mechanical/Electrical/Plumbing

- Plumbing and Electrical provided in each wing of the building

5.3.3 Building Opportunities & Constraints

Opportunities

- Large expansive windows allow for optimal daylight into the interior, as well as views to the exterior landscape
- Separation of the building into wings and allow for an initial entrance space and separation between the clinical and ritual spaces within the programme
- Peaked roofs allow adequate drainage
- A second level provides opportunities for views of the river and surrounding Winnipeg scenery. As well as creating separation between administration and educational programmatic elements of the project

Constraints

- Double height atrium of the entrance requires better ventilation and temperature control through sustainable design practices
- Large windows will require adequate solar and glare. Also, privacy for inside users will need to be examined

6.0 | Chapter 6 – Spatial Concept and Design

6.1 Spatial Concept

The concept of *hygge* was selected to inform the overall design approach for Communitas House (Fig.101). As a facility that deals with the importance of embracing and choosing the experiences individuals have at end-of-life, hygge encourages feelings of being at ease and present in the moment alongside a supportive collective. Since *communitas* is directly linked to community equality in liminal rituals, such as MAID, it is imperative that the design concept reflects this. Not only does hygge embody the importance of social rituals found in liminality, but also the overall wellness supported by incorporation of natural elements, as implemented through biophilic design. Therefore, the concept of hygge seeks to merge the theoretical components of liminality and biophilic design into the practicum by supporting the needs of the collective's experiences and supporting their various degrees of wellness throughout them.



Figure 101 - Exterior Entrance Perspective

6.1.1 Design Features

Communitas House incorporates design features that aim to embrace the coziness and intimacy of hygge, all the while engaging in the social constructs of end-of-life rituals. A mix of biophilic elements, both direct and indirect have been incorporated to augment these experiences by enhancing wellness and connection to what is inherently familiar, which are the expressions of the natural world. Direct connections to nature begin with various immediate views to the exterior landscape, which also means an abundance of natural daylight. Indirect connections have been incorporated through living walls, potted plants, acoustical moss wall tiles and water features seen throughout the facility. Symbolic representations of nature are seen through fine art, lighting features and material selections such as wallcoverings, paint, flooring, and upholstery.

Another symbolic feature incorporated into the design were circular formations These formations can be seen on various architectural planes fully formed or abstracted to subtly influence the idea of ‘gathering around’, thus supporting the collectives’ social moments. Also noting the importance of the circular form as an organic element, it has been carried through as an architectural language captured in furniture selections, upholstery details and lighting choices.

6.2 Design

The design outlined in the following section involves the design reuse of an existing resort building. This architectural model was used as a foundation for the newly defined hybrid hospice design specifically for individuals seeking MAID in Manitoba. The existing buildings, shown in Figure 103, have been demolished to accommodate for the new building The experience of the hospice starts at the entrance of Crescent Park where the architecturally adapted building has been designed among the natural landscape in order to capitalize on the

healing benefits associated with it (Fig.102). Ultimately the architecture of the existing building has been maintained as it reflects the design principals required of the project (Fig.108-111). These architectural features include the exterior architectural shell, original wood and stone cladding, timber post and beam details and exterior windows. Additional windows and doors have been added as well to capitalize on meaningful views, daylight and direct connection to the outdoors. Furthermore, the design includes alterations to the exterior landscape to best suit the programme of Communitas House.

The existing building's design of 'wings' (Fig.106) and floor level separation allowed the design and programme to suit a facility with different functions, but a similar goal: to better end-of-life care services and support meaningful user experiences. Strength of this goal derives from the naming of the facility itself. Communitas House focuses on the collective's experience and the value of choice in end-of-life healthcare settings. The facility's design aims to allow terminal patients to control their own end-of-life narrative within the comfort of a properly designed interiors for MAID. Ultimately the design acknowledges that there are a variety of end-of-life experiences that can occur and therefore Communitas House should be adaptable in order to support control over experiential narratives. With adaptability in mind, there remains the overall goal for users to experience feelings of coziness and comfort associated with hygge as they interact with their interior spaces.



Figure 102 - Site map showing Communitas House, Crescent Drive Park and surrounding residential area

6.2.1 Exterior Landscaping

Located in Winnipeg's Crescent Park area there is a direct connection between Communitas House and the natural environment. The existing landscape is ideal with the heavily forested area of the park and greenery of the existing golf course (Fig.102). However, additional

landscaped elements have been added to enhance the users' experience and enhanced wellness through connection to nature (Fig. 102, 104). Firstly, on the West side of the facility, a row of trees was added to create a visual separation between the interior of the outpatient clinic and the new parking lot (Fig.103,110). This parking lot was added directly next to the building to create accessibility. The existing lot, located farther away was maintained to act as overflow parking, especially in the instances of larger seminars or conferences. Since the South façade directly faces the street but is set back on the site, a vehicular access road and service road have been designed to create proper access to the site (Fig102, 104). The north portion of the site, which is more private, features a labyrinth design, pond and fire pit area (Fig.104,170-171). These landscape features allow users to engage with nature in different cultural and spiritual rituals, while also providing for physical and psychological wellness. The labyrinth design was inspired by the Bridgewater Active Healthcare's feature of it on an exterior terrace, discussed in Chapter 3, as a mode of spiritual and emotional transportation from the bounds of the clinical interior itself. The pond design was influenced by the cultural and spiritual references discussed in biophilic design in Chapter 2, as well as the relevant MAID precedent of Esther Supernault, discussed in Chapter 4. Due to the climate of the site, experiences of these landscape features will differ depending on the season and therefore it was an important consideration of the final design to incorporate variations of them within the interior.



Figure 103 - Site plan, showing existing buildings to be demolished in dashed lines



Figure 104 - Rendered site plan, showing Crescent Park Drive and main access roads into site, parking, landscaping and prominent architectural features

6.2.2 Entry and Spatial Organization

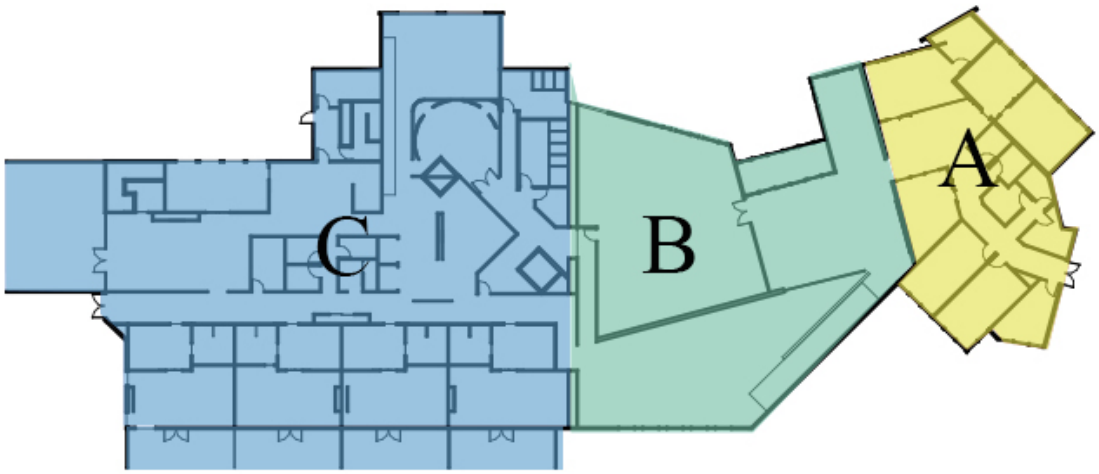


Figure 105 -Perspective of entrance to Communitas House at night

All users will enter Communitas House (Fig.105) through the main entrance on the South façade of the building (Fig.104). This allows for security of the building but also for a uniform experience of the interior itself. Depending on the type of user, they will navigate through the space differently, by the aid of wayfinding devices and guidance at the initial reception area (Fig.106-107,112). The separation of areas in lieu of their degree of privacy and accessibility was influenced by North London Hospice (NLH), as discussed in Chapter 3. These areas of separation are translated through the wings of Communitas House shown in a key plan below Figure 106. Wing A refers to the outpatient clinic area, B to the seminar and break out area and finally C where the main level hosts the residential area and second level the administration

offices (Fig.112,172). Key plans have been added to every sub-plan of the building for clarity of spatial organization between rooms, wings and the exterior.

An open-floor planning allowing connection between different common areas with visual and physical access to the outdoors was another important implementation from NLH. Keeping this openness in mind, it was imperative to also consider the intimacy and differing sizes of collective groups. Along with the necessity of options for MAID rituals, a variety of spatial options in various scales where constructed with movable and adaptable furniture selections, which can be referred to in detail in Appendix B. Furthermore, although the project maintained a strong focus on social gathering spaces, smaller and more flexible spaces were integrated into the design for individuals who desire more private experiences for pause and reflection.


C
B
A

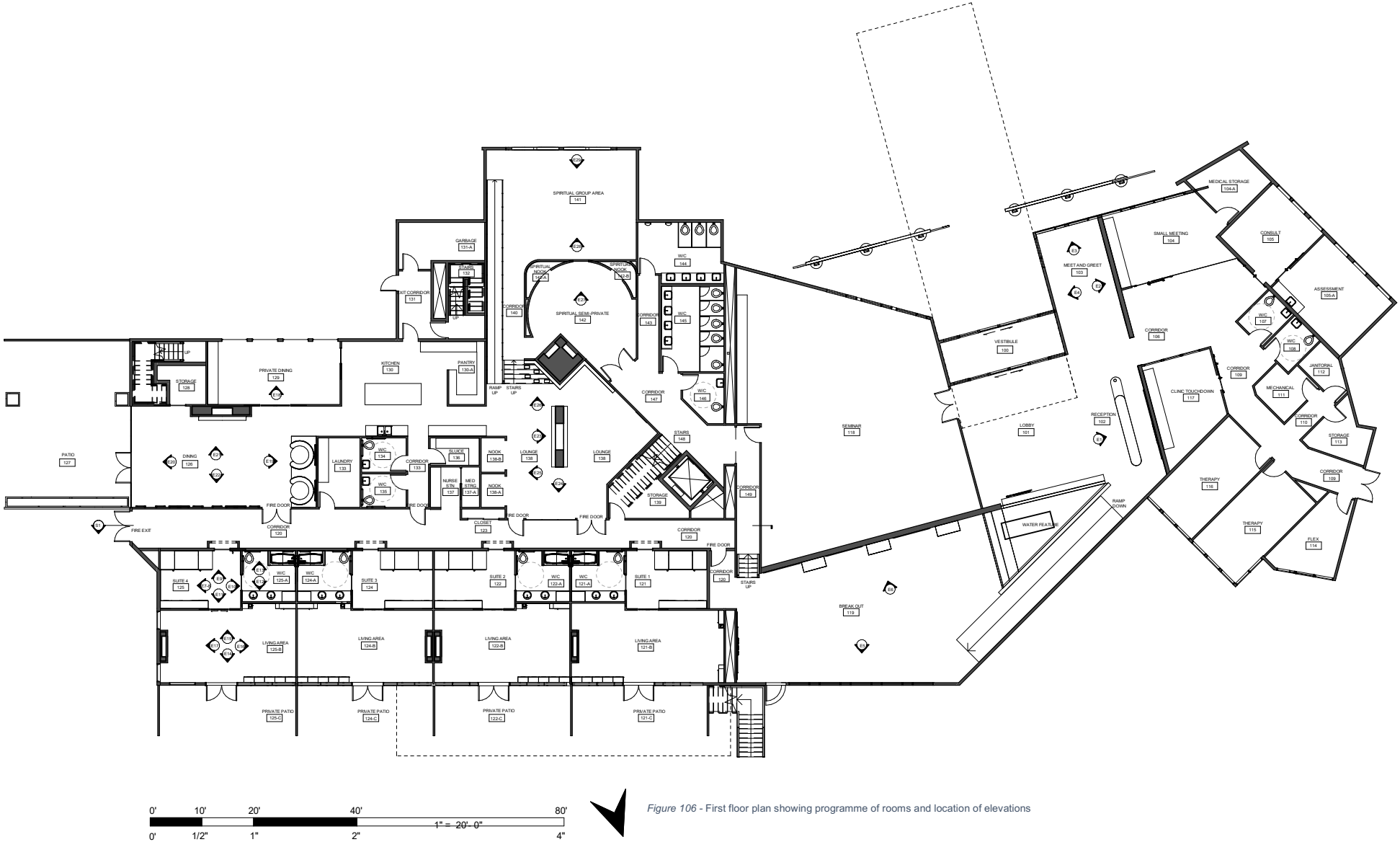


Figure 106 - First floor plan showing programme of rooms and location of elevations

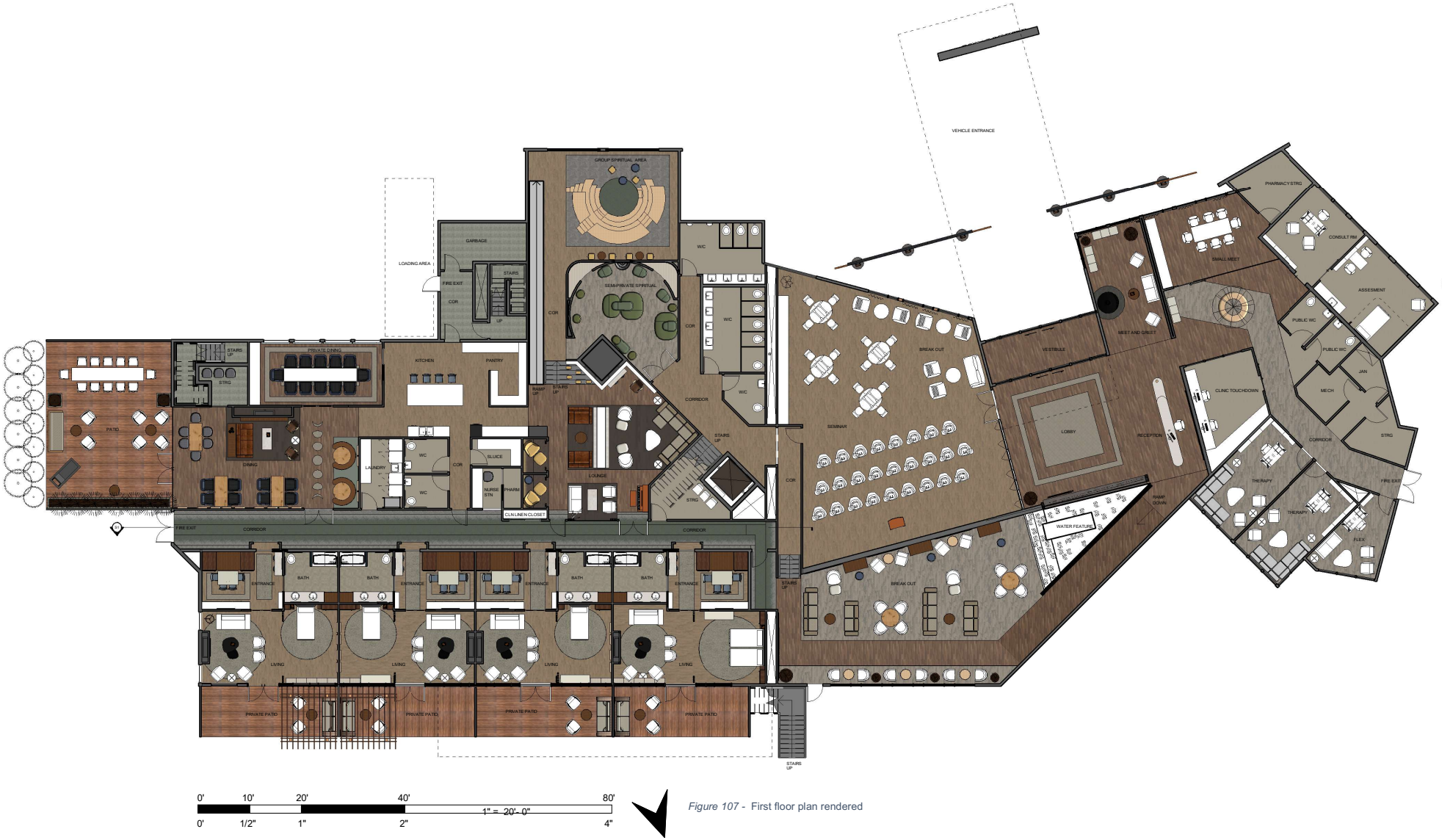


Figure 107 - First floor plan rendered



Figure 108 - North building elevation NTS



Figure 109 - South building elevation NTS



Figure 110 - East building elevation NTS



Figure 111 - West building elevation NTS

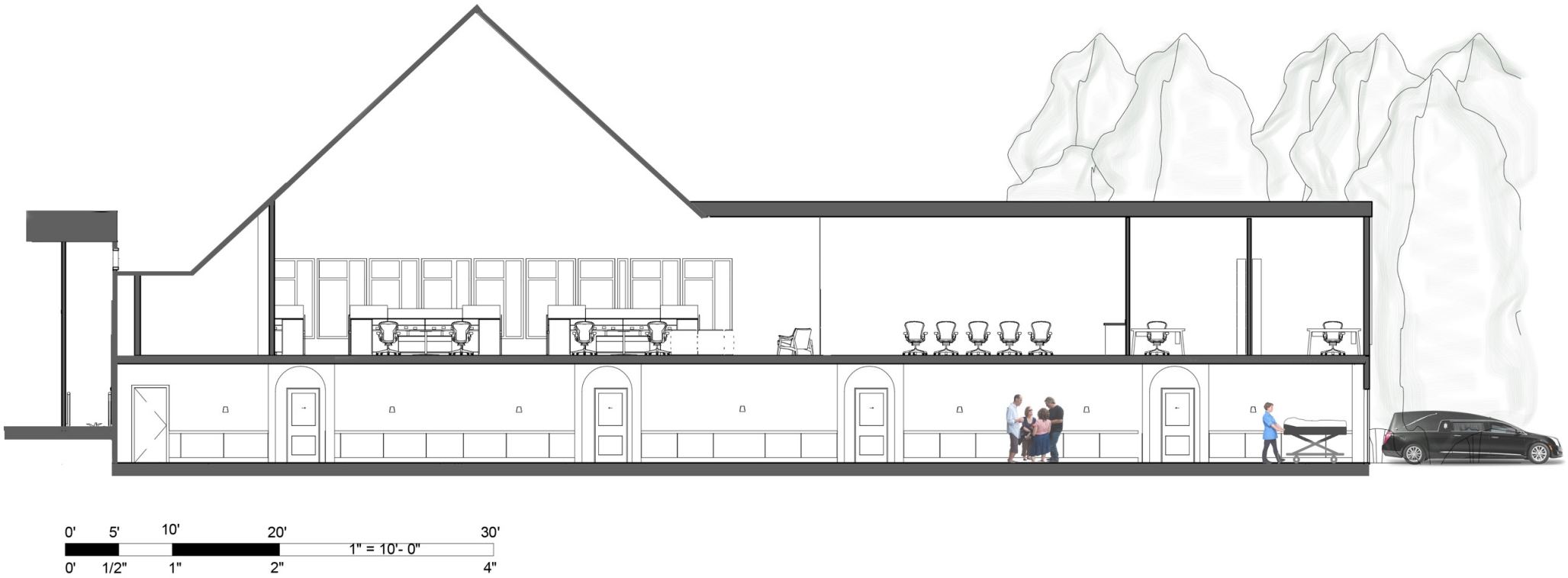


Figure 112 - S1 - North interior section NTS

6.2.3 Lobby, Reception and Meet and Greet

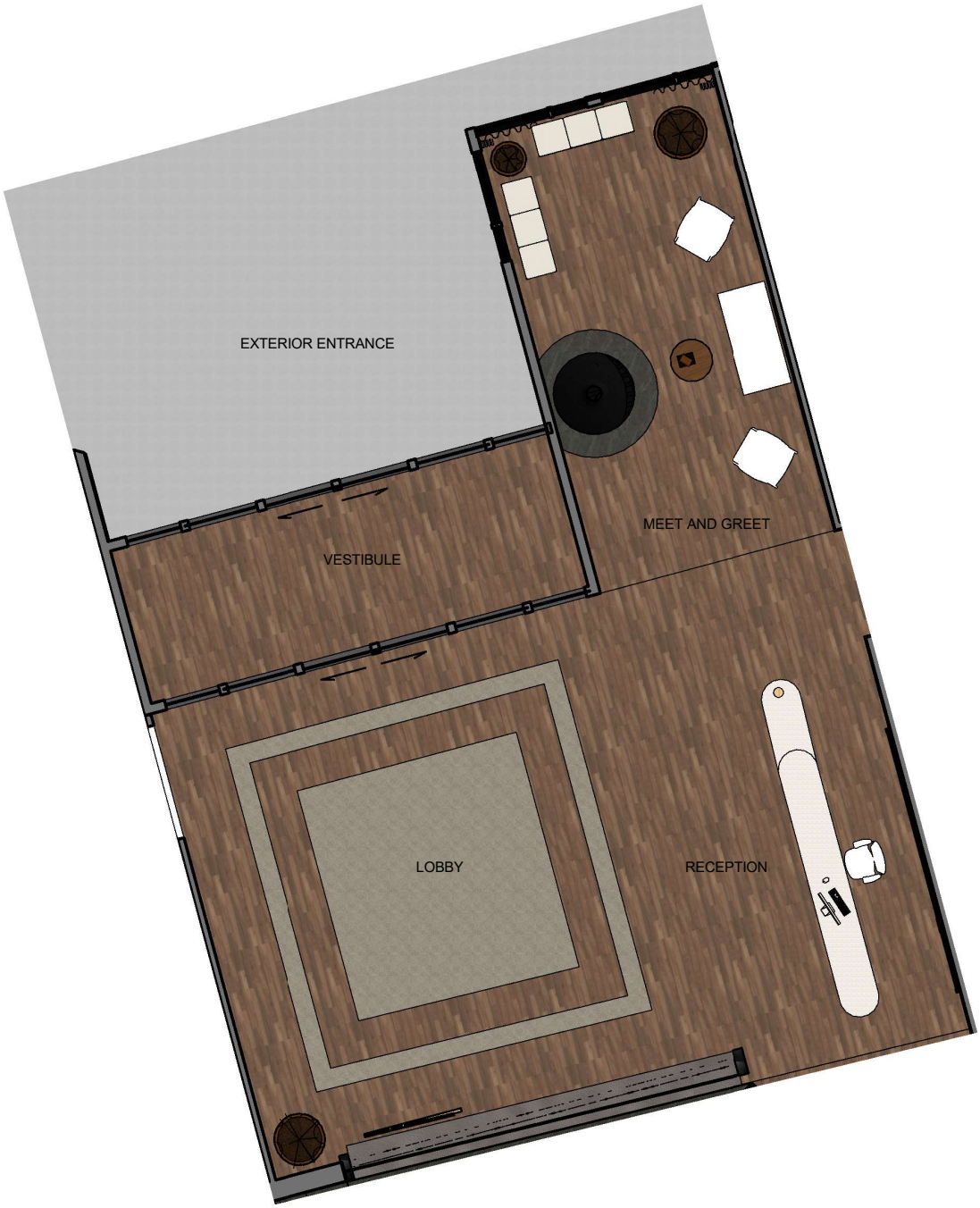


Figure 113 - Entrance floor plan rendered

Users will pass through the automatic glass sliding doors of the existing vestibule into the lobby area of Communitas House. The users' initial experience of the interior will be of the full height water-wall feature (Fig.114). The wall contains a welcome sign that operates as a method of wayfinding. Benefits to this water-wall are twofold: firstly, from a biophilic design standpoint there is a direct reference to nature that aims to capture the benefits of physical, emotional and spiritual wellness; secondly, the water feature aims to enhance air quality and maintain a balanced humidity in what is a larger atrium space. The aim of the interior is for the first impression to be focused on the familiar and natural world, rather than the clinical aspect of the facility.



Figure 114 - Interior entrance showing water wall and reception area

To the left of the lobby is a reception desk (Fig.114-115). Placed indirectly, the reception and merging of the meet and greet area offers an informal variation on healthcare intake. At reception users will be guided towards the appropriate wings: A, which is the outpatient clinic

located directly behind reception (Fig.115,168), B- the seminar area, (Fig.121) and C- the inpatient residential area on the first level and administration on the second level (Fig.112,172).

The backdrop to the reception area is a full height living wall composed of a variety of moss plants (Fig.115). Inlaid into the living wall is a black powder-coated silhouette of Winnipeg's two rivers. The scale and composition of the living wall behind reception aims to take away from the inherent negative associations with clinic spaces and traditional healthcare reception areas. While the greenery of the living wall itself has a direct connection to nature, the symbolic reference to Winnipeg's landscape contained in the river silhouette, creates a placed-based relationship with the site. This relationship subtly implies a geographic connection for users and allowing the architecture itself to contain a spirit of place.

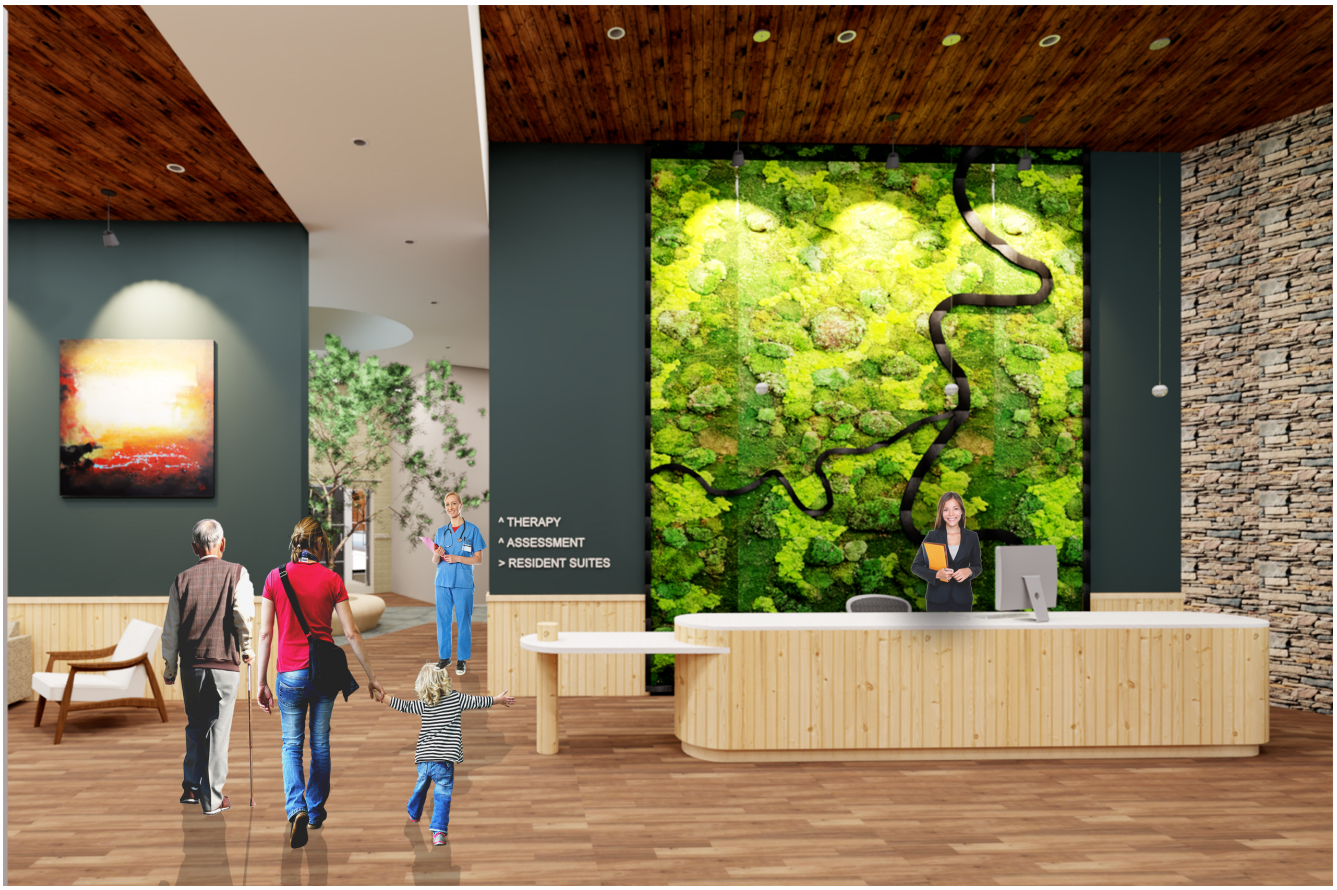


Figure 115 - Reception area and corridor to outpatient clinic area

The Meet and Greet area (Fig.116, 118-120) is an informal waiting area where patients can wait and meet with a member of the MAID clinical team before entering into the outpatient clinics for assessments or consultations. This space was adapted from the casual reception area focus of North London Hospice. Although the reception desk was a necessity for the scale and layout of the building, the Meet and Greet acts as an auxiliary space for a more casual greeting area between staff and patients. The space also facilitates as a waiting area for family members and other users. As a place of pause, the exterior windows allow for valuable viewpoints to the outdoors. The assemblage of comfortable furniture, modern fireplace, artwork and tall layering of draped curtains creates an inviting space indicative to that of a residential environment, rather than a clinical one.

To further maintain a warm and inviting atmosphere, while imposing functionality, a specific lighting plan was arranged (Fig.117-120). General lighting serves to give properly illuminate the entire entry area and pendant lighting is reserved for task work at the reception desk, while focus lighting highlights the vertical planes such as the water feature, living wall, and artwork.



Figure 116 - Meet and greet perspective

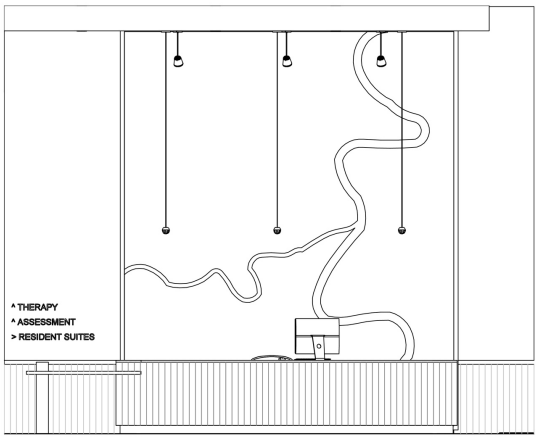


Figure 117 - *Reception - E1 - West Elevation - Scale: 3/16"=1'-0"*



Figure 118- *Meet and Greet - E2 - West Elevation - NTS*



Figure 119 - Meet and Greet-E3-South Elevation-3/16"=1'-0"

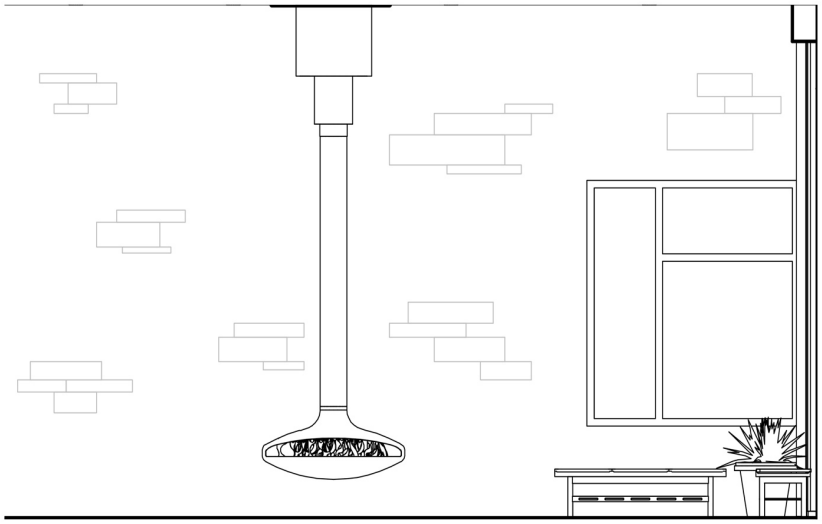


Figure 120 - Meet and Greet-E4-East Elevation-3/16"=1'-0"

6.2.4 Breakout and Seminar

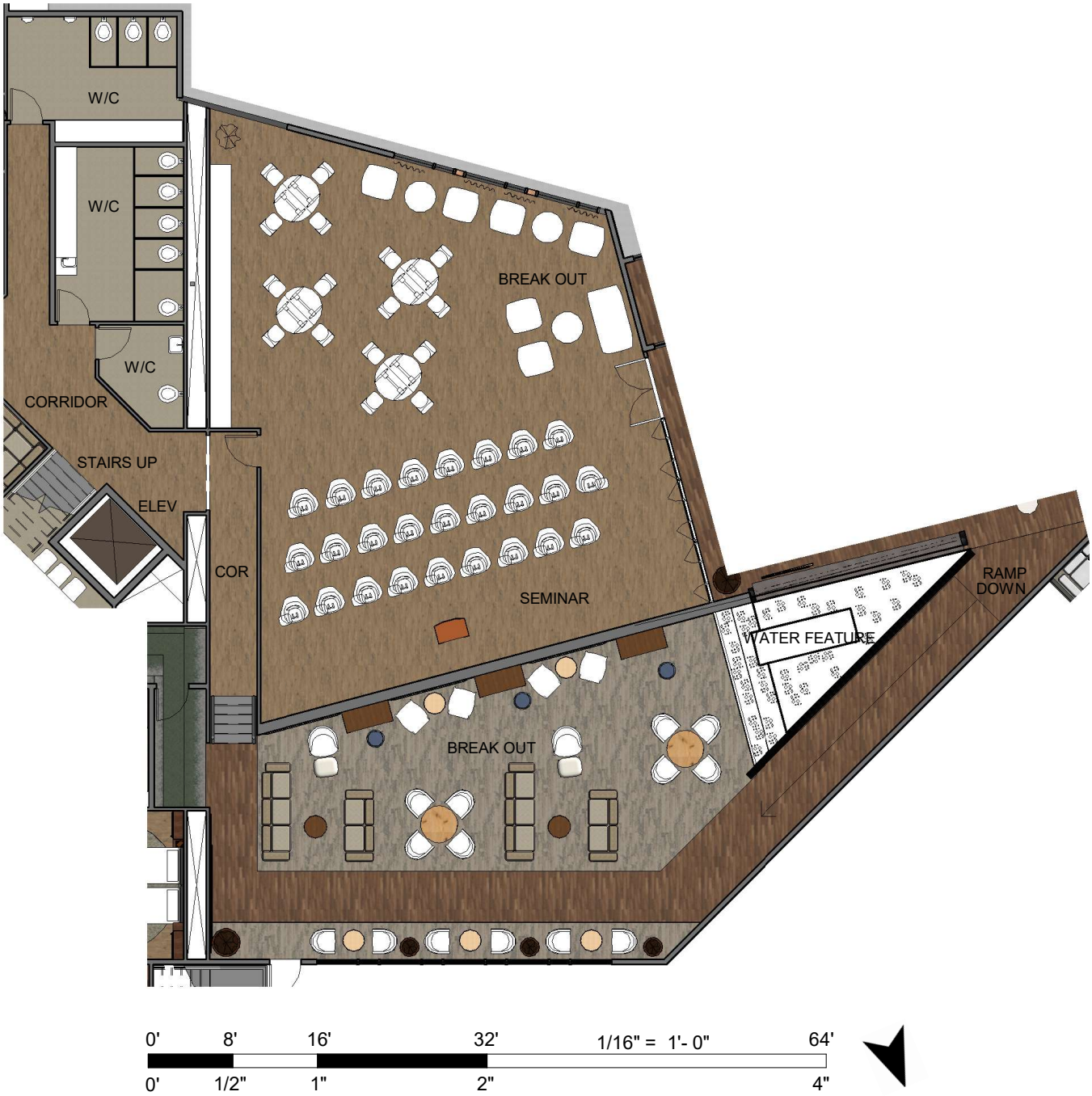


Figure 121 - Seminar and break out floor plans rendered

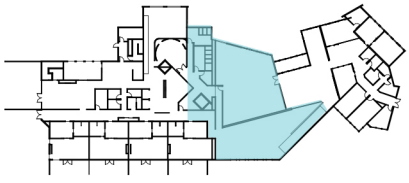




Figure 122 - Break out area perspective with view to exterior landscape

After patients and their families have registered in at reception, they will continue on past the lobby area, heading down the ramp and pass through the breakout area (Fig.121-122), before entering the residential wing of the building. The breakout area is meant as a retreat zone and central space for users from each area of the facility. Essentially it is a gathering spot able to be utilized by staff, patients, families, and workers of the facility, or visitors of any sort. Large expansive windows create a direct view to the outdoors and immediate connection to nature (Fig.122-123). Although this area features many of the same materials as in the initial entrance area, the composition and scale have varied to open it up to be an area of prospect, a transitional area between the spatial refuges designed within the meet and greet and resident suite areas of

the facility. Ideas of retreat and prospect are biophilic design elements, but also offer different types of comfort to embrace the overall feeling of hygge within the interior.

The breakout area offers a variety of seating options and spatial configurations, offering alternative ways in which people can gather or in selected instances, be alone (Fig.122-124). The sofa sectionals were selected for the specific purpose of spatial reconfiguration, as well as lightweight moveable side seating and ottomans. High-back seating allows for a semi-private option and finally, the integrated nooks allow for a solo seating arrangement. Large panels of natural white moss have been designed for acoustical absorbency within this large volume gathering space. While also maintaining the light open feeling of the breakout space, these panels also fulfill the aspirations for wellness, as the plants naturally filter the air throughout the space and create a closer connection to nature.

Changes in ceiling planes and flooring materials are used to denote different spatial areas in the break out area and carve out a direct walkway to the residential wing of the building. The wall-length of windows on the North Façade allows an abundance of diffused light into the interior during the day. Pendant lights, symbolic of birds will allow for an ambient glow in the evening hours, while general lighting will highlight the corridor path through this transitional space. Parallel to the breakout area is the Seminar room (Fig.121), also located just off of the main entrance lobby. The seminar room is unified by full-flood flooring with a natural wood-grain look. The space is divided by furniture assemblies, containing fixed, auditorium style seating on the North side of the room and group tables and breakout area on the South side. The space will host conferences, seminars, and workshops.



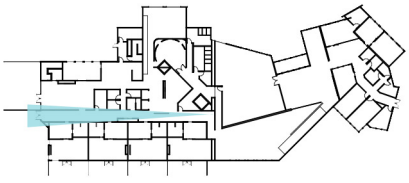
Figure 123 - Break Out- E5- North Elevation- NTS



Figure 124 - Break Out- E6- South Elevation- NTS



Figure 125 - Patient suite corridor perspective



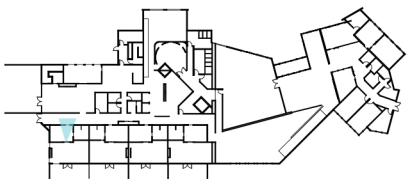
6.2.5 Patient Suites



Figure 126 - Patient suite floor plan rendered with alternate plan showing fold out bed in entrance



Figure 127 - Perspective showing entrance to patient suite and small gathering area



After passing through the break out space, patients will go through the entrance at the opposite end of the breakout space and head down the corridor (Fig.125). Located on the North side of the corridor are the four residential suites of Communitas House (Fig.107,126). All suites are identical, with exception of the first, which offers a slightly larger floor plan to accommodate for a two-patient room. This room type is to accommodate the option of having a joint MAID death, such as in the case of the Brickendens mentioned in Chapter 2.

The suites are composed of three separate rooms, with the intention of an open concept living area that also has the ability to be closed off in different ways. Firstly, patients and their families will engage with the suite through the entrance area (Fig.127). The entrance contains a small kitchenette area with cooler and storage for snacks and personal belongings, as well as integrated garbage and recycling (Fig.132). Off to the side is a small table area that can be converted to an overnight sleeping area (Fig.128-129). The table selected is foldable and chairs stackable for easy movability of spatial arrangements. A nook integrated into the millwork features another option for table seating or reading area while not in use for overnight sleeping (Appendix C for millwork details). An important feature, which adds to the users control of space is the Samsung Frame TV (Fig.132, 140-141). This technology allows users the ability to upload their own photos or digital art onto the screen to act as art when television viewing is not taking place.

Off of the entrance area is the patient suite bathroom (Fig.133-135). To maximize square footage and accessibility automatic pocket doors were specified for the suite (Fig.126, 131). The bathroom, while accessible has a material palette that aims to create a more spa-like feeling. Natural materials and symbolic architectural elements were carried through to capture the benefits of biophilic design and the feeling of hygge.

The largest, most open area of the suite is the living area (Fig.136,141), which can be accessed from the entrance. Along the North wall of the living area are an abundance of windows to create meaningful views (Fig.136-137,140-141) and allow for natural light to enter the space. Select windows are operable to allow fresh air into the space, as well as fulfill the needs of different death rituals. Double exterior doors also allow for direct access to the private patio area and the rest of the site (Fig.136, 142). Inside, the doors connecting the entrance area into the open living area have the ability to be left open and create more of a connection between spaces or to be closed for a sense of retreat, whether this is for users staying overnight in the pull out bed or for those family and friends who do not wish to directly partake in the Medically assisted death as it occurs (Fig.126).

Although the living area is an open concept there is the ability to section it off for more privacy. A curtain can be pulled to create a visual retreat from the portion of the space where the patient's bed is, to the lounge portion of the room. The sofa is also convertible to a sleeper so this curtain is necessary for privacy between both areas of the room (Fig.136).

In times when the collective wishes to gather there is a variety of flexible furniture options located in the lounge portion of the living space. Also, lightweight stackable chairs from the entrance area and ottomans can be carried into the other spaces to allow for increased seating. Finally, another source of seating comes from the millwork bench along the window directly across from the patients bed features a bench seating area (Fig.136-137) with storage underneath for users personal belongings.

Storage and display areas are important to the space as it allows for user control over their immediate interior environment. Horizontal surfaces such as the fireplace mantle, library shelves, and kitchenette counter offer a space to display objects, while a designated wall surface

behind the sofa may be utilized for personal photos or art pieces. Photos can also be uploaded to the Frame TV (Fig.140-141), which is located above the fireplace.



Figure 128 - Patient Suite Entrance- E7- East Elevation- NTS



Figure 129 - Patient Suite Entrance-E8- East Elevation bed unfolded- NTS

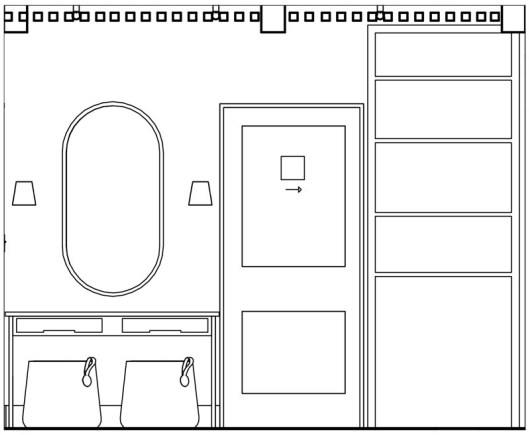


Figure 130 - Patient Suite Entrance-E10- West Elevation-NTS



Figure 131 - Patient Suite Entrance-E9- South Elevation-NTS

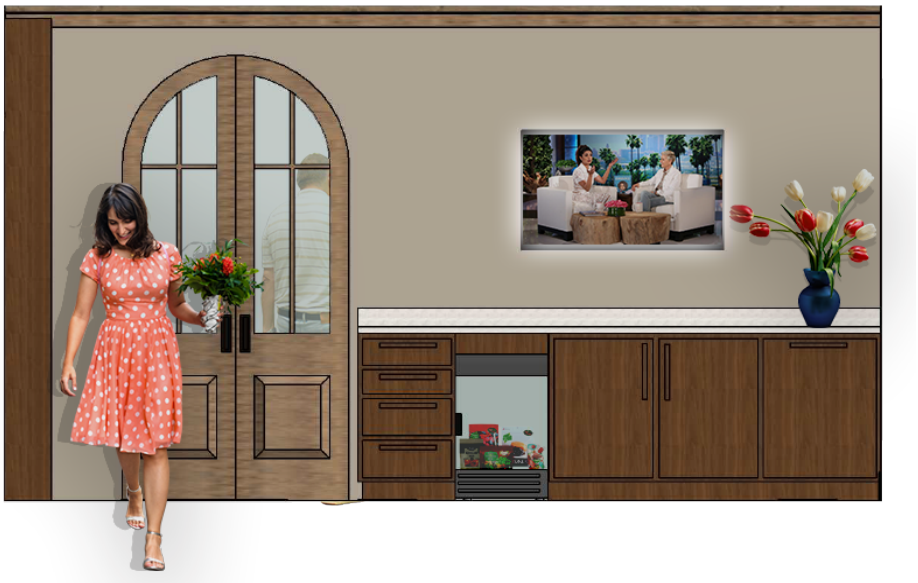


Figure 132 - Patient Suite Entrance-E11-North Elevation-NTS



Figure 133 - Patient suite bathroom perspective

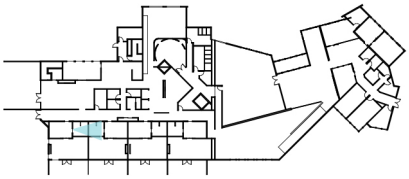




Figure 134 - Patient suite bathroom-E12-North Elevation-NTS



Figure 135 -Patient suite bathroom-E13-South Elevation-NTS



Figure 136 - View of patient resting area

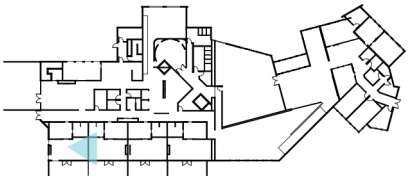




Figure 137 -Patient suite living area-E14-North Elevation-NTS



Figure 138 -Patient suite living area-E15-South Elevation-NTS

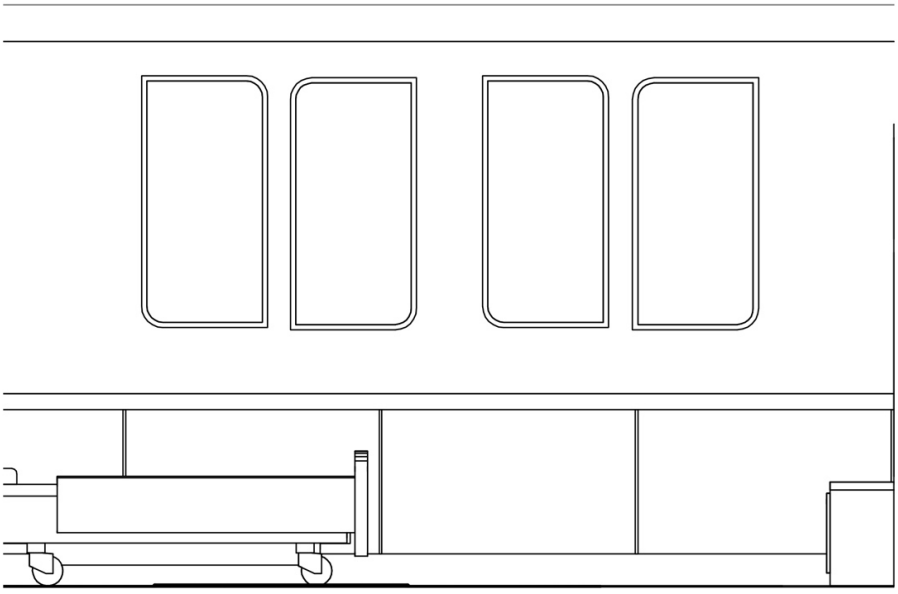


Figure 139 -Patient suite living area-E16-West Elevation-NTS



Figure 140 -Patient suite living area-E17-East Elevation-NTS



Figure 141 - Perspective of patient living and rest areas

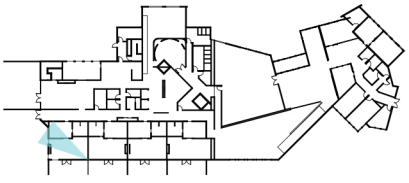




Figure 142 - Patient suite private patio rendering

6.2.6 Dining Area

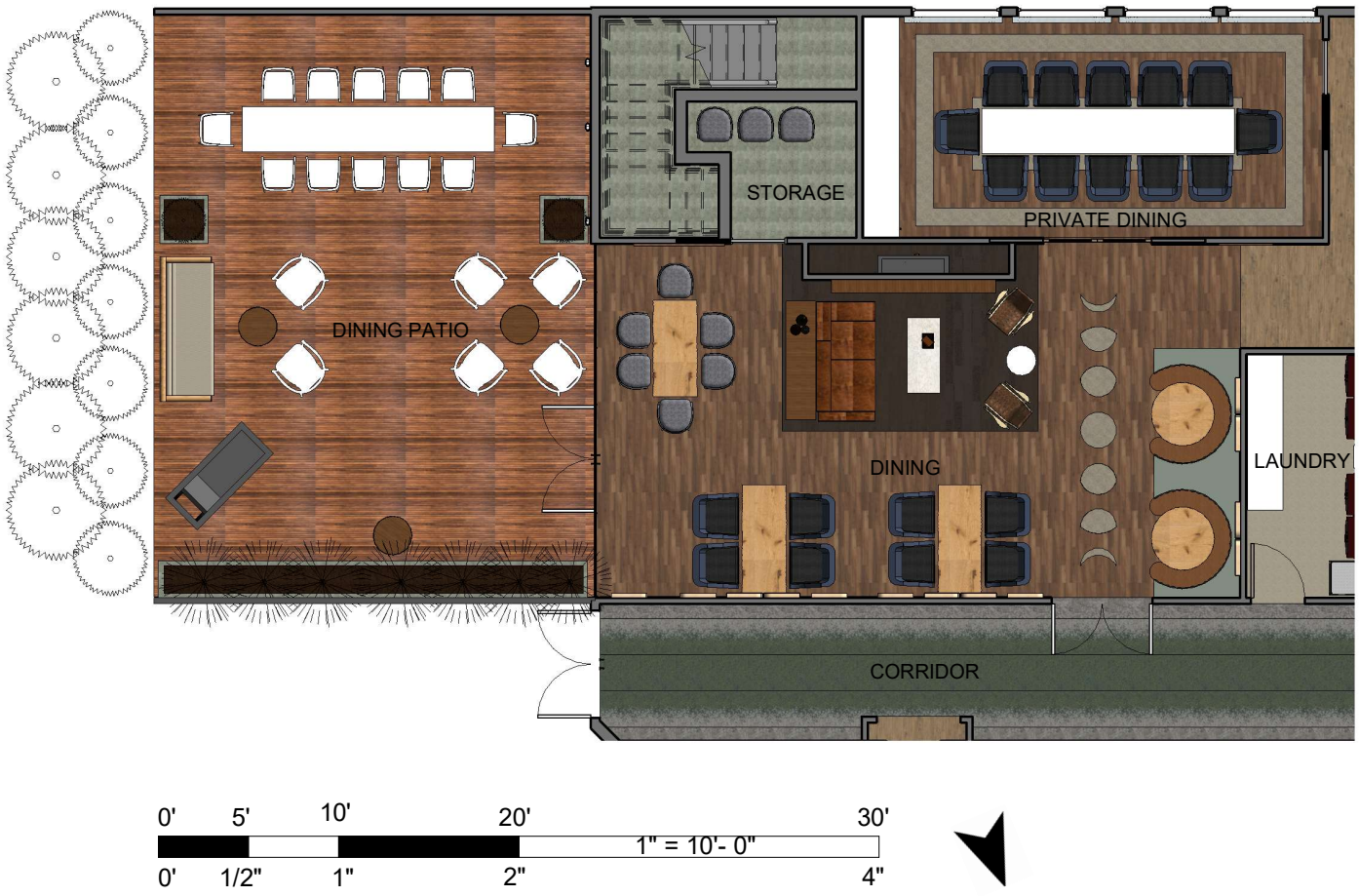
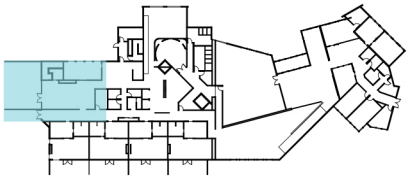


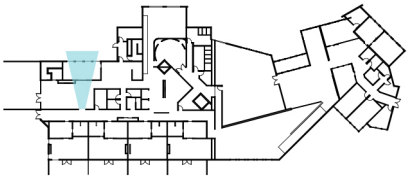
Figure143 - Dining area floor plan rendered



The dining area (Fig.143) is one of the common areas located directly across from the suite portion of Communitas House residential wing. This overall area features three distinct spaces: (1) interior open dining area (Fig.143,145,148-151) (2) private dining area (Fig 143,147,153) and (3) the exterior dining patio (Fig.146,152). Within the open dining area and exterior dining patio there are a variety of gathering options for both dining and lounge purposes.



Figure 144 - Entrance to dining area perspective



The fireplace, featuring local fieldstone, (Fig.144-145,148) acts as a central focal point for the entire interior dining area, where it can be seen from every gathering point. Other natural materials have been incorporated such as the wood baffles and moss tiles, to not only to enhance a sense of comfort and wellbeing through biophilic design but to also to absorb sound. Acoustically moss tiles (Fig.144-145,149-150) are found on several walls of the open dining area, where their functionality is preceded by their display as art. Comfortable lounge seating was selected to enhance the desire to gather and promote lengthened stays of social engagement. Upholstered seating, rounded booths, high back chairs maintain the open concept dining area, while also forming intimate spaces (Fig.144-145,148-151).

A private dining area and patio area contain long communal tables with the ability to host larger gatherings (Fig.147,152-153). Long, narrow custom tables encourage people to gather and share in food, which is an important life ritual. The dining spaces support these rituals that are important in end-of-life experiences. An example of such experiences was mentioned in the story of the Brickenden's found in Chapter 2, where the family engaged in a 'last meal important in end-of-life experiences. '



Figure 145 - Perspective of dining area

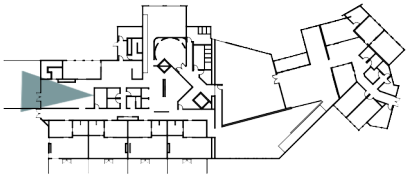
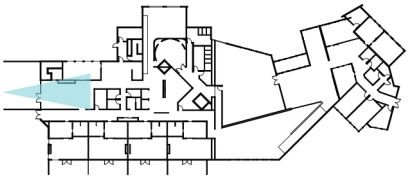




Figure 146 - Exterior dining patio perspective



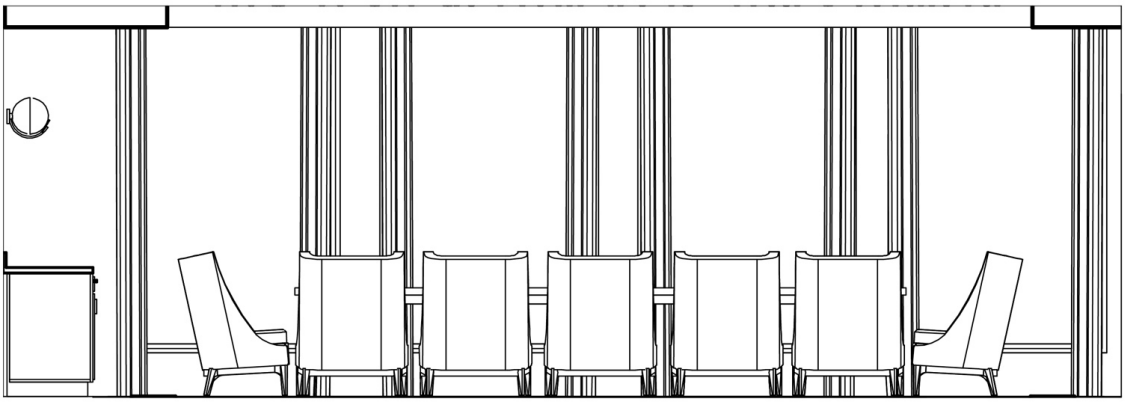


Figure 147 - Private Dining-E18-South Elevation-NTS

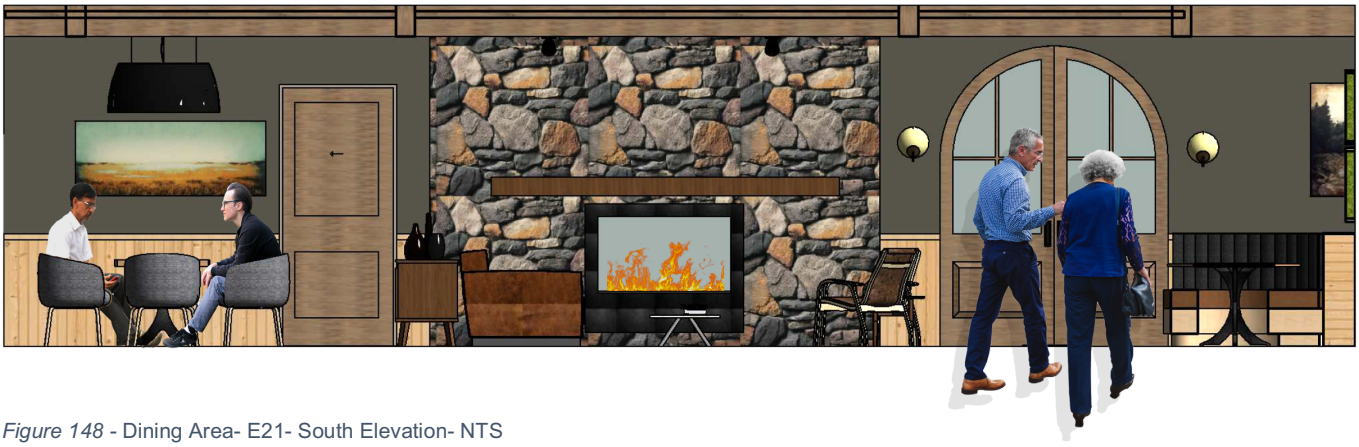


Figure 148 - Dining Area- E21- South Elevation- NTS

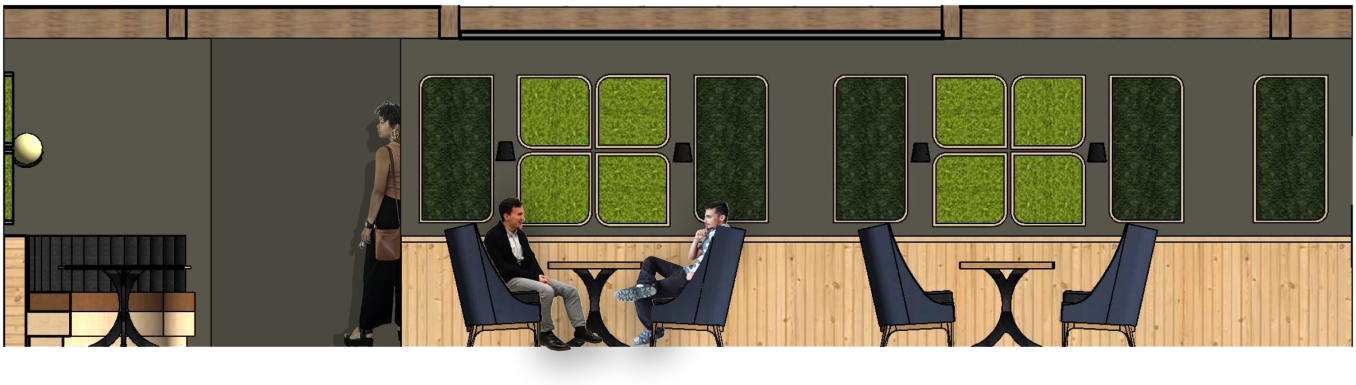


Figure 149- Dining Area- E22- North Elevation- NTS



Figure 150 -Dining Area-E19-West Elevation-NTS

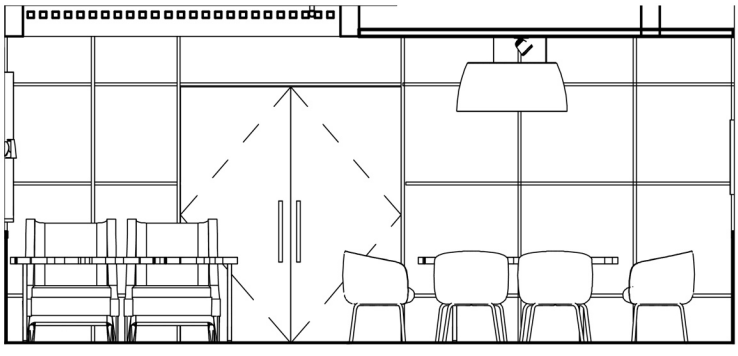


*Figure 151 -Di*ning Area- E20- East Elevation- NTS



Figure 152 - Perspective of exterior dining patio at night

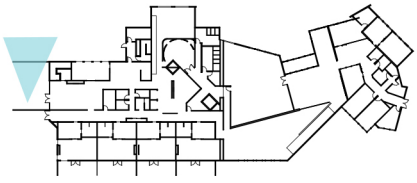




Figure 153 - Perspective of private dining room at night

6.2.7 Kitchen and Utility Areas.



Figure 154 - Kitchen and utilities floor plan rendered

As the heart of the home, the kitchen (Fig.154) was located centrally between the dining and lounge areas of the residential wing. An open concept floor plan allows for pedestrian flow between spaces and breaks down the barriers between the traditional back of house and front of house spaces. The openness provides cooks the ability to interact with guests, while also allowing families to partake in preparing their own meals. Guests are able to access the pantry and cooking elements, as well as stay and gather around a central island where they could visit or simply what the cooks at work.

Also located centrally in this wing are the utility spaces. Directly off of the kitchen is the garbage and exit doors, which allow for easy transfer between food and supplies coming in and waste going out. Washrooms are located in a through-way corridor between the kitchen and main suite hallway so they can easily be accessed from any residential area. Laundry can be accessed on the main suite corridor and is shared by both staff and visiting families. Across from the washroom and laundry areas are clinical spaces such as the sluice room, storage, nurse touchdown, and pharmacy storage. This spatial arrangement allows Communitas House medical staff to be accessible for patients and families throughout their stay. These rooms, inspired by Chapter 3's Sakura Suite also act as auxiliary spaces, for the MAID clinical team, as drugs and paper documents can be prepared here.

6.2.8 Lounge

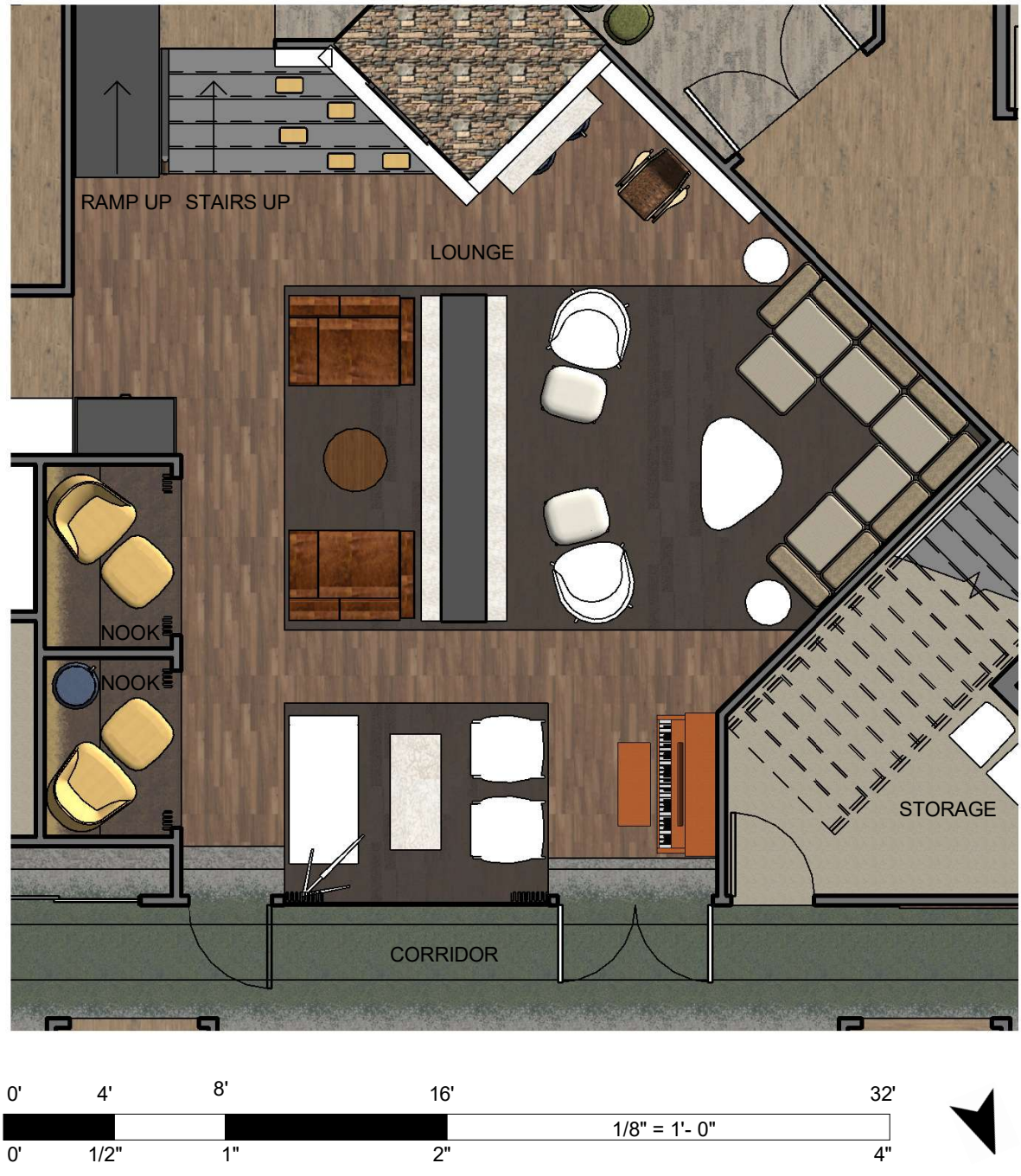


Figure 155 - Lounge floor plan rendered

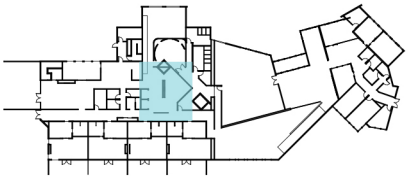




Figure 156 - Perspective of lounge showing different sitting areas

A communal lounge area (Fig.155-161) is located right of the main residential suite corridor and it can also easily be accessed from the dining area through the open kitchen. With a public programme for Communitas House guests, there can be interactions between MAID patients and their immediate collective, with other visitors and also staff members. The lounge is an alternative living area from those contained within the private suites. This option empathizes with the aspects of retreat that users may require if they want to escape situations occurring within the suite. As a common space, it can also simply give variation and atmosphere to other spatial gathering experiences. An example of this variation is the warmer aesthetic that is a result

of the rooms placement in the wing, where there is no immediate access to windows and natural daylight. Materially, also playing into this atmospheric quality is composed of a variety of warm earth tones from natural, textural hard materials, soft plush flooring, to the soft, neutral upholstery on the furniture.

Other examples of spatial variation are the multiple seating areas divided by a central double-sided fireplace (Fig.156-157,161). This notion deriving from the idea of the hearth as the center of the home, much like the kitchen. Referring back to Chapter 3, this design element engages with biophilic design principals and the feeling of hygge. Other elements such as library shelves, a glass 'window wall' (Fig.156,158), curtains, lamp, side and coffee tables, further play into the emphasis of creating a residential, homey feel.

Visitors can assemble and have control over their seating areas with the inclusion of a few flexible furniture options. Guest can rearrange or drag seating to form their own spatial requirements needed to engage or disengage with one another. Nooks (Fig.156,159) have been integrated into the wall for private moments of pause and retreat, for relaxation or can be used for intimate conversations.

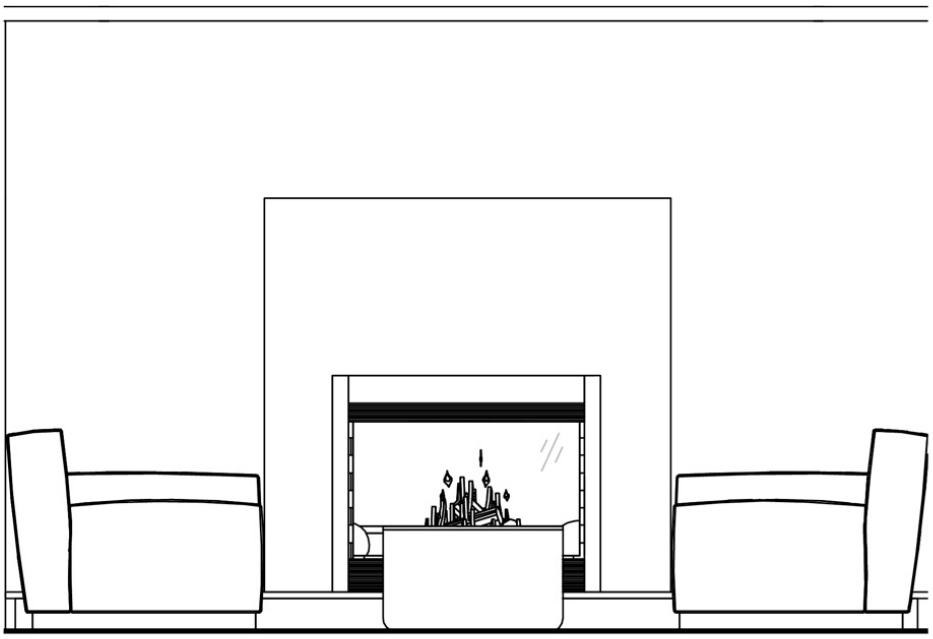


Figure 157 - Lounge Fireplace- E23- West Elevation- NTS

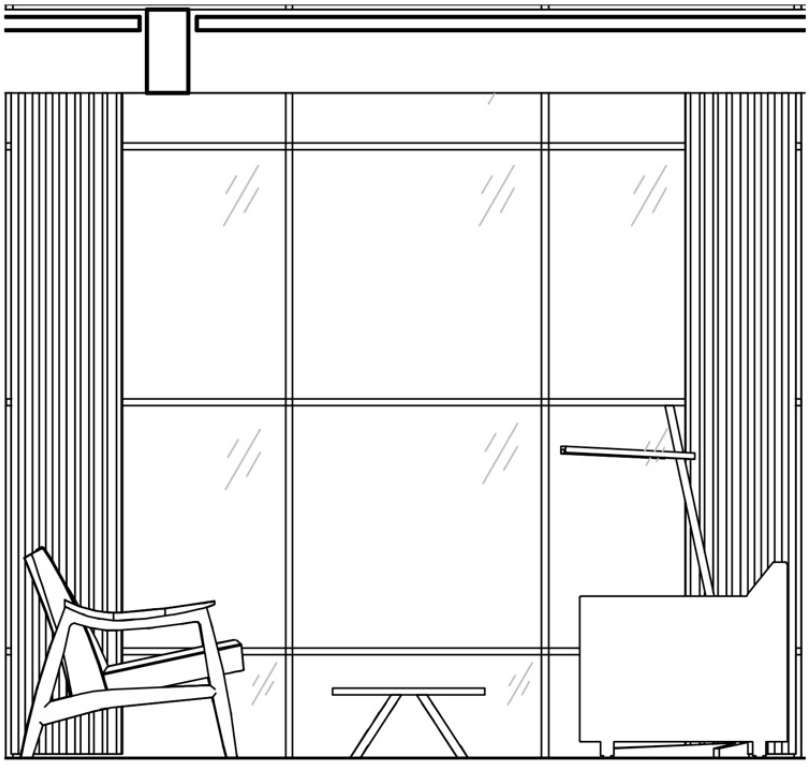


Figure 158 - Lounge Sitting Area- E24- North Elevation- NTS

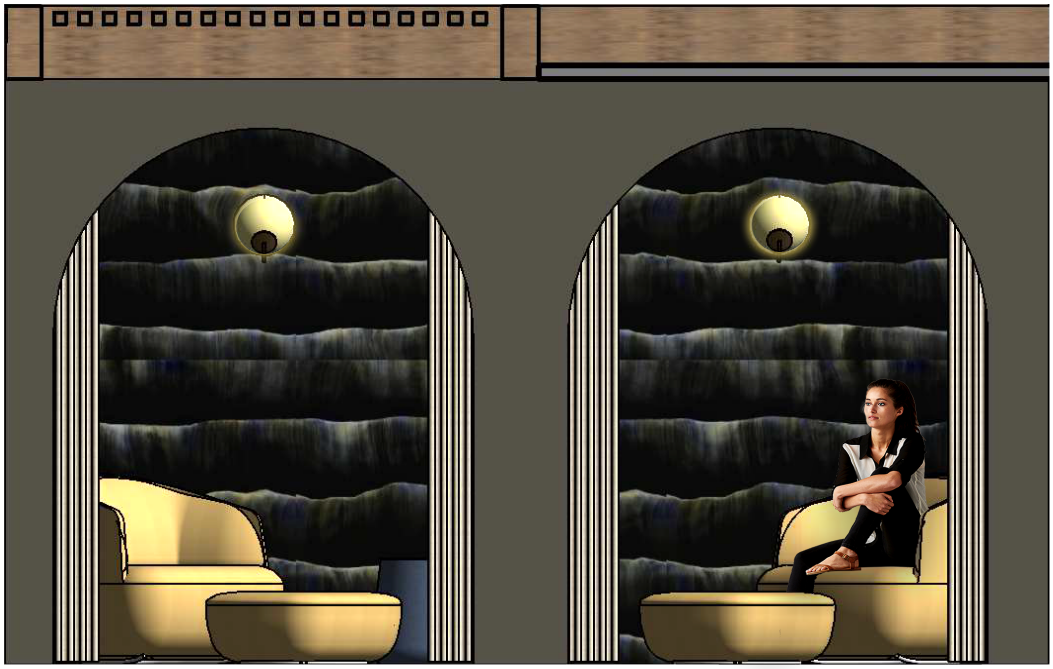


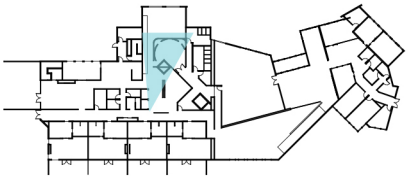
Figure 159 - Lounge Nooks- E25- East Elevation- NTS



Figure 160- Lounge Library Wall- E26- South Elevation- NTS



Figure 161 - Lounge perspective showing gathering areas and stairs to spiritual area



6.2.9 Spiritual Areas

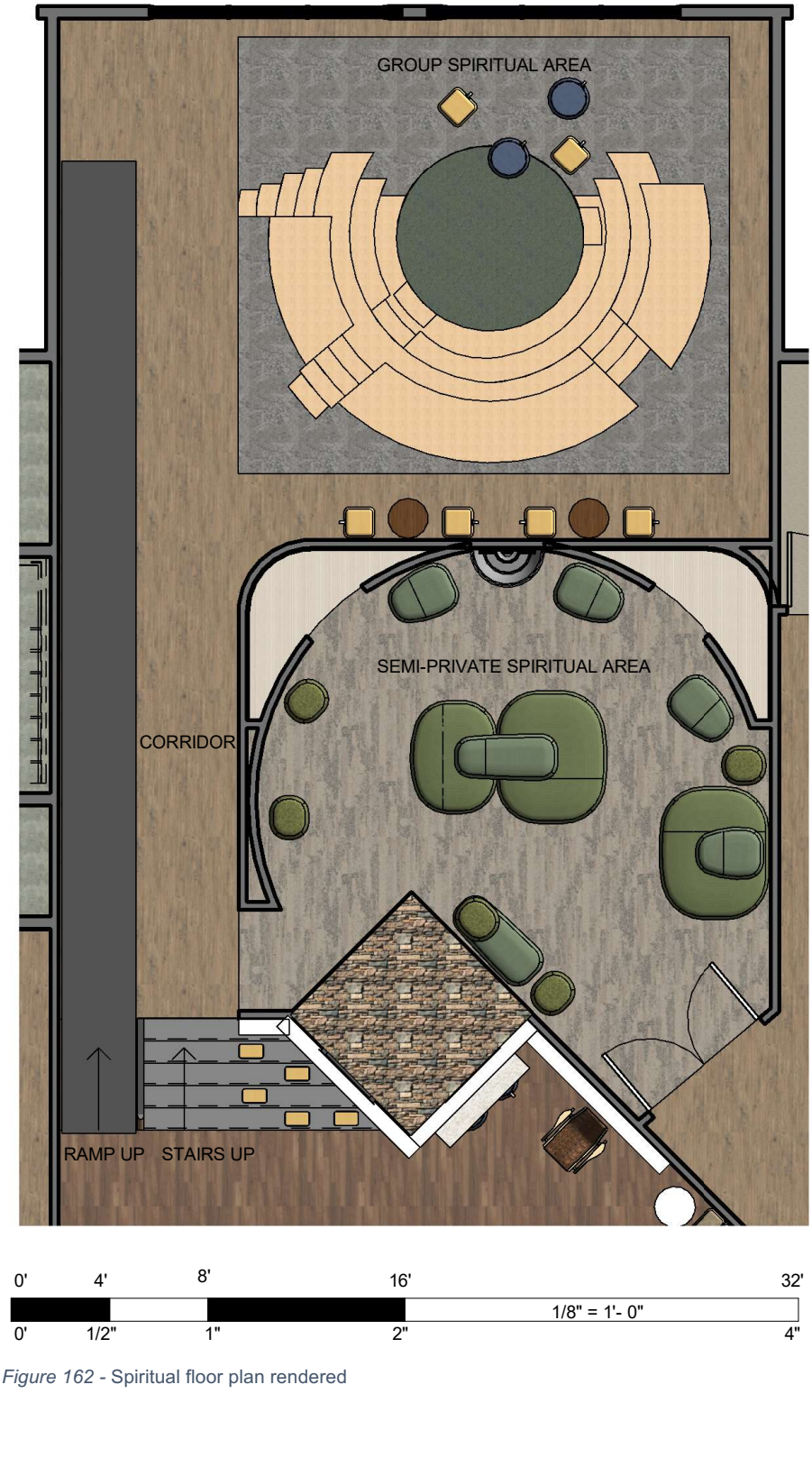


Figure 162 - Spiritual floor plan rendered

Leading up the stairs and ramp from the communal lounge area, two spiritual spaces (Fig.162) can be accessed. The spiritual programme was divided into two separate areas: (1) group spiritual area (Fig.162,164) and (2) semi-private spiritual area (Fig.162,163). This programme acknowledges the individual's need for variety in spiritual situations according to their emotional and psychological wellbeing. In one instance the individual may want to participate in a group spiritual gathering or cultural ritual, but on the other instance, they may require solitude and time for personal reflection.

The semi-private area (Fig 163) allows individuals to sit and reflect on their own time. This area is enclosed and devoid of natural light. Subdued, indirect lighting provides a calming and serene atmosphere, enhanced from the small water feature (Fig.163,165). Found along the curved wall, the water feature adds an acoustical element to the overall experience of the space, where its sounds are absorbed by the soft carpeting, plush seating and textured wall-covering.

Alternatively to the semi-private area is an open group gathering space (Fig.164). Featuring full-height south-facing windows (Fig.167) the space is flooded with natural daylight and direct views to the outdoors. This space offers a variation in spatial volume from the enclosed private area in which a double-sloped ceiling highlights the existing architecture of the building. Found in the middle of the group area is circular custom millwork seating (Fig.164,166). Individuals can 'gather around' on different levels and share in their collective ritual.



Figure 163 - Perspective of semi-private spiritual area

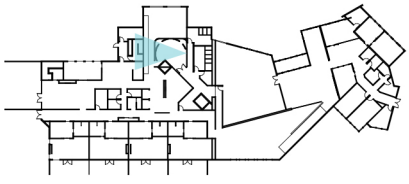
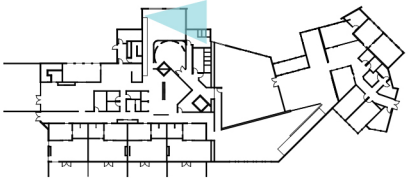




Figure 164 - Perspective of group spiritual area



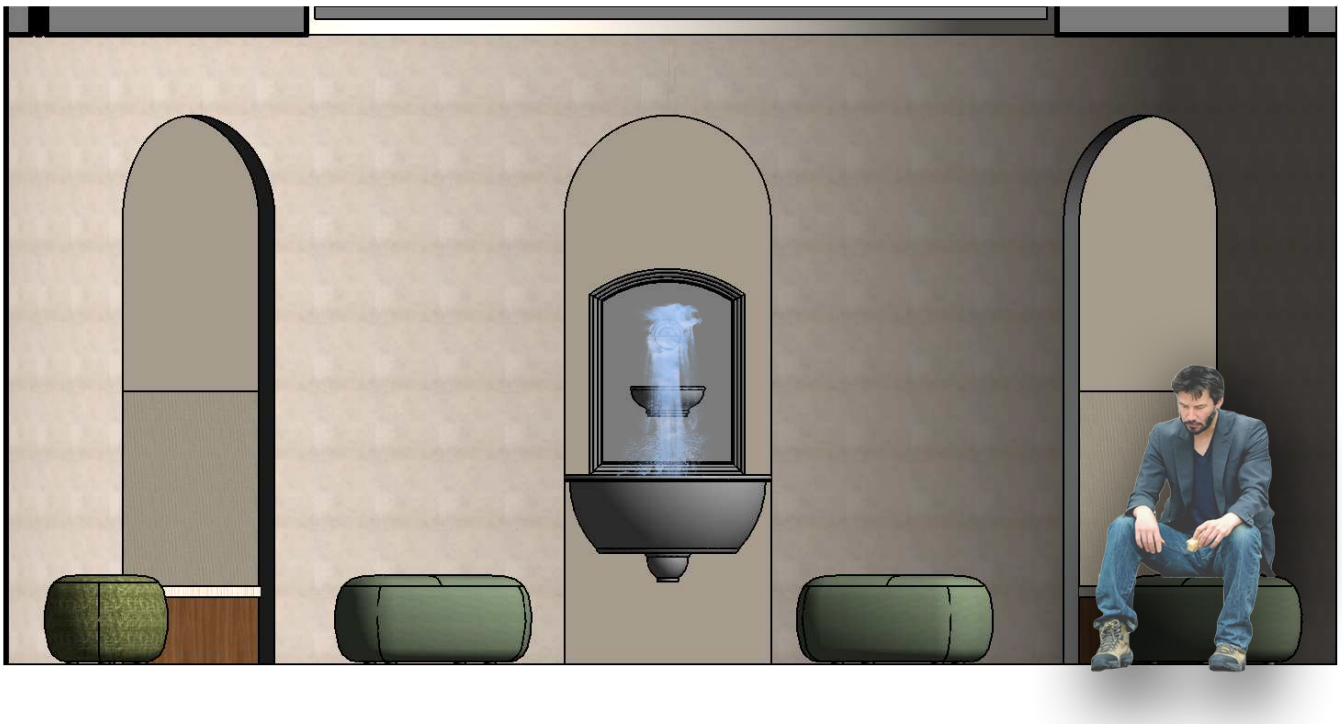


Figure 165 -Semi-private spiritual area- E27- South Elevation- NTS

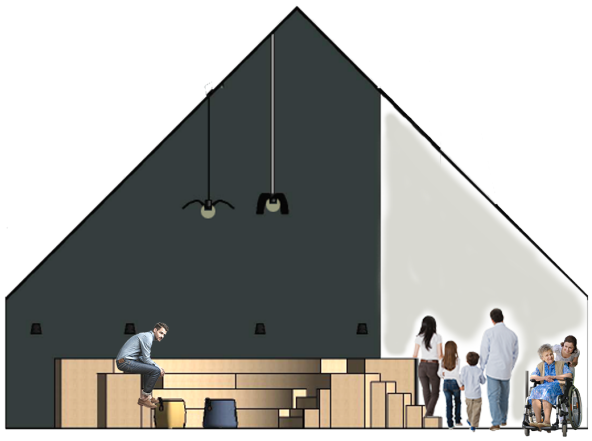


Figure 166 - Spiritual Group Area- E28- North Elevation- NTS

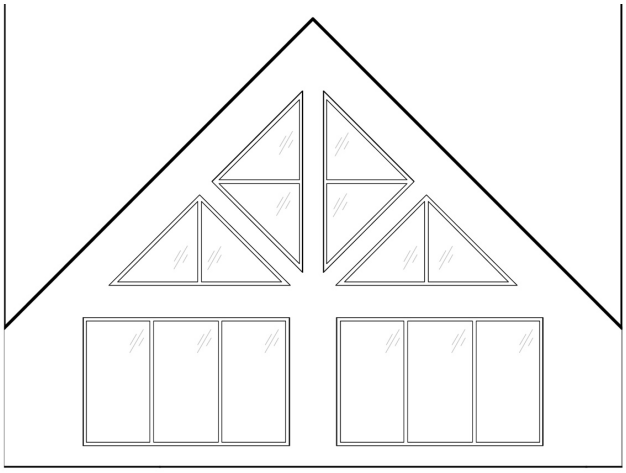


Figure 167 - Spiritual Group Area- E29- South Elevation- NTS

6.2.10 Outpatient Clinic



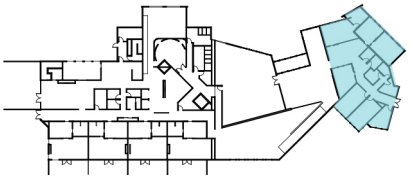


Figure 168 - Outpatient clinic floor plan rendered

Located on wing C, the outpatient clinic (Fig.168) features a programme catered to non-residents and future residents of Communitas House. Visitors can enter the clinic directly off the left of the main entrance, past reception. In order to maintain a non-clinical atmosphere on the residential wing of the building, the outpatient clinic was located on the opposite end of the building. For this reason, smaller centrally located clinical areas were integrated into the residents' wing, as they were necessary for accessibility of healthcare related needs.

The outpatient clinic features a small meeting space for medical staff and the MAID clinical team who can consult with one another and prepare before meetings with patients or the patients immediate collective. Patients who need consults or assessments can utilize the outpatient clinic, whether they plan on dying off-site or at a later date. Therapy rooms can also be used by family and friends, during or after MAID deaths occur, supporting them through the entire death ritual.

Materiality was carried through from the previous spaces of the building. Soft rubber flooring was selected for antimicrobial and sanitary healthcare requirements. Windows in the consult and assessment room provide patients with a connection to the natural environment to balance out the clinical ambiance. In the therapy rooms, soft carpeting and seating promote a comfortable, secure atmosphere. Exterior doors found immediately down the main corridor allow for direct access to the outdoors, where a labyrinth feature has been designed for alternative therapy space to enhance the wellbeing of the mind and soul. This feature was inspired by Bridgepoint healthcare's incorporation of this on a higher level exterior terrace.

6.2.11 Exterior Design Features



Figure 169 - Exterior wall of memorial perspective

Along with the labyrinth, other architectural landscape features are located on the North and private side of Communitas House; the first of which is the memorial building (Fig.169-170). Constructed of local limestone, the memorial house can be accessed through arched entryways on either side (Fig.167). Found in the centre of the room is a firepit, sunken into a circular cut-out of the limestone and above that, a circular opening displays the open sky

(Fig.167). Around the outside of the building are centered bands of polished smooth limestone, engravable for those who consent and wish to have their names included on the building. There is a layer of privacy that must be considered for both the bereaved and current residents of Communitas House. Names will only be engraved on the memorial building per request of the patients and their family. Also, by having the memorial in the park area of the site, rather than directly off the hospice building, this allows the bereaved to visit without infringing upon the experiences of current residents and their collectives. At the time of residence, family and friends will be informed that they can return to the site at a later date and access this memorial. Upon return, visitors will have to check in with Communitas House staff to maintain a sense of security for the site.

The memorial was an important design feature to the project as it supports the liminal phase of aggregation, allowing living members of the deceased to deal with grief and the ritual transitions after death. The need for a specific memorial site was influenced by the research of Karen Wilson Baptist (2013) in Chapter 1. The memorial building provides a physical space for the bereaved to commemorate their loved ones for years to come, way after the liminal transition is complete. Once over the threshold of death and into a state of aggregation, the memorial is a cue of remembrance and a constant supporter for continual spiritual and emotional wellbeing.

Lastly, another landscape feature promoting spirituality and supporting death rituals is the pond (Fig.171). Influenced by Esther Supernault's MAID journey, the pond is a biophilic element that is a vessel for a liminal transition. In Chapter 2, Esther Supernault's husband threw petals into the water to guide his wife to the creator, thereby helping her pass from the marginal phase to that of aggregation where she would be in a state of peace. Noted in the section on biophilic design, water is a strong symbolic element of spirituality. Its animistic traits, movements, and ability to support life make it a key component in an end-of-life space.



Figure 170 - Fire circle inside memorial site at night

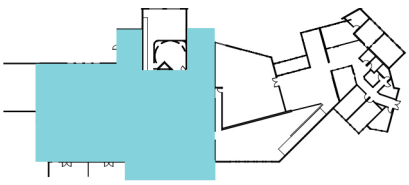


Figure 171 - Pond perspective showing man dropping petals into the water. Inspiration from Ester Supernault's MAID journey

6.2.12 Administration



Figure 172 – Second Storey Floor Plan-NTS



The final space of the Communitas House programme is administration (Fig.172), located on the second level of the building. This location was adapted from the floor plan of North London Hospice (NLH), where the private, business-related spaces where programmed on the higher levels of the building. Having the administration on the second level allows for visual and acoustical separation from the residential and clinical areas. Access to the second floor can be found directly through the seminar area when education is not in session and also through a corridor located adjacent to the seminar room, off of the break out area.

A balcony (Fig. 108,111,172), also inspired by NLH, is accessible off the main work area, so that staff has a direct connection to the exterior. This positioning allows for staff to take breaks and engage with nature without having to visit the main level of the building. Staff may also choose to take breaks or work in different ways using the break out spaces, located off of the main open-plan work zone.

The materiality of the administration space has been carried through from the main level, with the inclusion of earth tones, natural flooring, and biophilic inspired carpeting. A centrally located plant feature visually separates the staff work zone from the staff lounge, while also enhancing air quality. The staff lounge contains a kitchenette area, café seating and lounge space along the existing limestone fireplace. This space allows staff to decompress without having to leave the second level and also eliminates unnecessary interaction with patients and their families.

6.3 Design Summary

Communitas House, as a hybrid hospice, merges the elements of healthcare, residential, educational, and ritual space. The three wings of the building separate these spatial zones according to their need for visual and acoustical privacy. However, although separated, the

different spatial zones blend into one another in different ways, further enhancing the idea of a hybrid environment. For instance, although the healthcare component of the outpatient clinic is its own wing, clinical elements are also included within the residential area. These clinical spaces, such as the nurse station, sluice, and pharmacy storage are worked into the floor plan as to not detract from the residential atmosphere of the patient wing. Furthermore, although there are designated spiritual areas, ritual experiences can take place in common areas, in private suites or outside.

The goal of Communitas House was to shift away from traditional clinical healthcare interiors. While still adhering to the building code requirements, I have selected interior finishes, furniture and an overall architectural language that proposes the interior be a place of residence, rather than a hospital or funeral home. As home's are a place of life, this is what is celebrated in the interior. Therefore, end-of-life experiences can be about life's final moments, rather than about the beginning moments of death.

At the forefront of the design was the idea of communitas and how the interior design elements could support acts of gathering. I have defined these acts as rituals and they are understood through the theory of liminality. The lounge, dining areas, spiritual area, breakout area, and patients suites support these rituals in various ways. These areas allow for spaces of retreat and prospect by integrating private gathering environments and intimate communal environments. The key to my design was creating variety and flexibility within all spaces where end-of-life experiences could occur. This strategy aimed to enhance final life experiences and allow users to adapt the interiors in their own way according to their own death rituals. Also, it allows users to adapt within any interior space they choose to occupy, whether it is closed off by the curtains in their private suite or sitting around the fireplace in the open dining area. Therefore, although Communitas House is built around communitas, there is still an opportunity

for users to occupy space more intimately or in solitude. These areas of retreat supplement the notion of the collective gathering in MAID rituals.

In conjunction with liminality, the design concept of hygge acted as a filter for each design choice in these diverse gathering areas. Interior elements such as the texture of materials, softness of upholstery, wall colour, lighting quality, furniture style, and décor were all selected in their applicability to creating hygge. These choices meant creating spaces of 'feeling,' similar to the familiar notion of atmosphere. Therefore, these interior elements were chosen for their ability to translate the interior environments into spaces of comfort, security, and sanctuary. Overall, my material palette showed diversity, to enhance the eclectic ambiance of a lived in home. Examples of such applications are the use of soft carpeting in lounge sitting areas or to greet users into a specific spatial zone. Wood flooring is used to highlight pathways through and between different rooms. The textiles selected are in a variety of textures, colours, and fibers to enhance curiosity of the eye and touch of the hand.

Natural elements, patterns, and materials are a large component of the hospice. Communitas House, as an interior design project, strongly values a connection to nature. A goal of the design is to draw visual cues between outside and inside space. Biophilic design, as a major theoretical component of my project, provided a framework for the application of direct, indirect and symbolic representations of nature. Direct applications of nature are immediate connections to the exterior landscape, such as the features of the labyrinth, pond, trails, and memorial site. More constructed environments of this direct connection are the communal dining patio, private suite patios, and second storey balcony.

Indirect biophilic elements are shown in the use of living walls and plants within the interior spaces, offering an immediate understanding of the natural world. Another indirect feature is the abundance of windows throughout the hospice. The majority of spaces within the

residential wing connect MAID patients and their collectives to the exterior site. These spatial zonings allow users to visually retreat should they feel confined by what is happening in their immediate interior environment. Therefore, interior environments have been constructed with meaningful views in mind. Interior spaces such as the breakout area, patient suite and lounge all look out on the surrounding park scenery.

Taking up the majority of design elements in Communitas House are symbolic biophilic elements. These elements are truly in the details of the design, from small material patterns to large architectural structures. In flooring materiality, this is seen in the natural motifs. Carpeting selections feature leaf, moss, stone and pebble patterning. In the textiles, this is seen in the faux animal hyde looks, wood textures, and overall colour scheme. Several lighting choices also mimic nature, resembling clouds, fiddleheads, and birds.

In end-of-life spaces, nature is symbolic in representing the cycle of life and death. This cycle is a continual process and so it is often referred to as the 'circle of life'. The concept of the circle is also symbolic in referencing unity, togetherness, and the psyche being 'whole'. For all these reasons, the circle is incorporated into the hospice as a design motif. Seen within flooring patterns, millwork curves, lighting, and textile patterns the circle aims to entice users to gather and join together in final end-of-life experiences.

To conclude, it is the element of choice that drove the design of Communitas House forward. The rituals of MAID are complex because they are personal, as they are final life decisions made by the individual, but supported by their collective. Therefore, the interior provides the space for the collective to partake in the MAID patients chosen final experiences. These rituals have social, cultural, and religious implications and therefore they are diverse and endless. With this in mind, my design offers options of where to sit, eat, lounge, walk, read, pray, gather, and so on. The design while open and inviting takes into consideration intimacy and

privacy with operable architectural features, interior scale, and furniture design. Finally, it is the inclusion and unity of nature, social togetherness, and comfort of hygge that has the potential to allow for quality of life, death, and wellbeing in this end-of-life space.

Conclusion

The final design for Communitas House has been informed by a variety of research sources ranging from collections of news articles, local medical resources on MAID, to literature studies on liminality and biophilic design. Each research method offered a unique perspective and approach towards designing a hospice that could be adaptive to MAID and its influence on modern death rituals. Through the lenses of social end-of-life rituals, evidence-based design, biophilic design, lived MAID experiences and cultural concepts of wellbeing, Communitas House took shape. This approach helped to inform the emergence of a new hybrid hospice typology that could exceed the needs of MAID patients, their families, friends, and the caregivers engaged in this end-of-life decision. Additionally, this diverse inquiry process has guided the design outcome beyond traditional programmatic models for end-of-life space to reflect the unique needs of a MAID environment.

The project merged elements of healthcare, such as palliative care and hospital environments, with elements of home and sanctuary, thus arriving at the hospice as the ideal base model to adapt into and become Communitas House. Resulting from the design inquiries and research completed, the practicum project recognizes that the most unique and important element to MAID is that *no one dies alone*. Communitas House, found within the name itself, embraces the collective and celebrates in the ability to choose what an individual's end-of-life experiences will be. Choice in where, when and with whom you choose to die allows the interior design to embrace a narrative that is left up to the individual and supported by their collective through dying, death and beyond.

MAID, still in its infancy, limits the understanding of how far and large this new death ritual will grow. Limitations to the examples of existing MAID environments has made it difficult to create a new model for this type of healthcare space. However, these limitations have

also highlighted the need for interior design to take on an important role in enhancing quality of life and death, supporting a variety of positive and memorable experiences at end-of-life. Despite the limited literature and precedents on MAID, the variety of resources helped distinguish the programmatic and atmospheric goals of the project. In conclusion, the design of Communitas House has been successful in achieving answers towards the three design inquiries established in the introduction of Chapter 1.

Using biophilic design principals, how can nature enhance well-being at the end-of-life?

As a natural part of life, death is in itself nature. Akin to one another, nature enhances four aspects of wellbeing for the psyche: (1) emotional, (2) psychological, (3) physical, and (4) spiritual. Studies into biophilic design principals demonstrated that natural design elements can support all types of wellbeing in different ways. Nature is an empowering symbol in the cycles of life and death because it is understood as a continual rhythm of the natural world. In end-of-life spaces, natural elements, whether direct, indirect or symbolic, help to bring comfort, security and momentary awareness into interior experiences.

Simply by including those natural elements into the design, they maintain the ability to be activated in different ways when called upon by the user. Individuals will use different senses to interact with natural elements and find their own source of comfort. For instance, one person may find comfort in the aesthetics of the moss acoustical tiles, while another may touch them to feel relaxed. Another example is the water features, where one person may find comfort in the sound of falling water and another person tunes in with the feeling of mist and cooler air. Some people may engage with the colours of a nature-based painting, while for another person the organic lines or familiar scenery will activate a significant memory.

How can liminality, as a contemporary death ritual, support the dignified transition from life to death?

Through defining Turner's liminal phases in terms of MAID, it became clear that the transition from life to death is truly a social ritual. MAID patients are experiencing a new death ritual where they are dissolving boundaries between the phases of dying, death and beyond, or in respect to Turner, separation, marginality, and aggregation. Individuals who choose a medically assisted death are allowed a choice in the details of their death, some that traditionally would have been left up to the individual's collective. MAID patients have choice in such things as what and where they will eat their final meal, what music they will hear before and as they die, and most importantly who will celebrate with them in their last weeks, days and moments.

A empowered transition is established from the interior design's ability to support not only the dying individual but the entire collective. It thus falls upon the interior to allow people to gather, whether it is a small few or a large group. Furthermore, the idea of gathering requires the interior to accommodate for flexibility of how that collective wishes to gather. Gathering may take place around the bed of a loved one, sitting in the lounge beside the fireplace, walking outdoors, or surrounding a table sharing in a meal. Ultimately, because MAID is a choice the interior design accommodating for it must allow for this choice and not restrict the experiences of the patients and the their collectives.

How can hygge be applied as a design concept to enhance social togetherness and well - being at end-of-life?

Hygge, although a Danish phrase, is a universal concept. This concept symbolizes living in the moment, surrounded by the ones you love. The result of these experiences is a 'feeling' and one that can be translated through the ambiance of an individual's immediate atmosphere. Materiality, spatial volume, lighting, and spatial arrangements are hard design elements that play

into feelings of comfort and security. Whether or not an interior has or doesn't have hygge is not only dependant on these hard design elements, but also on the soft ones: the people. These are the elements that constantly move, adapt, and change spatial relationships to the interior environment. Hard and soft elements play hand in hand, supporting one another and ultimately achieving hygge. Therefore, hard elements must support the collective and provide for moments of social togetherness.

As discussed in earlier, social togetherness is the definition of the MAID ritual, therefore, it is beneficial for interior design to support it. If the collective is at the forefront of the design, user wellbeing has the opportunity to be at its fullest potential. However, reversely, if the interior does not support wellbeing, social togetherness may not be at its strongest. In environments where wellness is cultivated, users feel welcome and encouraged to engage with one another. This can be achieved through spatial zoning, appropriate materials, comfortable and varietal seating, and appropriate architectural language.

This helps to explain how hygge embodies both biophilia's impact on wellbeing and liminalities incorporation of the collective. In conclusion, biophilic design and ritual space are unified through the design filter of hygge in order to achieve quality of life within death. It is the programmatic decisions, spatial qualities and overall architectural language of Communitas House that have been shaped by these design inquiries. Having achieved these three inquiries, this Masters practicum project has demonstrated how the design of a hybrid hospice can support the needs patient and their collectives in the end-of-life experiences with a medically assisted death.

Limited resources of theoretical research and minimal established environments for MAID have been a challenging aspect of my practicum project. However, such challenges have led to the development of Communitas House and its composition as a hybrid hospice. In the coming future MAID rituals may change, guidelines may adapt and therefore the hybrid nature of my vision may fluxate. These changes to the hybrid hospice may meaning adding alternative spaces or eliminating some as MAID evolves.

The research within my practicum however, provides a foundation for a MAID environment for future interior design development. The work documented in this practicum follows MAID from its legalization to development of guidelines and from beginning design precedents to actual MAID deaths and finally, what those end-of-life rituals look like. While my practicum proposal is conceptual, the issues of MAID and its disconnection from designed environments are very real. Therefore, my proposal of Communitas House offers an ideal design model that encapsulates MAID as it exists currently. Elements of rituals and procedures may evolve and growth for demand may increase. These things can be predicted or hypothesized, but not yet proven. However, I believe at the core of this new death ritual, communitas will remain the constant.

In conclusion, Communitas House provides future interior designers and design researchers a platform for expansion on MAID's relationship to the interior environment. Continual updates from media sources and healthcare stats will help to further inform the direction MAID will take in Canada's design landscape. I believe that my practicum can enhance the knowledge of the interior design profession in the capacity of assisted death space. MAID, as a unique contemporary death ritual should not be structured to fit into what already exists in terms of healthcare or even end-of-life environments. Rather, MAID should be allowed to grow into its own space and function to provide the best quality of end-of-life healthcare possible.

Having choice is an inherent part of assisted death and therefore having choice over the environment you acquire is just as important. For patients, Communitas House symbolizes a space in which to live out their most empowered final moments and for the collective, it is a place of memorable experiences to look back upon. So, it is the intention of my practicum project to be a design precedent for future MAID environments and to push forward on the creation of interiors that value quality and overall wellbeing for death space.

Bibliography

About the Memorial. (n.d.). Retrieved May 28, 2018, from https://www.911memorial.org/about-memorial

Alvaro, C. & Kostovski, D. (2014, June 16). *Design and Evaluation: The Path to Better Outcomes. A Preliminary Report on the Bridgepoint Active Healthcare Pre- and Post Occupancy Evaluation*. Report prepared for the Health Capital Investment Branch, Ontario Ministry of Health and Long- Term Care.

Alvaro, C., Kostovski, D., Wilkinson, A., & Gardner, P. (2015, March). *Design and Evaluation: The Path to Better Outcomes. The Final Report on the Bridgepoint Active Healthcare Pre and Post Occupancy Evaluation.* Report prepared for the Health Capital Investment Branch, Ontario Ministry of Health and Long Term Care.

Anderson, I. (January). *Indigenous Perspectives on Death and Dying*. Lecture presented at Continuing Education in End-of-Life Care. Retrieved May 22, 2018, from https://www.cpd.utoronto.ca/endoflife/Slides/PPT Indigenous Perspectives.pdf

Augustin, S., and J. A. Wise. 2000. "From Savannah to Silicon Valley." *IIDA Perspective*, Winter/Spring, 67-72. Retrieved from hhtp://www.haworth.com/Haworth/assets/From%20Savannah%20to%20Silicon%20Valley.pdf.

Badcock, C., & Bleyer, J. (n.d.). Tend and Defend. Retrieved May 30, 2018, from https://www.questia.com/magazine/1P3-4317825521/tend-and-defend

Badshah, Nadeem. " Final family meal of father 54, on his way to Dignitas." The Times. 2015 from https://www.thetimes.co.uk/article/final-family-meal-of-father-54-on-his-way-to-dignitas-sfc899s6rc5. Accessed May 13, 2018.

Baptist, Karen Wilson. (2013). Reenchanting Memorial Landscapes: Lessons From The Roadside. *Landscape Journal: design, planning and management of the land*, Vol.32 (1), pg 35-50. https://muse-jhu-edu.uml.idm.oclc.org/article/521392/pdf

Be, Rev. Bodhi. (2017). "In Case You Might Die One Day." *Journey With Deanna*. (Podcast Interview) Retrieved May 18, 2018, from https://player.fm/series/journey-with-deanna/rev-bodhi-be-on-in-case-you-might-die-one-day

"Bridgepoint Active Healthcare." (2015). Retrieved May 30, 2018 from https://www.archdaily.com/771080/bridgepoint-active-healthcare-stantec-architecture-plus-kpmb-architects-plus-hdr-architecture-plus-diamond-schmitt-architects-plus

Canada Act 1982. C. 11 S.7. (1982, April 01). Schedule B Constitution Act. Retrieved June 01, 2017 from http://www.legislation.gov.uk/ukpga/1982/11/contents

Canada, H. (2017, October 06). 2nd Interim Report on Medical Assistance in Dying in Canada. Retrieved May 18, 2018, from https://www.canada.ca/en/health-

canada/services/publications/health-system-services/medical-assistance-dying-interim-report-sep-2017.html

Cash, M. (2012, December 20). New life for Hecla Resort. Retrieved May 1, 2018, from https://www.winnipegfreepress.com/business/new-life-for-hecla-resort-184225921.html

Chapin, A. (2014, March 17). Can recovering addicts save Manitoba's failed Hecla Oasis resort? Retrieved May 1, 2018, from http://www.macleans.ca/economy/business/a-last-resort-plan/

Charles Jencks and Edwin Heathcote, *The Architecture of Hope*, (London: Francis Lincoln Ltd. 2010

Chochinov, Harvey M. "Physician- Assisted Death in Canada." *JAMA.* 2016;315(3):253-254. doi:10.1001/jama.2015.17435. (2016)

Crescent Drive Park - Recreation. (2017, April 22). Retrieved May 28, 2018, from https://volunteeringwinnipeg.ca/place/crescent-drive-park

Dangerfield, Katie. (2016) A History of right-to-die legislation in Manitoba. *Global News Online.* Winnipeg MB.

De Swaan A, Jenks C, Verderber S, et al. In Wagenaar C, editor. (2006). *The Architecture of Hospitals.* Rotterdam (NL): NAi Publishers. Pg 271-89

Doka, Kenneth J. "Grief is a Journey: Finding Your Path Through Loss." 2016
Knapp, M. (2015, January 1). Why Leave the Window Open? A Danish Death Tradition [Web log post]. Retrieved May 23, 2018, from http://blog.sevenponds.com/cultural-perspectives/why-leave-the-window-open-a-danish-death-tradition

Dying with Dignity Canada (2016, February 11). "Groundbreaking poll: 8 in 10 Canadians support the right to advance consent for assisted dying." Retrieved May 31, 2017 from http://www.dyingwithdignity.ca/advance_consent_assisted_dying_poll

Frumkin, Howard. "Nature Contact and Human Health: Building the evidence base." In Kellert, Stephan ; Heerwagen, Judith H; Mador, Martin L (Ed.), Biophilic Design (43-57). New Jersey: Wiley.

Gentleman, Amelia. "Inside the Dignitas House." *The Guardian*. 2009 from https://www.theguardian.com/society/2009/nov/18/assisted-suicide-dignitas-house. Accessed May 13, 2018.

Government of Canada. (n.d). Medical assistance in dying. Retrieved May 30, 2018, from https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html#a4

Grant, Kelly. "Medically Assisted Death Allows Couple Married Almost 73 Years to Die Together." Globe and Mail. 2018.

Gull Habour Resort and Conference Centre

https://www.gov.mb.ca/sd/parks/popular_parks/popular_parks/hecla_grindstone/info.html

Gustavo de Roza. (n.d.). Retrieved May 30, 2018, from http://www.winnipegarchitecture.ca/gustavo-da-rosa/

Hansen, Judith F. (1980). *We are a Little Land: Cultural assumptions in Danish everyday life*. New York: Arno Press. Pg 58

Harris, Kathleen. (2017, February 05). 'Tragic trend': More Canadians travelling to Switzerland to end their lives. CBC Online News. Quebec, CA. Retrieved May 30, 2017, from http://www.cbc.ca/news/politics/dying-canadians-switzerland-dignitas-1.3966295

Harting, Terry et al. "Restorative Enviornmental Deisgn: What, Where, When and For Whom?" In Kellert, Stephan ; Heerwagen, Judith H; Mador, Martin L (Ed.), Biophilic Design (133-151). New Jersey: Wiley.

History of Crescent Park. (n.d.). Retrieved May 01, 2018, from http://now.winnipeg.ca/history/crescent-park

House, Tina (Journalist). (2017). APTN Investigates- Dying with Dignity [Television Documentary Interview]. In n.a (Producer), *APTN National News*. Vancouver, British Columbia: APTN. Accessed September 25 2018 from http://aptnnews.ca/2017/02/17/aptn-investigates-dying-with-dignity/

Hygge House / Plain Projects Pike Projects Urbanink. (2013, August 06). Retrieved May 30, 2018, from https://www.archdaily.com/412014/hygge-house-plain-projects-pike-projects

Investors eye Gull Harbour resort. (2018, April 20). Retrieved May 1, 2018, from https://www.theglobeandmail.com/news/national/investors-eye-gull-harbour-resort/article25679340/

Jenks, Charles and Heathcote, Edwin. *The Architecture of Hope*. London: Francis Lincoln Ltd, 2010.

Jones, A. (2016, April 05). Bob: I will die today at 2pm in Swiss suicide clinic. Retrieved September 27, 2018, from https://www.thesun.co.uk/archives/news/188494/i-will-die-today-at-2pm/

Kaplan, R. "The Role of Nature in the Context of the Workplace." *Landscape and Urban Planning* 26:192-201.

Kellert, Stephan R. (2005). Building for Life: Designing and Understanding the Human-Nature Connection. Island Press.

Kellert, Stephan R. (2008). "Dimensions, Elements and Attributes of Biophilic Design." In Kellert, Stephan; Heerwagen, Judith H; Mador, Martin L (Ed.), Biophilic Design (87-106). New Jersey: Wiley.

Knapp, M. (2015, January 1). Why Leave the Window Open? A Danish Death Tradition [Web log post]. Retrieved May 30, 2018, from http://blog.sevenponds.com/cultural-perspectives/why-leave-the-window-open-a-danish-death-tradition

"Legal Basis." Dignitas. Retrieved November. 20, 2018 from http://www.dignitas.ch/index.php?option=com_content&view=article&id=12&Itemid=15&lang=en

Levisen, Carsten. (2013). Cultural Semantics and Social Cognition: A Case Study on the Danish Universe of Meaning. *Trends in Linguistics. Studies and Monographs*. Berlin: Walter de Gruyter. vol 257.

Levitt, Andrew. *The Inner Studio*. Cambridge: Riverside Architectural Press, 2007.

Li, Madeline, et al. (2017) "Medical Assistance in Dying-Implementing a Hospital-Based Program in Canada. The New England Journal of Medicine. Vol.376(21), p.2082-2088. DOI: 10.1056/NEJMms1700606

Lincourt, John. "A Place for Empathy: Ethics Involving Architectural Designs in Healthcare." HEC Forum June, 2002. 86-98.

Mador, Martin L. (2008) "Water, Biophilic Design and The Built Environment." In Kellert, Stephan ; Heerwagen, Judith H; Mador, Martin L (Ed.), Biophilic Design (43-57). New Jersey: Wiley.

Malone, Kelly. " Two More Resignations Follow St. Boniface Hospital Descision on Assisted Death." CBC. 2017

Martin, Susan. "Fight to the Death: Why Canadian Physician-Assisted Dying Debate has only Begun." Globe and Mail. 2018.

Masden, Kenneth G. and Salingaros, Nikos A."Neuroscience, the Natural Enviornemnt and Building Design." In Kellert, Stephan ; Heerwagen, Judith H; Mador, Martin L (Ed.), Biophilic Design (59-83). New Jersey: Wiley.

Mix, Jeanette. (2017, February 10). In Neville, et al (Directors) *Abstract: The Art of Design.* Retrieved May 30, 2018, from https://www.netflix.com/watch/80093808?trackId=14170286&tctx=3,0,6a473d20-1af5-4610-865e-05521680ef51-236943250,a7b0e917-6e1a-4d1d-9f19-1b2c09e9e8f1_29100119X3XX1527690070245,a7b0e917-6e1a-4d1d-9f19-1b2c09e9e8f1_ROOT

N.A (Host). (2018). Letting Her Go [Radio Documentary Series]. In Jean Paetkau (Producer), *A Good Goodbye*. Victoria, British Columbia: CBC. Accessed September 25 2018 from https://www.cbc.ca/news/canada/british-columbia/dave-miller-storm-medical-assistance-in-dying-physician-assisted-death-good-good-bye-1.4475736

National Board of Antiquities. (2005). Nomination of Paimio Hopsital for Inclusion in World

heritage List. Helsinki (Finland). Retrieved February 11, 2017, from www.nba.fi/tiedostot/c760469d.pdf.

"North London Hospice by Allford Hall Monaghan Morris," Dezeen. May 08, 2015, Accessed April 20, 2017, https://www.dezeen.com/2013/04/26/north-london-hospice-by-allford-hall-monaghan-morris/.

Our Story. (n.d.). Retrieved May 30, 2018, from https://www.etthem.se/the-experience/our-story/

Pallasmaa, Juhani. "Inhabiting Time." *Architectural Design*. 2016 Vol 86(1) p. 50. Accessed November 6, 2017.

Pratchett, Terry. (2011). "Terry Pratchett: Choosing to Die." Directed by Charlie Russel. Retrieved November 20, 2018 from https://vimeo.com/229120539

Poldma, Tiiu Vaikla., Vasilevich, Drew. (2013). Poststructuralism, Phenomenology, and Lived Expereince: About Meaning Held within Design and Spaces. In Meanings of Designed Spaces. T.Vaikla- Poldma (Ed.) New York, NY: Fairchild Books. 102-106

Roxby, A. (2012, May 21). 'Are nursing rituals and superstitions helpful?' [Web log post]. Retrieved May 23, 2018, from https://www.nursingtimes.net/students/are-nursing-rituals-and-superstitions-helpful/5045136.blog

Simonds, John O. 1961. *Landscape Architecture, A Manual of Site Planning and Design*. 2nd ed. NY: McGraw Hill.

Stantec. (n.d). "Bridgepoint Active Healthcare." (n.d). Retrieved May 20, 2018 from https://www.stantec.com/en/projects/canada-projects/b/bridgepoint-active-healthcare

Steg, L., van den Berg, Agnes., de Groot, Judith. (2012). *Environmental psychology: An introduction*. Wiley.

Sternberg, Esther. *Healing Spaces: The Science of Place and Well-Being*. Cambridge: First Harvard University Press, 2010.

Supreme Court of Canada. (2015). Carter v. Canada, Attorney General. 1 SCR 331. Retrieved February 20, 2017, from https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do

Swift, Lucy. *North London Hospice Information Pack*, 1st ed. London: Allford Hall Monaghan Morris, Web, 20 Apr. 2017.

Thordarson, Sigurdur Arni. "Liminality in Icelandic Religious Tradition." (1989). Michigan (A Bell & Howell Co).

Turner, Victor W. "The Ritual Process." (1969) Chicago (Adline Publishing Co.)

Wels, Harry; Van Der Waal, Kees; Spiegel, Andrew; Kamsteeg, Frans. "Victor Turner and liminality: An Introduction." (2011) *Anthropology Southern Africa.* 34 (1-2) p 1-4. Routledge.

WHO Definition of Palliative Care. (2012, January 28). Retrieved May 3, 2018, from http://www.who.int/cancer/palliative/definition/en/

WRHA. (n.d.). Patients and Families. Retrieved May 28, 2018, from http://www.wrha.mb.ca/MAID/patients_and_families_faq.html#7

Wilson, E.0. "Biophilia." (1986). Chicago (Harvard University Press).

Wiking, Meik. "The Dark Side of Happiness", *TedX Copenhagen*. 2016 from https://www.youtube.com/watch?v=PbtzY-8IFTQ.

Wiking, Meik. *The Little Book of Hygge: the Danish way to live well*. Penguin: UK, 2016.

Winnipeg's Indigenous population highest in Canada, but growth rate is slowing | CBC News. (2017, October 25). Retrieved May 30, 2018, from http://www.cbc.ca/news/canada/manitoba/aboriginal-population-statistics-canada-1.4371222

Wise, J. A. and T. Leigh-Hazzard. 2002. "Fractals: What Nature Can Teach Design." *American Society of Interior Designers ICON*. March, 14-21.

Worpole, Ken. *Modern Hospice Design: the architecture of palliative care*. London: Routledge, 2009.

Ubelacker, S. (2018, May 16). Drugs for physician-assisted death: What will they cost and who will pay? Retrieved May 28, 2018, from https://www.theglobeandmail.com/news/national/drugs-for-physician-assisted-death-what-will-they-cost-and-who-will-pay/article30414929/

UHN framework on medical assistance in dying. (n.d.). Retrieved May 30, 2018, from http://www.uhn.ca/corporate/News/Pages/UHN_framework_on_medical_assistance_in_dying.aspx

Ulrich, Roger S. "Biophilic Theory and Research for Healthcare Design." In Kellert, Stephan; Heerwagen, Judith H; Mador, Martin L (Ed.), Biophilic Design (87-106). New Jersey: Wiley.

Ulrich R. S. 1983. "Aesthetic and Affective Response to Natural Environment." *In Human Behavior and Environment, Vol. 6: Behavior and the Natural Environment*, edited by I. Altman and J. F. Wolhill, 85-125. New York: Plenum.

Ulrich, R. S. "Effects of Health Facility Interior Design on Wellness: Theory and Recent Scientific Research." *Journal of Healthcare Design* 3:97-109.

Appendix A – Material Selections

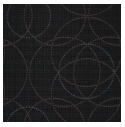
Room & Surface	Symbol	Description	Manufacturer	Product Name	Type	Dimension	Environmental Specifications
125 – Patient Suite Entrance							
Floor	LVT1 	TP034 Luxury Flooring -Pine Oak Design in Bronze	Armstrong	Pine Oak Bronze	Luxury Vinyl Tile, Plank, Full Flood	152.4 mm x 914.4 mm x 3.2 mm	FloorScore ® Certification
	LVT2 	TP083 Luxury Flooring-Natural Creations Classics ,Casablanca Design in Anise	Armstrong	Casablanca Anise	Luxury Vinyl Tile, Full Flood	457.2mm x 457.2mm x 3.2mm	FloorScore ® Certification
	CT1 	105213 Pewter Carpet Tile Product no. 25670AK00	Interface	Pewter	Carpet Tile, Tufted Cut and Loop, Directional installation	9.845 in x 39.38 in	Total Recycled Content 76% -Post Industrial 67% -Post Consumer 10% NSF/ANSI-2440 Gold
Wall	P1 	SW 0037 Morris Room Grey	Sherwin Williams	Morris Room Grey Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
	P2 	SW 2809 Rookwood Shutter Green	Sherwin Williams	Rookwood Shutter Green Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
Base	RB1 	Snow White Baseworks™ Thermoset Rubber (Type TS) Part No. TSBT 01 6 LIC 1/8 Toeless	Johnsonite	Baseworks™ 6” Toeless 01 in Snow White	Rubber Wall Base. Straight Strip	6” x 4 1/8”	-Total Recycled Content 14% -Rapidly Renewable Content 2% -Cradle to Cradle Silver -Phthalate-free - FloorScore® C ertification
Ceiling	WS1	Custom Wood Slat					
	WB1	Wood Beam					
Doors	WV1 	Marea Concealed Sliding Door with	Linvisible	Marea	Concealed Sliding Door with Molded Panel in Rovere Dogato , Flush to Wall Plate	3’ x 7’ x 1”	

					Motorized Control		
Millwork	SW1 	Walnut Solid Wood Kitchenette Cabinet	Netley Millwork				
	SS1 	Corian® Solid Surface Sand Storm	DuPont™ Corian®	Solid Surface Sand Storm	Solid Surface		Greenguard Certified for Low Chemical Emissions
125-A Patient Suite Bathroom							
Floor	VS1 	34343 Vinyl Sheet DécorArt Rejuvenations Stonerun in Delhi Dacite	Armstrong	Stonerun Delhi Dacite	Vinyl Sheet, Full Flood	457.2mm x 457.2mm x 3.2mm	FloorScore ® Certification
Wall	P1 	SW 0037 Morris Room Grey	Sherwin Williams	Morris Room Grey Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
	T1 	4DD733 4D Max 16x32 Deep Blue Hexagon Glazed Wall Tile Matte-Rectified	Ames Tile	Deep Blue Hexagon	Wall Tile, Matte-Rectified	16 in x 32 in	
	WP1	Palladium® G2-406 0101 Inpro® Wall Protection in Designer White	Inpro	Designer White Palladium G2 Sheet	Rigid Sheet Trim in BioBlend®	4’ x 8’ x 1/16” standard	Greenguard Certified for Low Chemical Emissions
Base	RB1 	Snow White Baseworks™ Thermoset Rubber (Type TS) Part No. TSBT 01 6 LIC 1/8 Toeless	Johnsonite	Baseworks™ 6” Toeless 01 in Snow White	Rubber Wall Base. Straight Strip	6” x 4 1/8”3	-Total Recycled Content 14% -Rapidly Renewable Content 2% -Cradle to Cradle Silver -Phthalate-free - FloorScore® Certification
Ceiling	P1 	SW 0037 Morris Room Grey	Sherwin Williams	Morris Room Grey Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
	P3	SW 0053 Porcelain	Sherwin Williams	Porcelain Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions

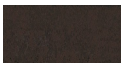
Millwork	SW1 	Walnut Solid Wood Cabinet with Glass Doors Framed with Wood	Netley Millwork				
	SS1 	Corian® Solid Surface Sand Storm	DuPont™ Corian®	Solid Surface Sand Storm	Solid Surface		Greenguard Certified for Low Chemical Emissions
125-B Living Area							
Floor	LVT1 	TP034 Luxury Flooring -Pine Oak Design in Bronze	Armstrong	Pine Oak Bronze	Luxury Vinyl Tile, Plank, Full Flood	152.4 mm x 914.4 mm x 3.2 mm	FloorScore ® Certification
	CT1 	105213 Pewter Carpet Tile Product no. 25670AK00	Interface	Pewter	Carpet Tile, Tufted Cut and Loop, Directional installation	9.845 in x 39.38 in	Total Recycled Content 76% -Post Industrial 67% -Post Consumer 10% NSF/ANSI-2440 Gold
Wall	P4 	SW2803 Rookwood Terra Cotta	Sherwin Williams	Rookwood Terra Cotta Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
	WP2 	Palladium® G2-406 0101 Inpro® Wall Protection in Pepperdust with Designer White Trim and Top Guard	Inpro	Pepperdust Palladium G2 Sheet	Rigid Sheet Trim in BioBlend®	4’ x 8’ x 1/16” standard	Greenguard Certified for Low Chemical Emissions
Base	RB1 	Snow White Baseworks™ Thermoset Rubber (Type TS) Part No. TSBT 01 6 LIC 1/8 Toeless	Johnsonite	Baseworks™ 6” Toeless 01 in Snow White	Rubber Wall Base. Straight Strip	6” x 4 1/8”3	-Total Recycled Content 14% -Rapidly Renewable Content 2% -Cradle to Cradle Silver -Phthalate-free - FloorScore® C ertification
Ceiling	P3	SW 0053 Porcelain	Sherwin Williams	Porcelain Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
	WB1	Reclaimed Oak Wood Beam					

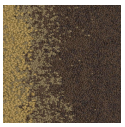
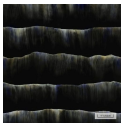
	ACT1 	BuzziMood Rectangular Leaf Acoustic Wall Solution	BuzziSpace	BuzziMood Acoustic Wall Solution	BuzziMood Rectangular Leaf with Dark Green Reindeer Moss Filling and Black Powder Coated Frame	W 47.24" x D 23.62" x H 2.95"	
Millwork	SW1 	Walnut Solid Wood Cabinet	Netley Millwork				
	TX1 	3949-101 Split Upholstery	Designtex	Split in Wisp	98 Acrylic 2% Polyester Stain Repellent, Water Repellent with Non-Woven Acrylic Backing	Repeat V 5.5 " x H None	Greenguard Gold Certified
Window Coverings and Curtains	TX2 	3874-101 Kami Upholstery	Designtex	Kami in Oat from Origami Collection	17% Polyester (Non-halogenated Flame Retardant Trevira CS) 83% Polyester	Repeat V 4.9" x H 4.3"	
126-Dining							
Floor	LVT3 	NA230 Luxury Vinyl Tile Plank Natural Creations Arborart with Diamond 10 Technology in Walnut Blonde	Armstrong	Natural Creations Arborart in Walnut Blonde	Luxury Vinyl Tile Plank, Low Gloss	Full Flood 4" x 36"	FloorScore ® Certification
	LVT2 	TP083 Luxury Flooring-Natural Creations Classics ,Casablanca Design in Anise	Armstrong	Casablanca Anise	Luxury Vinyl Tile, Full Flood	457.2mm x 457.2mm x 3.2mm	FloorScore ® Certification
	CT2 	HN840 - 104227 Earth Carpet Tile Product no. 127620AK0H	Interface	104227 Earth Carpet Tile from Human Nature Collection	Carpet Tile Plank, Tufted Pattern Loop	9.845" x 39.38"	Total Recycled Content 92% Post- Industrial 66% Post- Consumer 27% Green Label Plus NSF/ANSI-2440 Platinum
	CT3 	HN850 - 104211 Earth Carpet Tile	Interface	104211 Earth Carpet Tile from Human	Carpet Tile Plank,	9.845" x 39.38"	Total Recycled Content 92%

		Product no. 127600AK0H		Nature Collection	Tufted Sheared		Post- Industrial 65% Post- Consumer 27% Green Label Plus NSF/ANSI-2440 Platinum
	CT4 	HN810 - 104219 Earth Carpet Tile Product no. 127610AK0H	Interface	104219 Earth Carpet Tile from Human Nature Collection	Carpet Tile Plank, Tufted Sheared	9.845” x 39.38”	Total Recycled Content 92% Post- Industrial 65% Post- Consumer 28% Green Label Plus NSF/ANSI-2440 Platinum
Wall	P5 	SW 2846 Roycroft Bronze Green	Sherwin Williams	Roycroft Bronze Green Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
	ACT1 	BuzziMood Rectangular Leaf Acoustic Wall Solution	BuzziSpace	BuzziMood Acoustic Wall Solution	BuzziMood Rectangular Leaf with Dark Green Reindeer Moss Filling and Black Powder Coated Frame	W 47.24” x D 23.62” x H 2.95”	
	ACT2 	BuzziMood Square Leaf Acoustic Wall Solution	BuzziSpace	BuzziMood Acoustic Wall Solution	BuzziMood Square Leaf with Light Green Reindeer Moss Filling and Fluo Yellow Frame	W 23.62” x D 23.62” x H 2.95”	
	WP3 	BB-G2-405-HW Palladium® G2 Beadboard Sheet in 0548 Sugar Maple	Inpro	Sugar Maple in Palladium® G2 Beadboard Sheet	Rigid Sheet Beadboard with Woodland Faux-Wood Pattern	H 36” x 44” W x D 3/64” (Custom Sizing)	Greenguard Certified for Low Chemical Emissions
	WP4 	EnviroGT G2-700 Wall Guard	Inpro	Sugar Maple in EnviroGT G2 Wall Guard	Wall Guard with Woodland Faux-Wood Pattern	H 7-3/4” x D 1” x 4”	Greenguard Certified for Low Chemical Emissions Post-Consumer Content 20%
	ST1 	Local Fieldstone					
Ceiling	WG1	Woodworks® Grille	Armstrong	Woodworks® Grille in Custom Colour	Wood Plank Ceiling	1-1/4” Slat W, Slat H 3-1/4” with 4 Slats per Panel,	

					Finish in Brushed Oak	Slat Spacing 2-3/4”	
	WB1 	Brushed Oak Wood Beam					
	SW2 	Oak Wood Planks with Dark Walnut Stain					
	P3	SW 0053 Porcelain	Sherwin Williams	Porcelain Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
Millwork	SW1 	Walnut Solid Wood Banquet	Netley Millwork				
	TX3 	3888-105 Hyde Upholstery	Designtex	Hyde in Saddle	100% Vinyl, Solid and Textured, Backing in Knit Polyester	W 54”	
	TX4 	466193-009 Boundary	Maraham	Boundary in Truffle	100% Vinyl with Antimicrobial Protective Topcoat, Polyester Backing	Repeat 8 ¾” V 9-1/4” H	
	WP3 	BB-G2-405-HW Palladium® G2 Beadboard Sheet in 0548 Sugar Maple	Inpro	Sugar Maple in Palladium® G2 Beadboard Sheet	Rigid Sheet Beadboard with Woodland Faux-Wood Pattern	H 36” x 44” W x D 3/64” (Custom Sizing)	Greenguard Certified for Low Chemical Emissions
Door	W2 	Custom Wood Panel Door in Brushed Oak	Wood Anchor				
129-Private Dining							
Floor	LVT3	NA230 Luxury Vinyl Tile Plank Natural Creations	Armstrong	Natural Creations Arborart in Walnut Blonde	Luxury Vinyl Tile Plank, Low Gloss	Full Flood 4” x 36”	FloorScore ® Certification

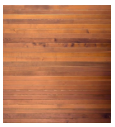
		Arborart with Diamond 10 Technology in Walnut Blonde					
	LVT2 	TP083 Luxury Flooring- Natural Creations Classics ,Casablanca Design in Anise	Armstrong	Casablanca Anise	Luxury Vinyl Tile, Full Flood	457.2mm x 457.2mm x 3.2mm	FloorScore ® Certification
Wall	WC1 	5102P-802 Denali II Wallcovering	Designtex	Denali II in Birch	100% Polyester Wallcoveri ng	Repeat V 13.6" x H 13.5"	
	ACT1 	BuzziMood Custom Acoustic Wall Solution	BuzziSpace	BuzziMood Acoustic Wall Solution	BuzziMood Custom with Dark Green Reindeer Moss Filling and Hidden Black Powder Coated Frame	Custom to Fit Wall	
Base	RB1 	Snow White Baseworks™ Thermoset Rubber (Type TS) Part No. TSBT 01 6 LIC 1/8 Toeless	Johnsonite	Baseworks™ 6" Toeless 01 in Snow White	Rubber Wall Base. Straight Strip	6" x 4 1/8"3	-Total Recycled Content 14% -Rapidly Renewable Content 2% -Cradle to Cradle Silver -Phthalate-free - FloorScore® C ertification
Ceiling	P2 	SW 2809 Rookwood Shutter Green	Sherwin Williams	Rookwood Shutter Green Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicid al Interior Eggshell		Greenguard Certified for Low Chemical Emissions
Millwork	SW1 	Walnut Solid Wood Cabinets with Glass Doors	Netley Millwork				
	SS1 	Corian® Solid Surface Sand Storm	DuPont™ Corian®	Solid Surface Sand Storm	Solid Surface		Greenguard Certified for Low Chemical Emissions
Window Coverings and Curtains	TX2 	3874-101 Kami Upholstery	Designtex	Kami in Oat from Origami Collection	17% Polyester (Non-halogenate d Flame Retardant	Repeat V 4.9" x H 4.3"	

					Trevira CS) 83% Polyester		
138-Lounge							
Floor	LVT3 	NA230 Luxury Vinyl Tile Plank Natural Creations Arborart with Diamond 10 Technology in Walnut Blonde	Armstrong	Natural Creations Arborart in Walnut Blonde	Luxury Vinyl Tile Plank, Low Gloss	Full Flood 4" x 36"	FloorScore ® Certification
	CT2 	HN840 - 104227 Earth Carpet Tile Product no. 127620AK0H	Interface	104227 Earth Carpet Tile from Human Nature Collection	Carpet Tile Plank, Tufted Pattern Loop	9.845" x 39.38"	Total Recycled Content 92% Post- Industrial 66% Post- Consumer 27% Green Label Plus NSF/ANSI-2440 Platinum
	CT3 	HN850 - 104211 Earth Carpet Tile Product no. 127600AK0H	Interface	104211 Earth Carpet Tile from Human Nature Collection	Carpet Tile Plank, Tufted Sheared	9.845" x 39.38"	Total Recycled Content 92% Post- Industrial 65% Post- Consumer 27% Green Label Plus NSF/ANSI-2440 Platinum
	CT4 	HN810 - 104219 Earth Carpet Tile Product no. 127610AK0H	Interface	104219 Earth Carpet Tile from Human Nature Collection	Carpet Tile Plank, Tufted Sheared	9.845" x 39.38"	Total Recycled Content 92% Post- Industrial 65% Post- Consumer 28% Green Label Plus NSF/ANSI-2440 Platinum
Wall	P5 	SW 2846 Roycroft Bronze Green	Sherwin Williams	Roycroft Bronze Green Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
	T2 	ANIGM24 Graphite Tile	Ames Tile	Anima Porcelin Rectified in Graphite	Matte Porcelain Rectified Square Tile	24"x24"	
	T3 	4DE064 White Nature Tile	Ames Tile	4D Series Nature Porcelain Tile	Glazed Porcelain Matte	8"x8"	
	ST2 	Existing Culture Stone					

Base	ST3 	Tyndall Stone Fireplace Base					
Ceiling	WG1 	Woodworks® Grille	Armstrong	Woodworks® Grille in Custom Colour	Wood Plank Ceiling Finish in Brushed Oak	1-1/4" Slat W, Slat H 3-1/4" with 4 Slats per Panel, Slat Spacing 2-3/4"	
	WB1 	Brushed Oak Wood Beam					
	SW2 	Oak Wood Planks with Dark Walnut Stain					
Window Coverings and Curtains	TX2 	3874-101 Kami Upholstery	Designtex	Kami in Oat from Origami Collection	17% Polyester (Non-halogenated Flame Retardant Trevira CS) 83% Polyester	Repeat V 4.9" x H 4.3"	
Millwork	SW1 	Walnut Solid Wood Floating Library Shelves	Netley Millwork			1' D x 1" H Custom Lengths	
138-A, 138-B Nooks							
Floor	CT5 	UR101-103501 Bark/Moss Carpet Tile Product no. 127110250H	Interface	103501 Bark/Moss Carpet Tile from Urban Retreat Collection	Carpet Tile Plank, Tufted Pattern Loop	19.69" x 19.69"	Total Recycled Content 92% Post- Industrial 66% Post- Consumer 26% Green Label Plus NSF/ANSI-2440 Platinum
	CT6 	UR102-102991 Bark Carpet Tile Product no. 127100250H	Interface	102991 Bark Carpet Tile from Urban Retreat Collection	Carpet Tile Plank, Tufted Pattern Loop	19.69" x 19.69"	Total Recycled Content 92% Post- Industrial 66% Post- Consumer 26% Green Label Plus NSF/ANSI-2440 Platinum
Wall	WC2 	Item #WC22445 Cascade in Aurora	Knoll	Atmosphere Collection Cascade in Aurora	Wallcovering with 86% Thermoplastic Olefin, 14% Recycled	Repeat H 50" x V 60"	

					Glass, Polyester Backing		
Window Coverings and Curtains	TX2 	3874-101 Kami Upholstery	Designtex	Kami in Oat from Origami Collection	17% Polyester (Non-halogenated Flame Retardant Trevira CS) 83% Polyester	Repeat V 4.9" x H 4.3"	
142-Spiritual Semi-Private							
Floor	CT7 	HN850-104210 Shale Carpet Tile Product no. 127600AK0H	Interface	104210 Shale Carpet Tile from Human Nature Collection	Carpet Tile Plank, Tufted Sheared	9.845" x 39.38"	Total Recycled Content 92% Post- Industrial 65% Post- Consumer 27% Green Label Plus NSF/ANSI-2440 Platinum
Wall	ST2 	Existing Culture Stone					
	WC3 	394001-110 Whirlwind in Pebble Wallcovering	Maraham	Whirlwind Wallcovering in Pebble	95% Non-Phthalate Vinyl, 5% Polyester High Traffice Wallcovering with Polyester/Cotton Backing	Repeat is Non-Match	
	P1 	SW 0037 Morris Room Grey	Sherwin Williams	Morris Room Grey Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
Ceiling	P3	SW 0053 Porcelain	Sherwin Williams	Porcelain Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
142-A, 142- B Spiritual Nooks							
Wall	P1 	SW 0037 Morris Room Grey	Sherwin Williams	Morris Room Grey Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
Ceiling	P3	SW 0053 Porcelain	Sherwin Williams	Porcelain Paint Shield Microbicidal	Paint Shield Microbicid		Greenguard Certified for

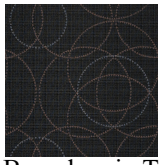
				Interior Latex Paint	al Interior Eggshell		Low Chemical Emissions
Millwork	SW1 	Walnut Solid Wood Seat Frame	Netley Millwork				
	TX1 	3949-101 Split Upholstery	Designtex	Split in Wisp	98 Acrylic 2% Polyester Stain Repellent, Water Repellent with Non-Woven Acrylic Backing	Repeat V 5.5 " x H None	Greenguard Gold Certified
141-Spiritual Group Area							
Floor	CT8 	UR102-102996 Stone Carpet Tile Product no. 127100250H	Interface	102996 Stone Carpet Tile from Urban Retreat Collection	Carpet Tile Plank, Tufted Pattern Loop	19.69" x 19.69"	Total Recycled Content 92% Post- Industrial 66% Post- Consumer 26% Green Label Plus NSF/ANSI-2440 Platinum
	CT9 	UR103-100639 Ivy Carpet Tile Product no. 127120250H	Interface	100639 Ivy Carpet Tile from Urban Retreat Collection	Carpet Tile Plank, Tufted Pattern Loop	19.69" x 19.69"	Total Recycled Content 92% Post- Industrial 66% Post- Consumer 27% Green Label Plus NSF/ANSI-2440 Platinum
	LVT1 	TP034 Luxury Flooring -Pine Oak Design in Bronze	Armstrong	Pine Oak Bronze	Luxury Vinyl Tile, Plank, Full Flood	152.4 mm x 914.4 mm x 3.2 mm	FloorScore ® Certification
Wall	P2 	SW 2809 Rookwood Shutter Green	Sherwin Williams	Rookwood Shutter Green Paint Shield Microbicidal Interior Latex Paint	Paint Shield Microbicidal Interior Eggshell		Greenguard Certified for Low Chemical Emissions
	SW3 	Existing Cedar Planks					

Base	RB1 	Snow White Baseworks™ Thermoset Rubber (Type TS) Part No. TSBT 01 6 LIC 1/8 Toeless	Johnsonite	Baseworks™ 6” Toeless 01 in Snow White	Rubber Wall Base. Straight Strip	6” x 4 1/8”3	-Total Recycled Content 14% -Rapidly Renewable Content 2% -Cradle to Cradle Silver -Phthalate-free - FloorScore® Certification
Ceiling	SW3 	Existing Cedar Planks					
Millwork	SW4 	Oak					

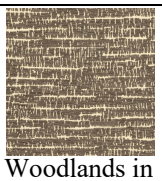


Material Board

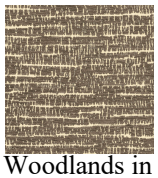
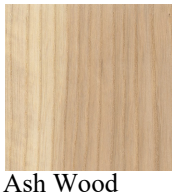
Appendix B – Furniture Selections

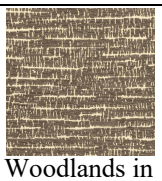
Furniture				
Image	Description	Manufacturer	Finishes	Location (Room No)
	Aspen Lounge Seating	Nemschoff	 Lariat in Ivory ZLR13 Nemschoff  Walnut- Matte WT Nemschoff	103 105 114 115 116 119 121-B 122-B 124-B 125-B 138
	Sophora Lounge Seating	Nemschoff	 Lariat in Lake ZLR20 Nemschoff  Walnut- Matte WT Nemschoff	119 121-B 122-B 124-B 125-B
	Iris Lounge Seating	Nemschoff	 Cover Cloth in Indigo 7CC12 Nemschoff  Boundary in Truffle 466193-009 Maraham	126 129

			 WO White Oak- Matte Nemschoff	
	Leonard II Sleep Double Sofa	Nemschoff	 Oath in Ecru 7TH13 Nemschoff  UL Natural Maple Nemschoff	121-B 122-B 124-B 125-B
	Tamarak Bench	Nemschoff	 Lariat in Ivory ZLR13 Nemschoff  Walnut- Matte WT Nemschoff	103 106
	Boxplay Lounge S24601 Settee S24605	Hightower	 EcoSoft Leather 33001 175C Hightower	126 138
	Gimbal Low Lounge Rocker HT4110 and Gimbal Ottoman HT4120	Hightower	 Atlas in Plantain #K12362 Knoll	138-A 138-B

	Kilo Islands Large Configuration GZ100L Small Configuration GZ100S Solo 1 GZ01 Solo 3 GZ03 Solo 4 GZ04	Hightower	 Chroma in Eucalyptus #K34515 Knoll  Chroma in Moss #K34516 Knoll	142
	Kona Sectional L Shape KN20 Three Seat Sofa with Arms KN11	Hightower	 Woodlands in Sycamore #K204910 Knoll  Dune in Boardwalk #K20472 Knoll	119 138
	Kona Pouf Round KN3850 Square KN3855	Hightower	Color Field in Straw #K22263  Colour Field in Blueprint #K22268	119 121 122 124 125 138 141

	Nest Easy Highback Lounge with Wood Base GZ7200SK Ottoman with Wood Base GZ7250	Hightower	 Dune in Boardwalk #K20472 Knoll --- Soaped Oak Wood Finish Hightower	119 138
	Laminett Chair S23101	Hightower	 Light Brown Sheepskin Hightower  Beech Hightower	126 138
	Nest Lounge Low Chair GZ6300	Hightower	 Woodland in Blue Spruce #k20493 --- Soaped Oak Wood Finish Hightower	119 126 137

	Grace Stack Chair S22900 Grace Barstool S22920	Hightower	 Woodlands in Sycamore #K204910 Knoll --------  Ash Wood Hightower	121 122 124 125 130
	Aeron Office Chair	Herman Miller	Black	102 104 106 105 114 115 116
	Keyn Chair With Five-Star Base	Herman Miller	 Ace in Oceanside 3AC17  Studio White Base 9B	118
	Crosshatch Chair	Herman Miller	 Walnut  Lariat in Lake ZLR20 Nemschoff	121-C 122-C 124-C 125-C 127

	Bevel Sofa Item No. AL6C1003EN22H 12NFR	Herman Miller	 Woodlands in Sycamore #K204910 Knoll	103 114
	Hemlock Side Table	Nemschoff	 Walnut- Matte WT Nemschoff	114 115 116 121-B 122-B 124-B 125-B 126 138
	Tyndall Table	Thom Fougere		126 138
	Noguchi Table Item No. 1N500U	Herman Miller	 Walnut	114 115 116 138
	Breck Tables Large BR3300 Small BR3400	Hightower	 Walnut Veneer  Atlas in Plantain #K12362 Knoll	138 141

	Four Cast Tables FC Four Eating Folding Table FC120000	Hightower	White Wilsonart Laminate Chrome Base	121 122 124 125
	Insula Small Coffee Table EJ1900 Large Coffee Table EJ1910	Hightower	Black Powder Coat	121-B 122-B 124-B 125-B
	Intersect Folding Table	Herman Miller	 White Laminate – 91  Metallic Silver -MS	118
	Basin Coffee Table	Hollis + Morris	 Walnut Spun Black aluminum Powder Coated	103 119 127
	Drum Stools	Indigo Arrows	Custom	119

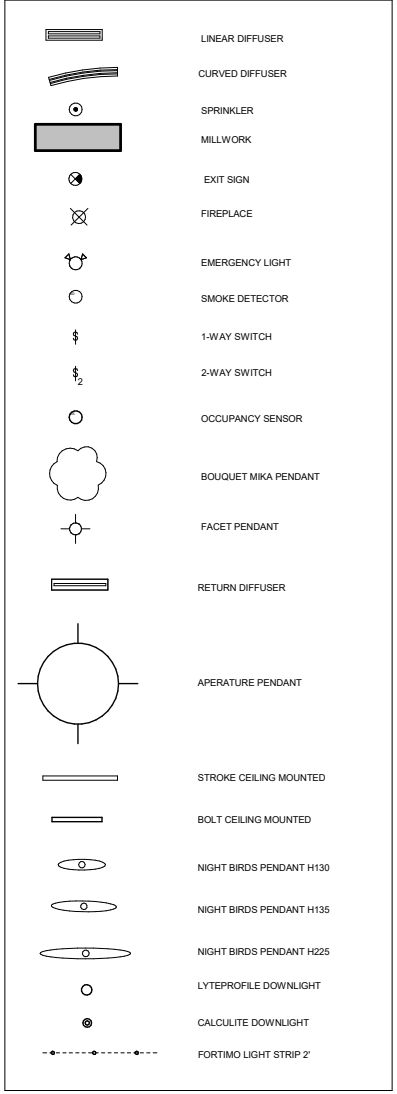
	Round Oak Custom Table	Wood Anchor	Oak Steel	126
	Rectangular Custom Table	Wood Anchor	Oak Steel	126
	Custom Sofa Table	Wood Anchor	Oak Tyndal Steel	122-122, 124-125 138

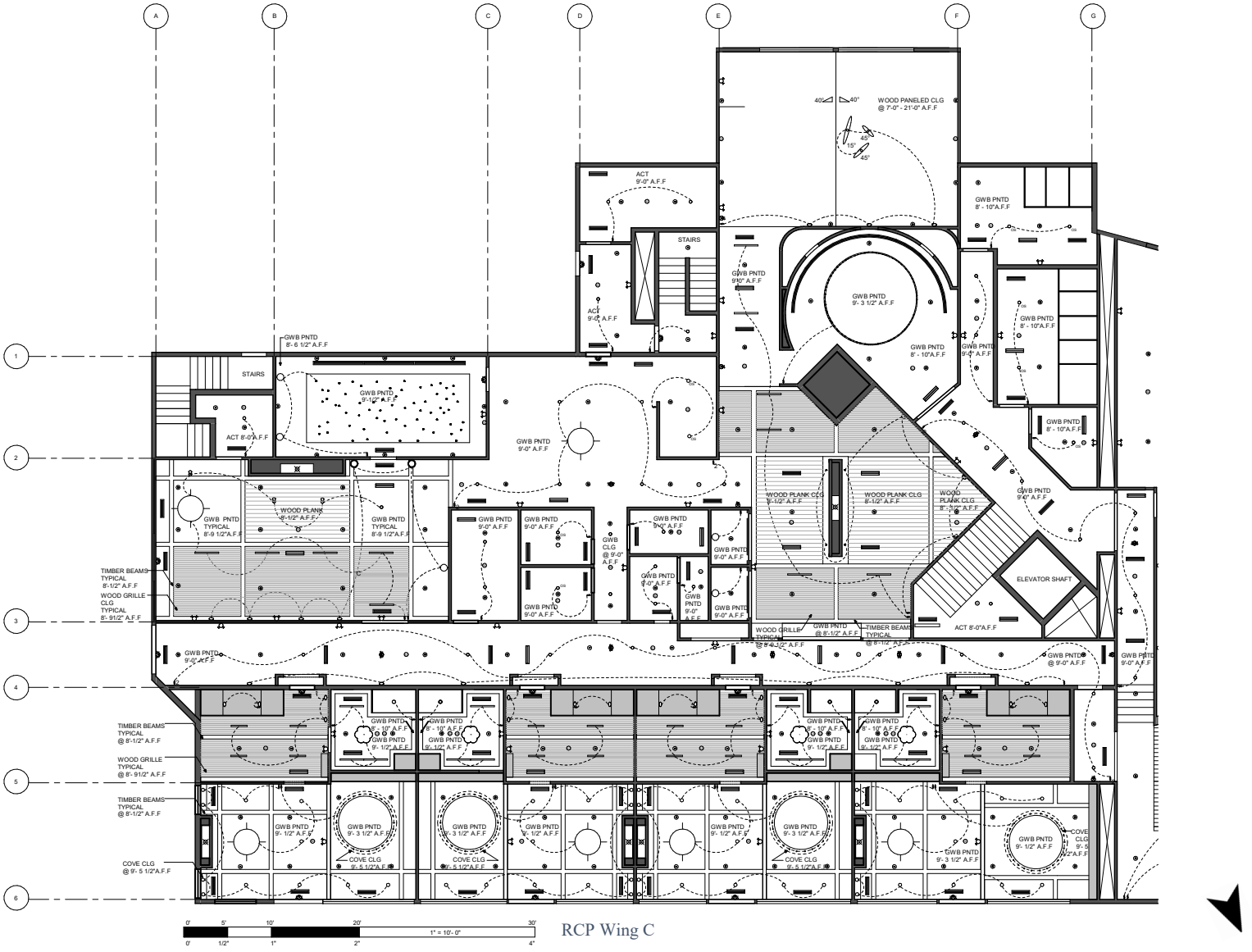
Appendix C – Reflected Ceiling Plans and Detail Drawings

LUMINAIRE SCHEDULE

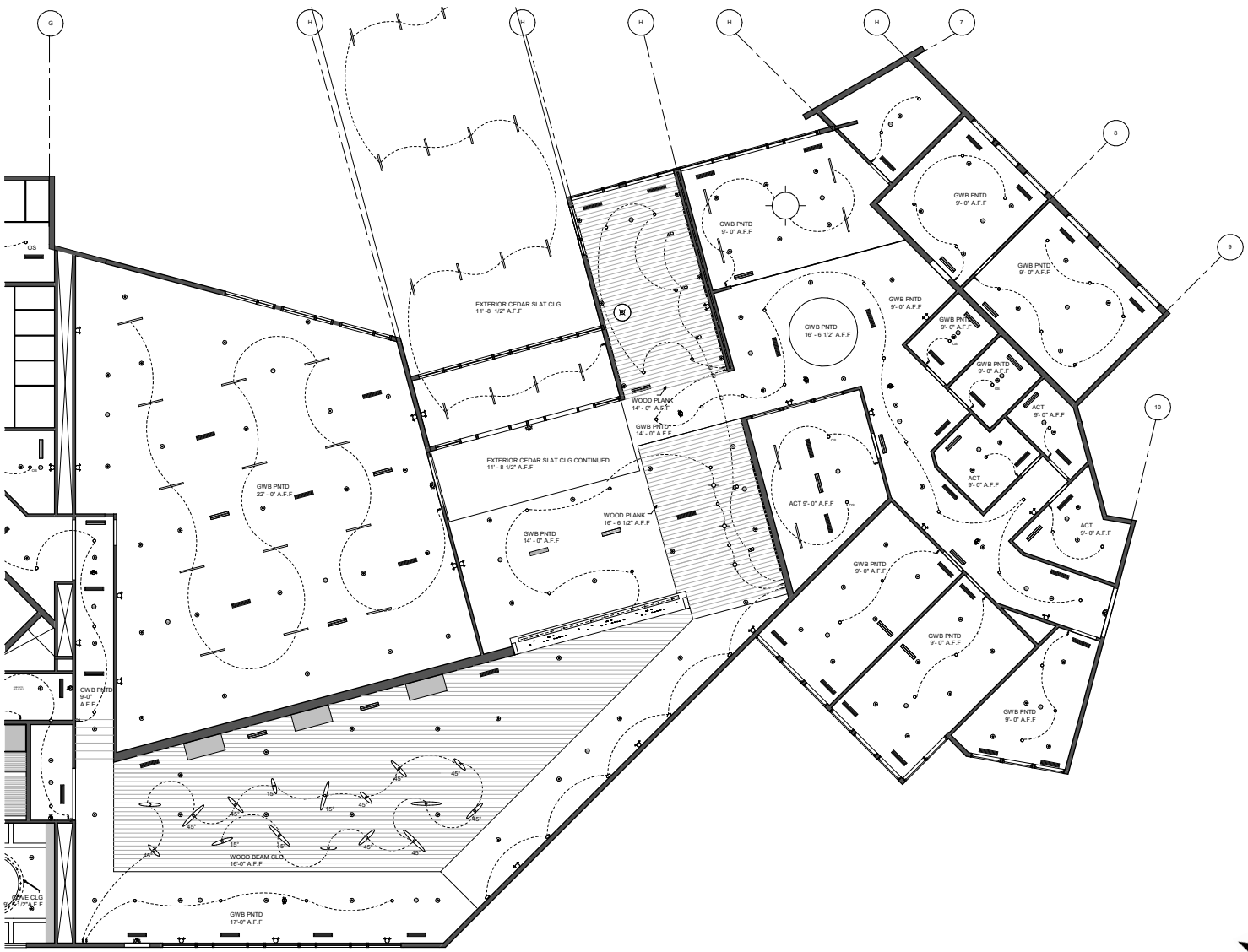
SYMBOL	DESCRIPTION	MANUFACTURER	LUMENS	WATTS	DIMENSIONS	ROOM LOCATION AND QUANITITY
	BOUQUET MIKA 4428-10-RAP-7 CEILING SUSPENDED LED 3000 K 0-10V DIMMING (120-277V) WHITEFINE TEXTURE WITH WHITE DIFFUSER	EUREKA LIGHTING	NA	9W EACH X 7 BULBS = 63 W TOTAL	10" DIA CANOPY 35.31" TOTAL WIDTH 11.8" DIA GLOBE 12" CUSTOM CABLE LENGTH 33.8" TOTAL HEIGHT	121-A QTY 1 122-A QTY 1 124-A QTY 1 125-A QTY 1 TOTAL QTY 4
	FACET 4029-UFC-SC-CLR-SAA CEILING SUSPENDED LED 4000 K 0-10V DIMMING (120-277V)	EUREKA LIGHTING	400	4W	4.5" DIA CANOPY X 1.75" H 3.23" H GLOBE X 3.5" DIA 96.5" CABLE LENGTH CUSTOM	102 QTY 3 TOTAL QTY 3
	APERATURE 24" 4256-24-18AC-060- LED30.DV.8-CHR-ANTE-WHM CEILING SUSPENDED LED 3000 K 0-10V DIMMING (120-277V)	EUREKA LIGHTING	1538	32.4 W	SHADE 16" HEIGHT X 24" DIA 8.5" CUSTOM CABLE LENGTH 24.5" TOTAL LENGTH	121-B QTY 1 122-B QTY 1 124-B QTY 1 125-B QTY 1 126 QTY 1 TOTAL QTY 5
	STROKE 3542-24- DV-FRO-WHE CEILING MOUNTED LED 3000 K 0-10V DIMMING (120-277V)	EUREKA LIGHTING	923	9 W	24.66" LENGTH 2.54" WIDTH 3.54" HEIGHT	100 QTY 4 124-A QTY 3 104 QTY 4 125-A QTY 3 117 QTY 2 126 QTY 5 118 QTY 13 138 QTY 4 121-A QTY 3 140 QTY 2 122-A QTY 3 TOTAL 46
	BOLT 3544- 12-DV-FRO-WHE CEILING MOUNTED LED 3000 K 0-10V DIMMING (120-277V)	EUREKA LIGHTING	965	8 W	13.3" LENGTH 3.6" WIDTH 4" DIA	121 QTY 4 122 QTY 4 124 QTY 4 125 QTY 4 TOTAL QTY 16
	NIGHT BIRDS PENDANT D780 H130 PRODUCT NO PC962 CEILING SUSPENDED LED 2700 K 0-10V DIMMING (120-277V) CGC882 SMOKE GREY GLASS CECL149 TRANSPARENT CABLE	BROKIS	336	5 W	780 MM X 130 MM X 1.5 M CUSTOM LENGTH CABLE	119 QTY 5 141 QTY 1 TOTAL QTY 6
	NIGHT BIRDS PENDANT D780 H135 PRODUCT NO PC963 CEILING SUSPENDED LED 2700 K 0-10V DIMMING (120-277V) CGC882 SMOKE GREY GLASS CECL149 TRANSPARENT CABLE	BROKIS	336	5 W	780 MM X 135 MM X 1.5 M CUSTOM LENGTH CABLE	119 QTY 6 141 QTY 1 TOTAL QTY 7
	NIGHT BIRDS PENDANT D610 H225 PRODUCT NO PC964 CEILING SUSPENDED LED 2700 K 0-10V DIMMING (120-277V) CGC882 SMOKE GREY GLASS CECL149 TRANSPARENT CABLE	BROKIS	336	5 W	610 MM X 225 MM X 1.5 M CUSTOM LENGTH CABLE	119 QTY 5 141 QTY 1 TOTAL QTY 6
	LYTEPROFILE 4" LED DOWNLIGHT P4RD-W LED 4000 K WHITE PAINTED DIFFUSER AND FLANGE	LIGHTOLIER BY SIGNIFY PHILIPS	1000	24.5 W	4.5" DIA X 4.5" HOUSING HEIGHTX 5.5" HOUSING DIA	101- 103 QTY 12 126 QTY 1 105- 117 QTY 38 130-137 QTY 22 119-120 QTY 16 139 QTY 1 121A-B, 122A-B QTY 28 143-149 QTY 13 124A-B,125A-B QTY 28 TOTAL QTY 159
	CALCULITE 1.75" LED DOWNLIGHT C2L09-930--E1-D2L-WH-W- R03 LED 3000 K WHITE PAINTED DIFFUSER AND FLANGE ROUND GLASS APERATURE	LIGHTOLIER BY SIGNIFY PHILIPS	900	13.9 W	2.5" DIA X 2.63" DIA HOUSING X 5.88" HOUSING HEIGHT	129 QTY 62 138 QTY 4 TOTAL QTY 66
	FORTIMO LED STRIP MODULES PLT-1486DS GEN3 LED 3000 K	PHILIPS	1400	NA	20 MM WIDTH X 24" LENGTH	101 QTY 10 STRIPS (DIST 19'3") 121-C QTY 11 (DIST 21') 122-C QTY 11 124-B QTY 11 125-B QTY 11 142 QTY 17 (DIST 33') TOTAL QTY 61
	SLANT WALL SURFACE 3413 SCONCE LED 3000 K BLACK FINISH WITH CLEAR DIFFUSER	EUREKA	140	2	6" HEIGHT X 3.32 DEPTH X 4" WIDTH TOP TO 6" WIDTH BOTTOM	119-120 QTY 11 121-122 QTY 8 124-126 QTY 12 138 QTY 3 141 QTY 3 TOTAL QTY 37
	FIDDLEHEAD SCONCE LED 2700 K BRUSHED BRASS STEEL WITH CREAM GLASS	ROLL & HILL	200	6	10.5" HEIGHT X 10" WIDTH X 11" DEPTH	126 QTY 3 129 QTY 2 138-A-138-B QTY 2 TOTAL 7
	FOCUS TRACK HEADS 2047 LED 3000 K BLACK FINISHES 15° BEAM ANGLE	EUREKA	2177	18	4.70" D X 4.5" DIA CUSTOM STEM 12"	102-103 QTY 5 126 QTY 3 TOTAL QTY 8

LEGEND




A
B
C
D
E
F
G
1
2
3
4
5
6
WOOD PANELED CLG @ 7'-0" - 21'-0" A.F.F
40°
40°
45°
15°
45°
ACT 9'-0" A.F.F
STAIRS
GWB PNTD 8'- 10"A.F.F
GWB PNTD 9'10" A.F.F
GWB PNTD 9'- 3 1/2" A.F.F
GWB PNTD 8'- 6 1/2" A.F.F
GWB PNTD 9'-0" A.F.F
ACT 8'-0"A.F.F
GWB PNTD 9'-1/2" A.F.F
GWB PNTD 9'-0" A.F.F
WOOD PLANK 8'-1/2" A.F.F
GWB PNTD TYPICAL 8'-9 1/2"A.F.F
GWB PNTD TYPICAL 8'-9 1/2"A.F.F
GWB CLG @ 9'-0" A.F.F
WOOD PLANK CLG 8'-1/2" A.F.F
WOOD PLANK CLG 8'-1/2" A.F.F
WOOD PLANK CLG 8'-1/2" A.F.F
ELEVATOR SHAFT
TIMBER BEAMS TYPICAL 8'-1/2" A.F.F
WOOD GRILLE CLG TYPICAL 8'- 91/2" A.F.F
GWB PNTD @ 8'-1/2" A.F.F
TIMBER BEAMS TYPICAL @ 8'-1/2" A.F.F
GWB PNTD @ 9'-0" A.F.F
WOOD GRILLE TYPICAL @ 8'- 91/2" A.F.F
TIMBER BEAMS TYPICAL @ 8'-1/2" A.F.F
COVE CLG @ 9'- 5 1/2"A.F.F
GWB PNTD 8'- 10" A.F.F
GWB PNTD 9'- 1/2" A.F.F
GWB PNTD 9'- 3 1/2" A.F.F
COVE CLG 9'- 5 1/2"A.F.F
0' 5' 10' 20' 30'
0' 1/2" 1" 2" 4"
1" = 10'- 0"

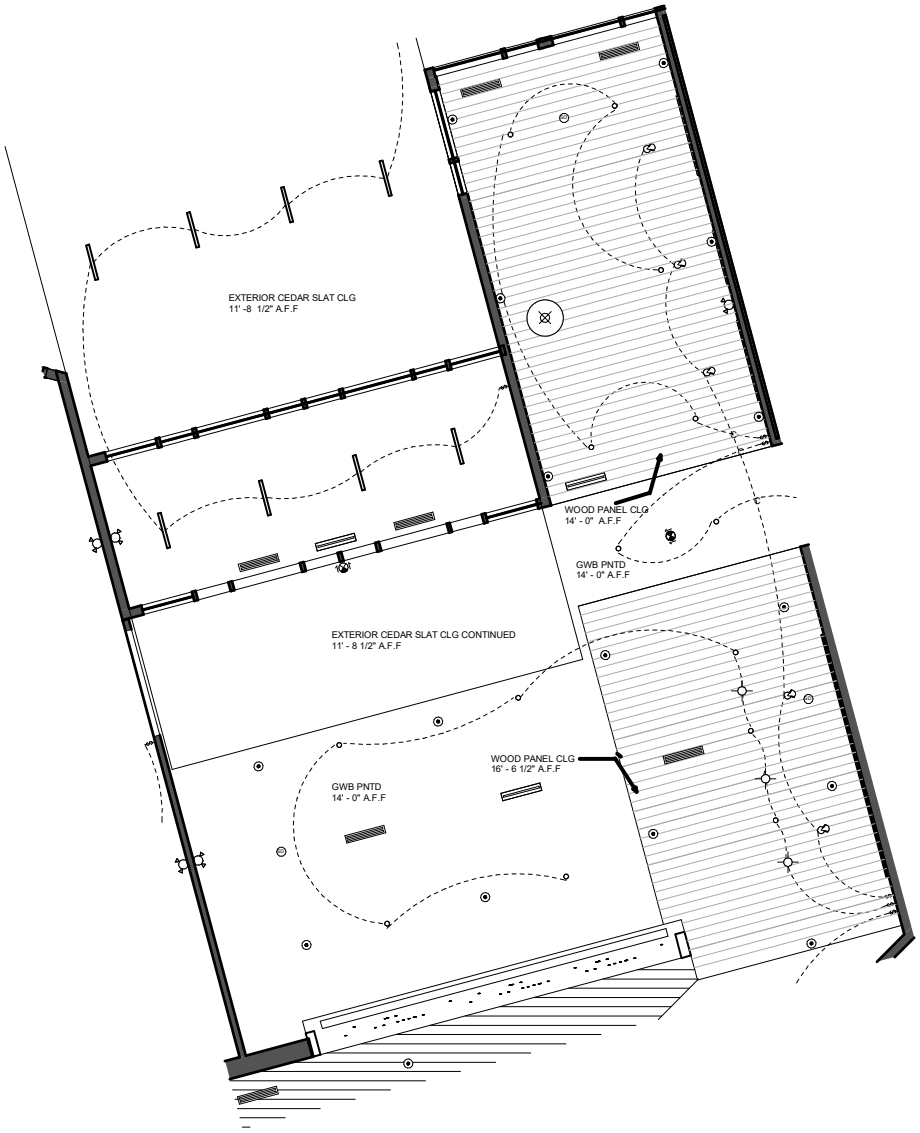
RCP Wing C



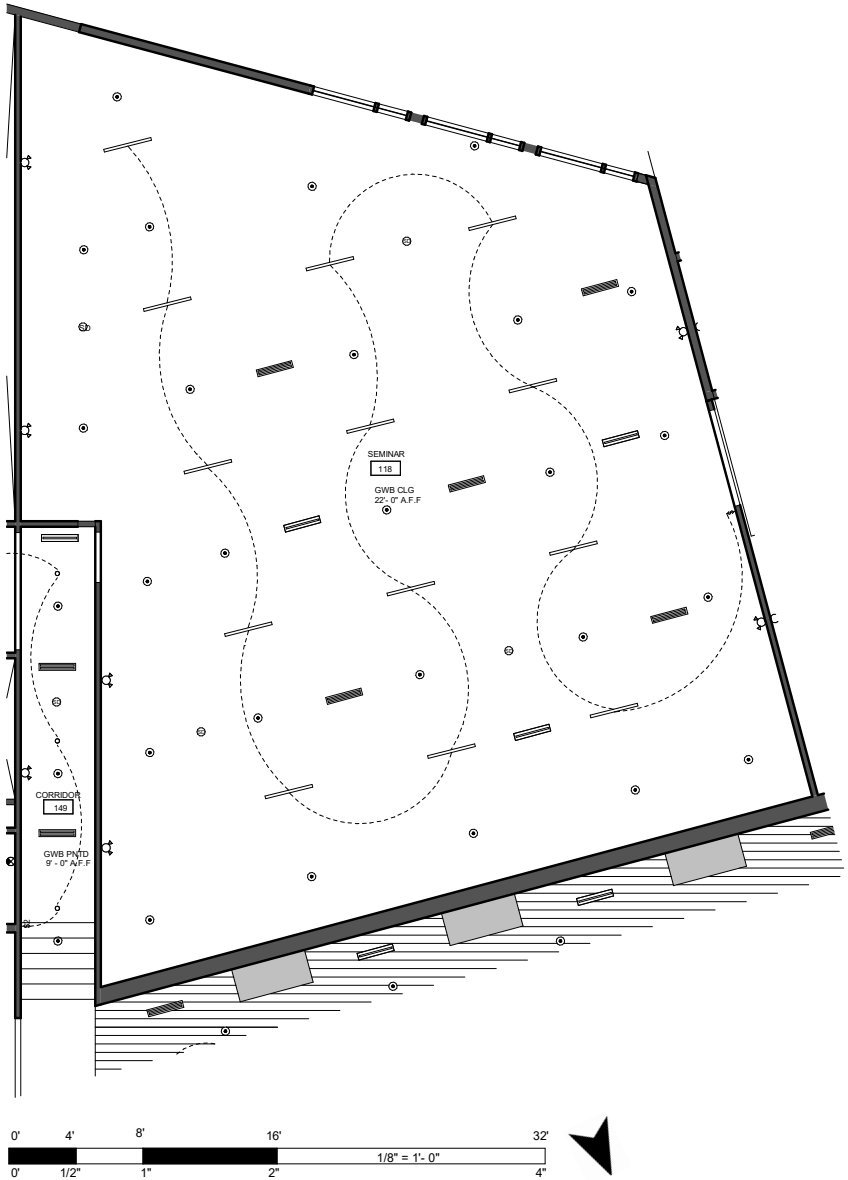
RCP Wing A and B



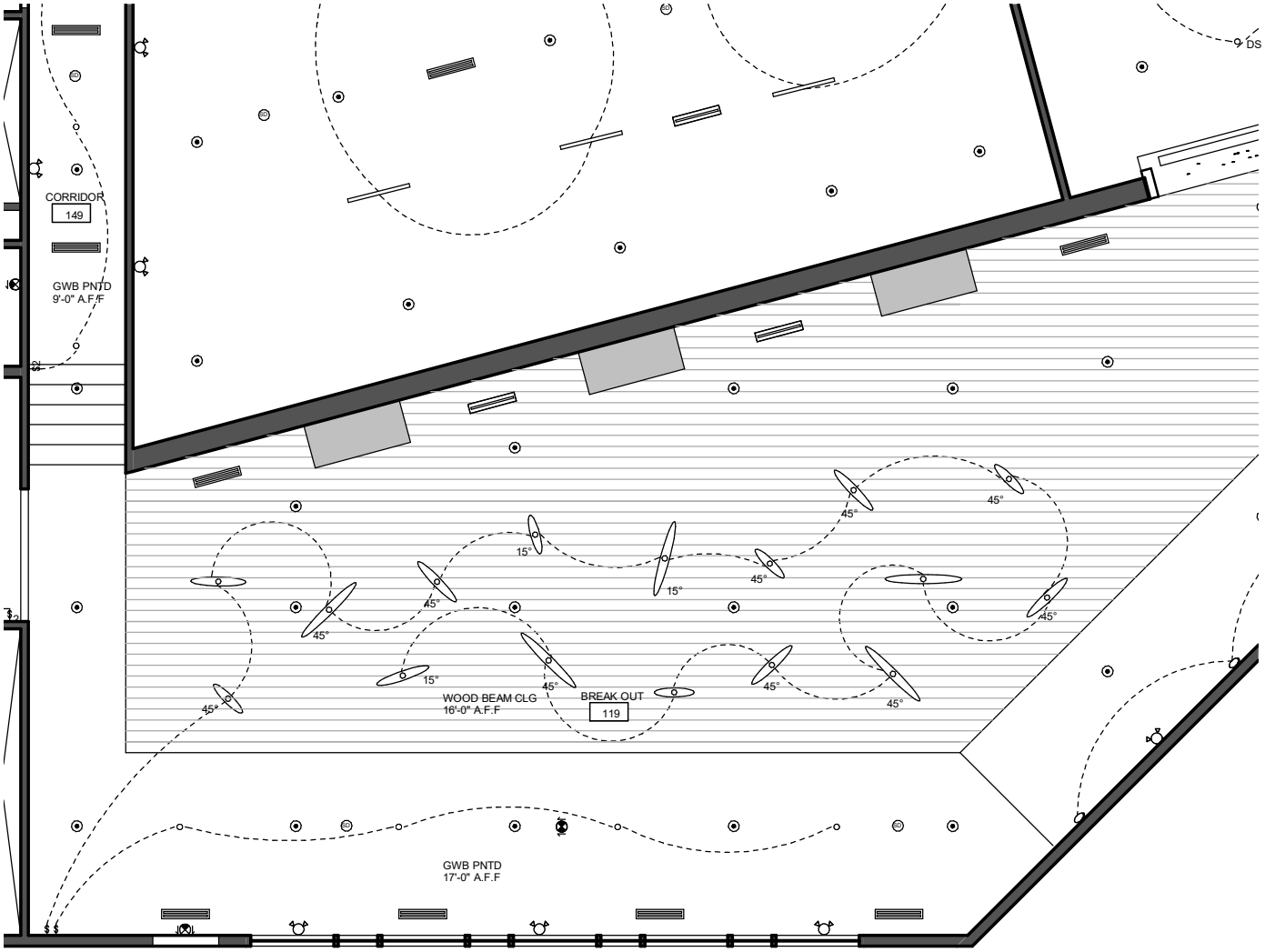
RCP of Outpatient Clinic – Wing A



RCP of Entry – Wing B Subplan



RCP of Seminar Area - Wing B Subplan

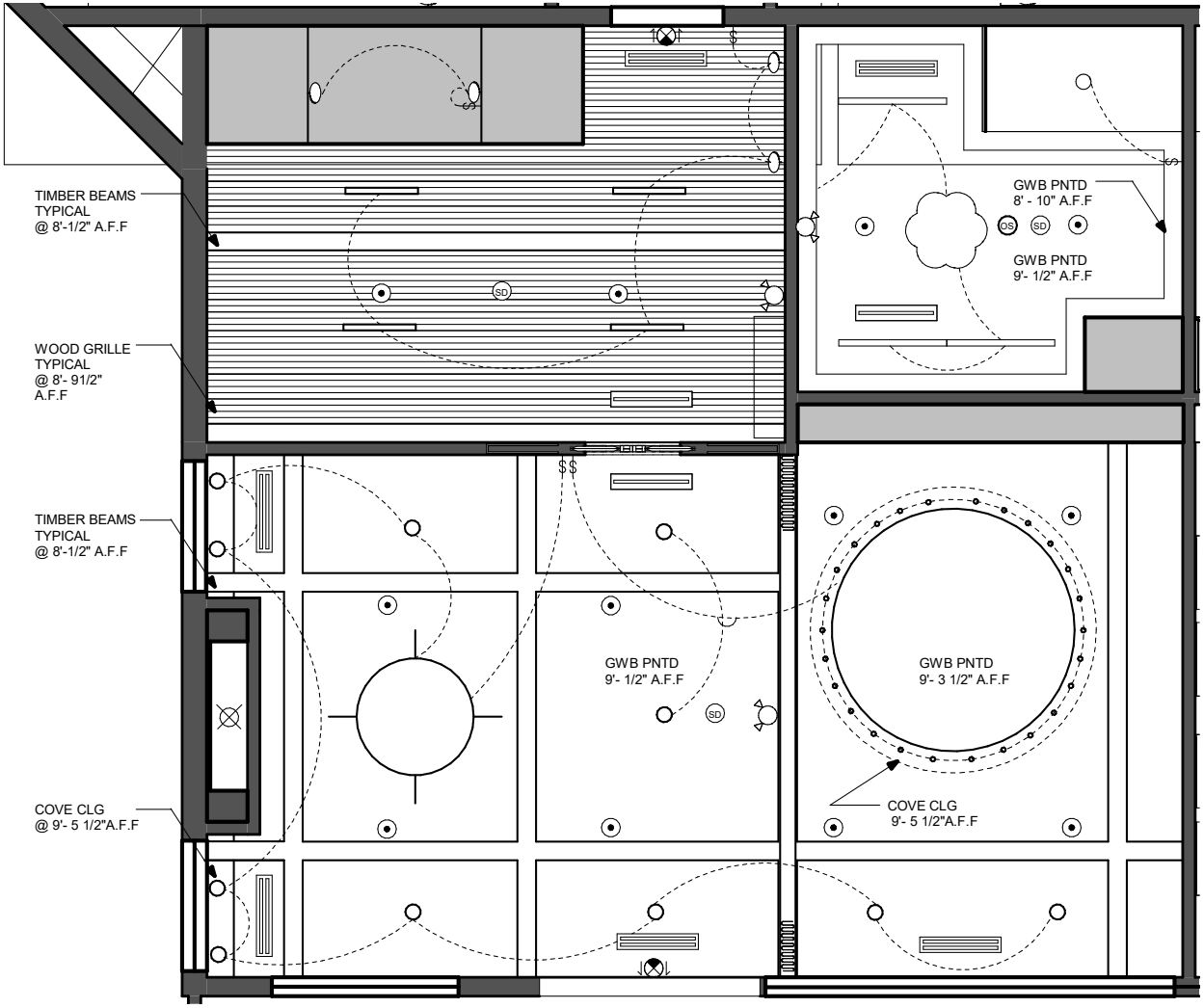


0' 4' 8' 16' 32'

1/8" = 1'- 0"

0' 1/2" 1" 2" 4"

RCP of Breakout Area - Wing B Suplan



0' 2' 4' 8' 16'

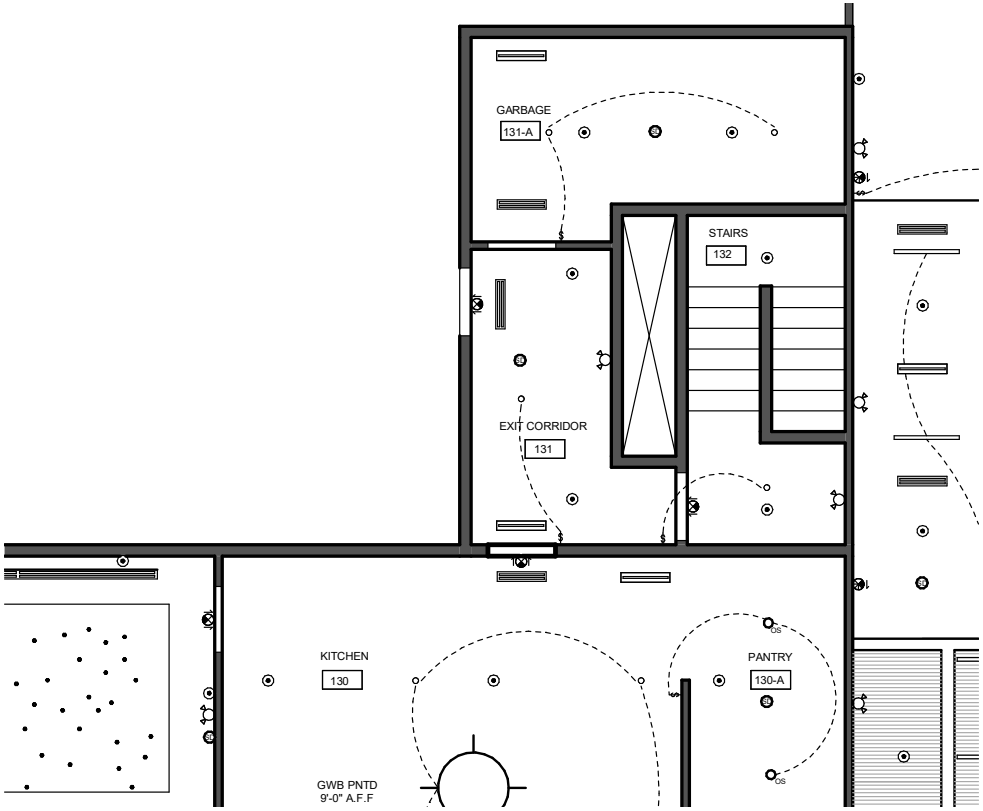
1/4" = 1'- 0"

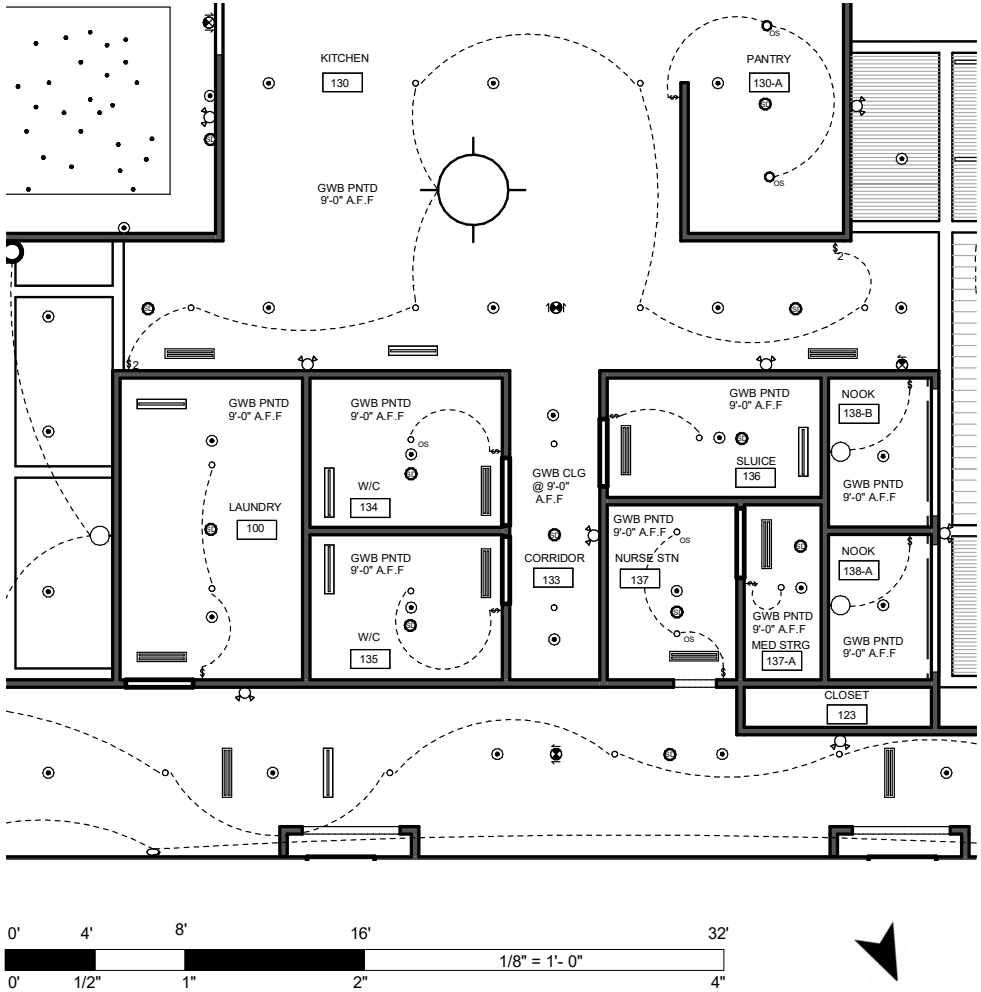
0' 1/2" 1" 2" 4"

RCP of Typical Patient Suite - Wing C Subplan

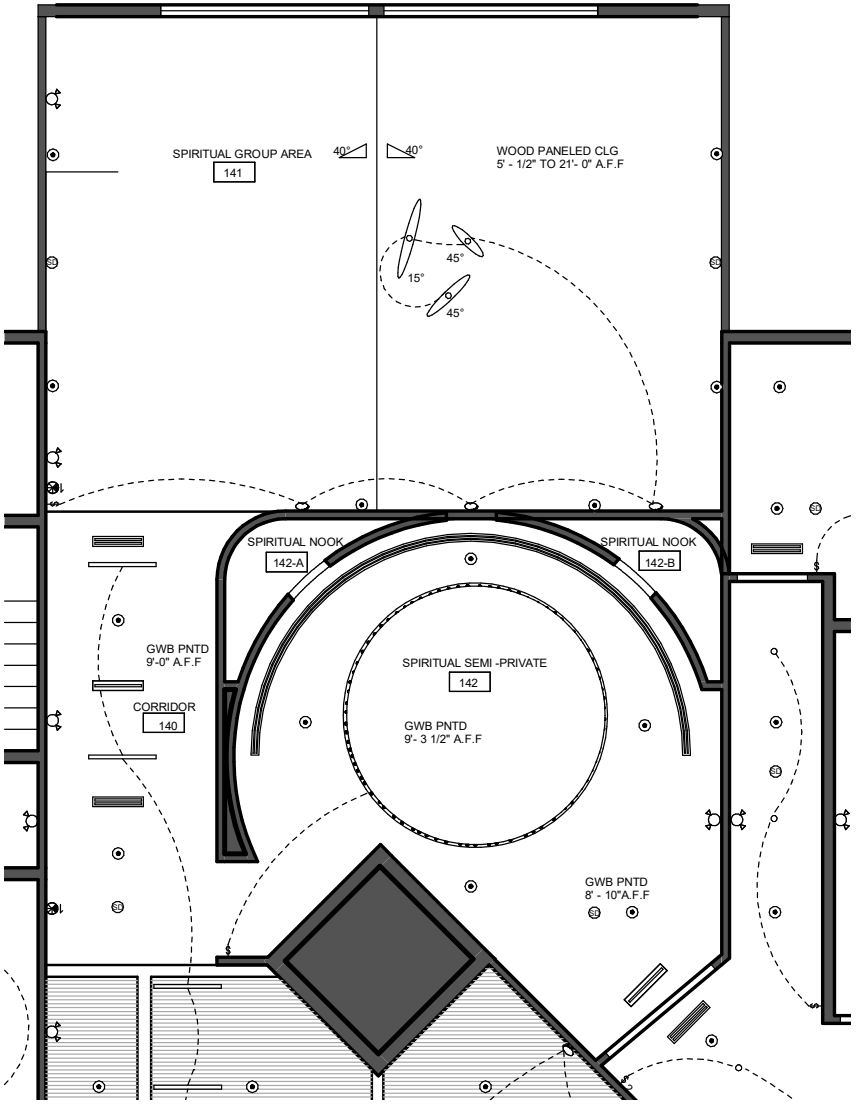


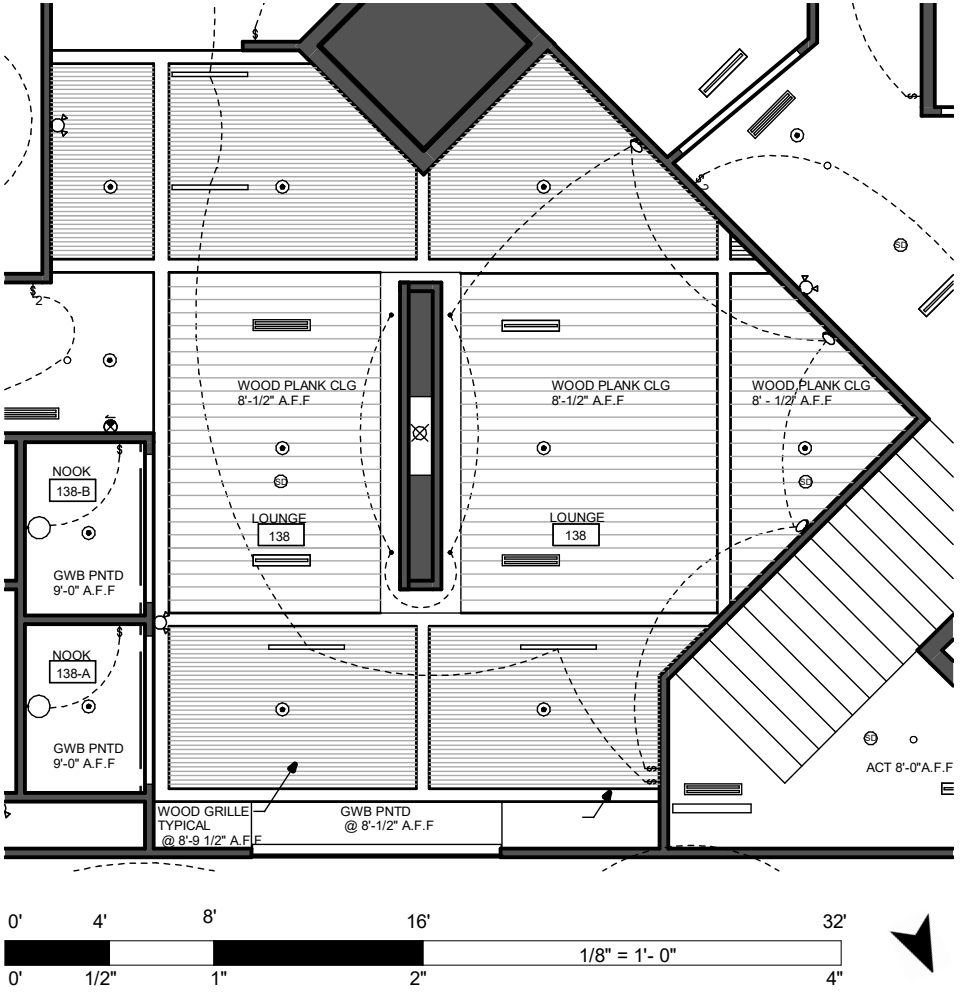
RCP of Dining Area - Wing C Subplan





RCP of Kitchen and Utilities - Wing C Subplan





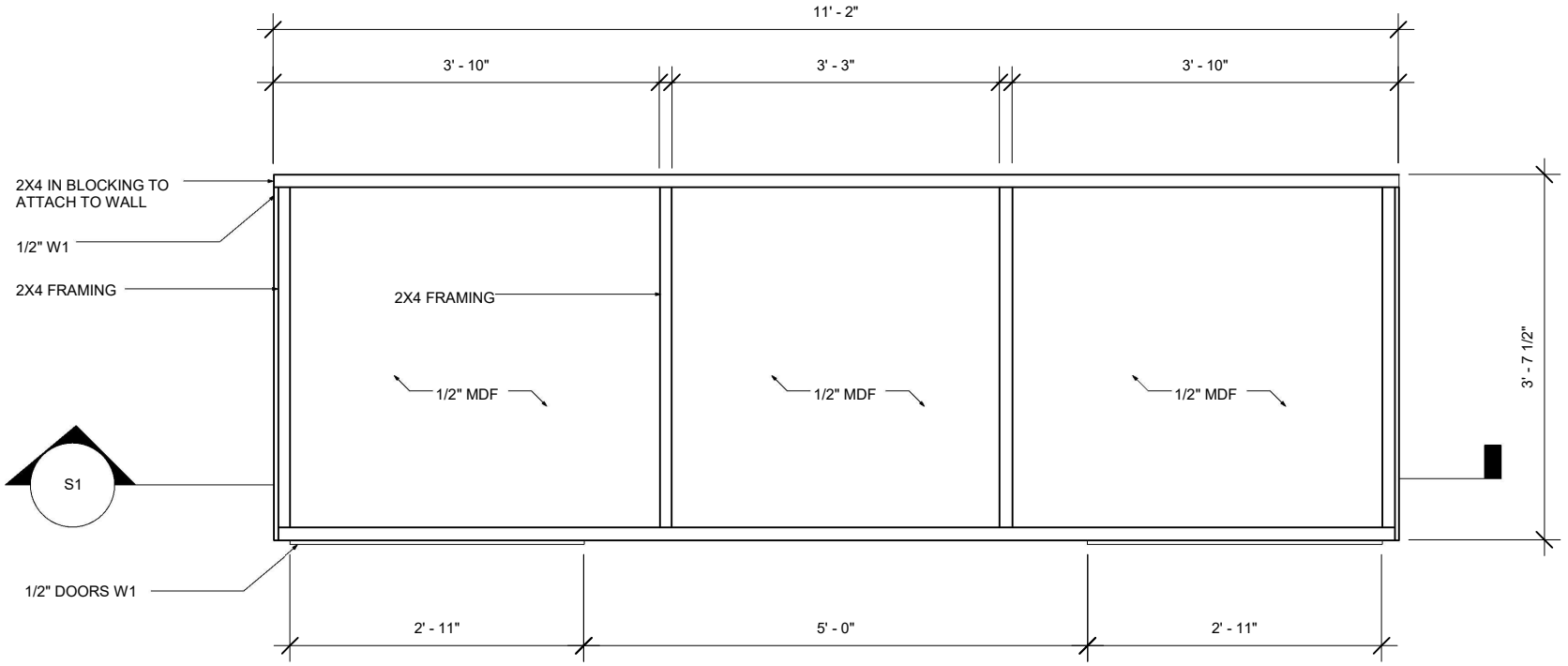
RCP of Lounge and Spiritual Areas - Wing C Subplan



Nook perspective – bed stored



Nook perspective – bed extended



DD1 Millwork Plan

SCALE: 3/4" = 1' - 0"

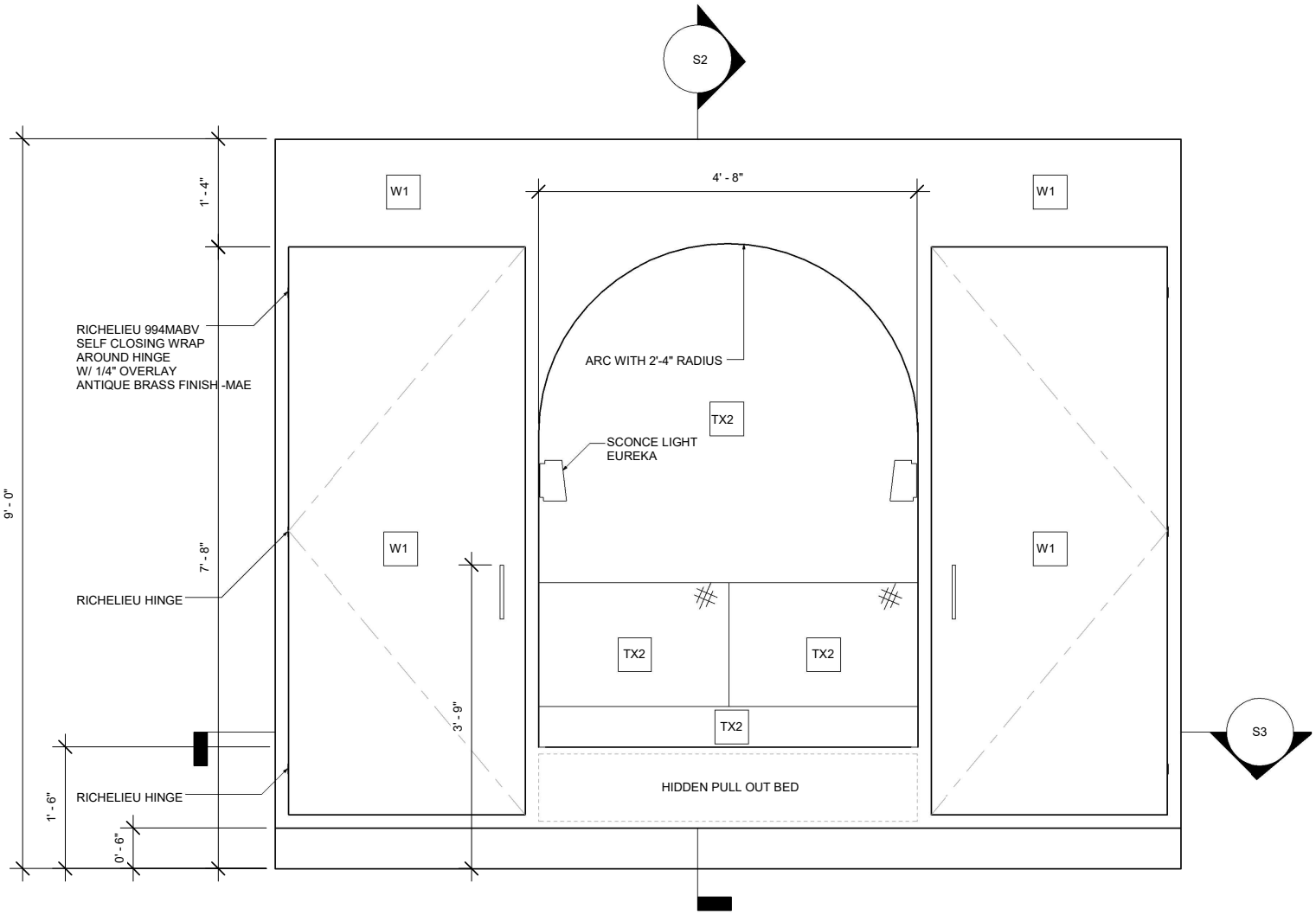
MATERIALS

P1 - SHERWIN WILLIAMS
MORRIS ROOM GREY W/ SATIN FINISH
SW 0037

TX1 - DESIGNTEX
SUBTLE IN POOL
3951-403

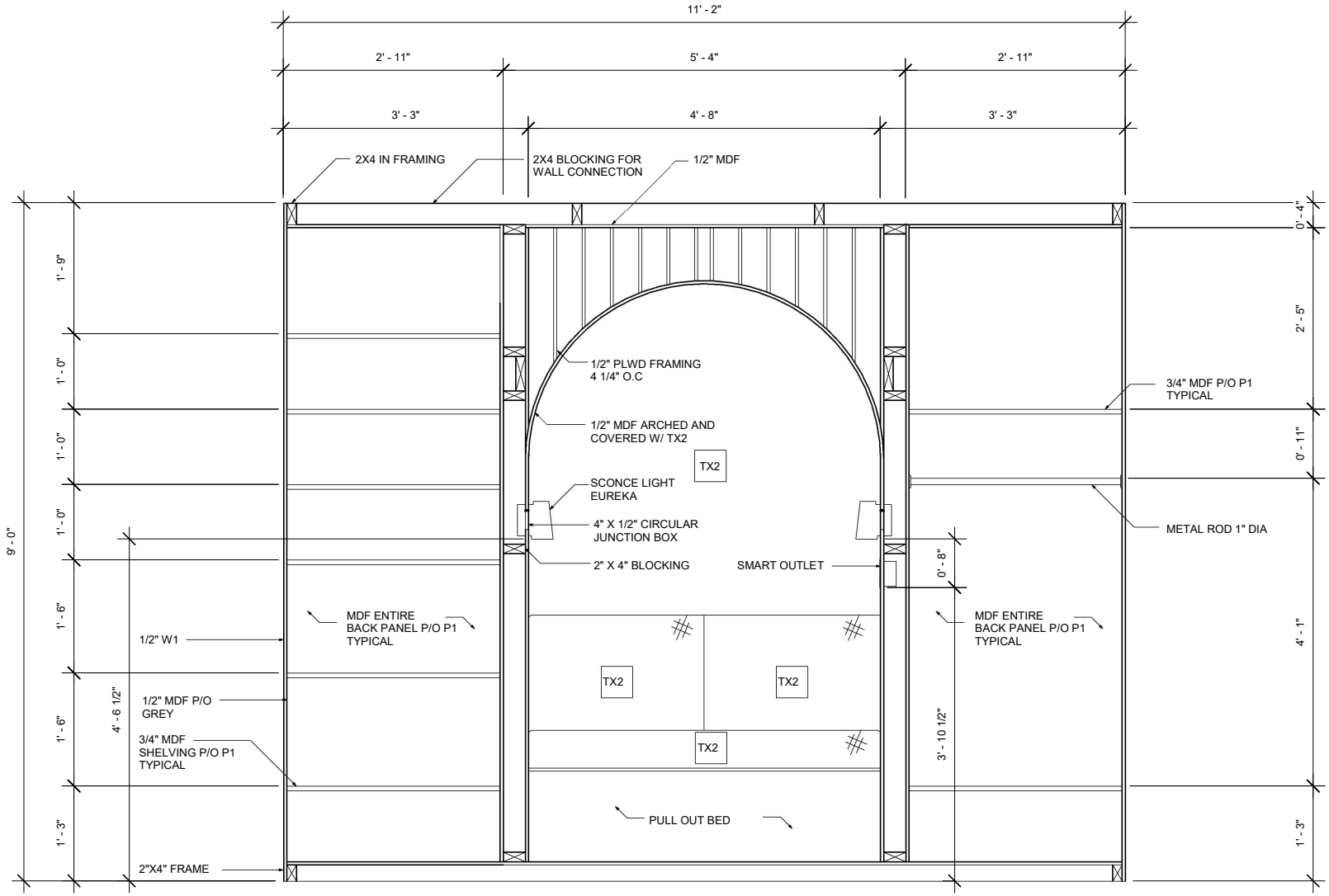
TX2- KNOLL
ATELIER IN OASIS
K16073

W1 - WALNUT STAINED BEECH



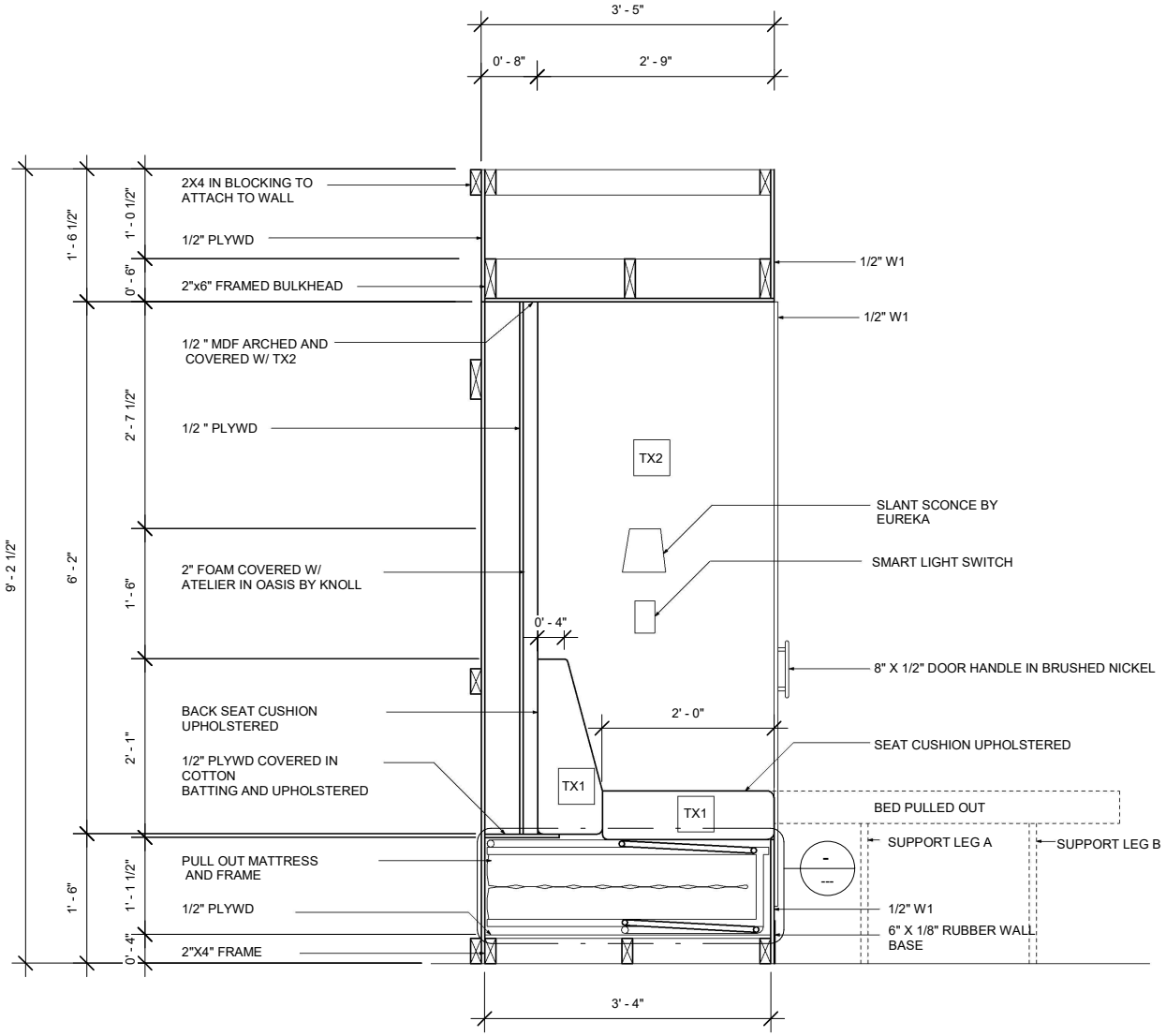
DD2 FRONT ELEVATION

SCALE: 3/4" = 1' - 0"



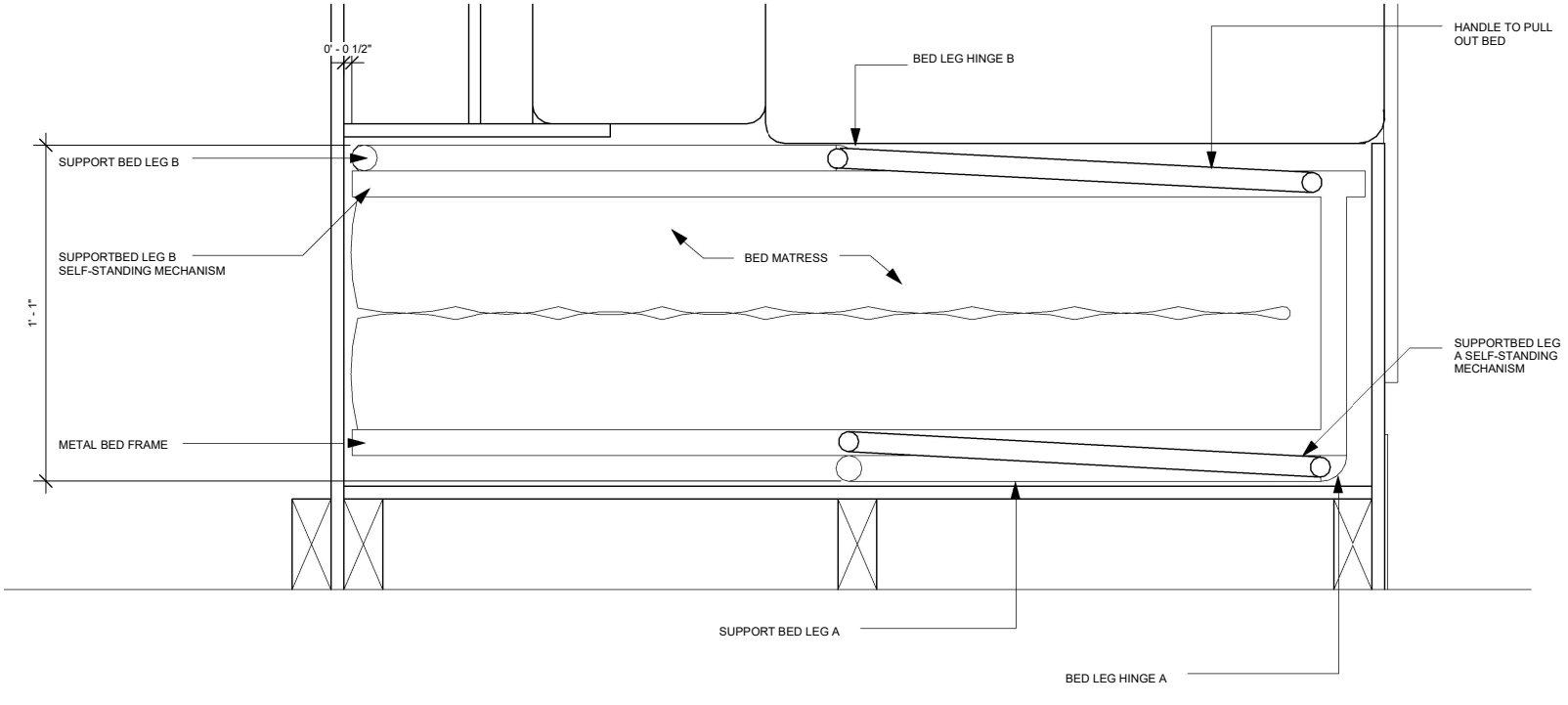
S1 FRONT MILLWORK SECTION

SCALE: 3/4" = 1' - 0"



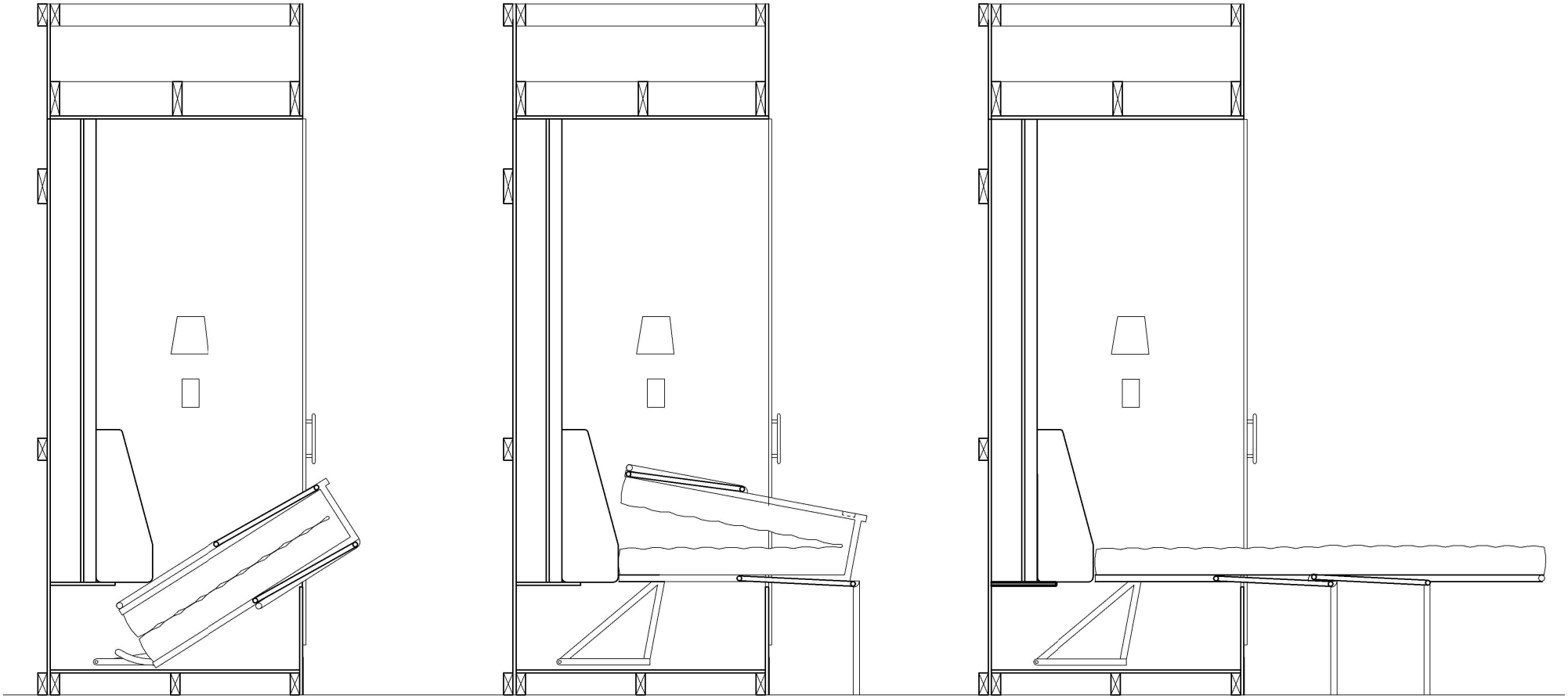
S2 SIDE MILLWORK SECTION

SCALE: 3/4" = 1' - 0"



S2.2 SIDE MILLWORK SECTION

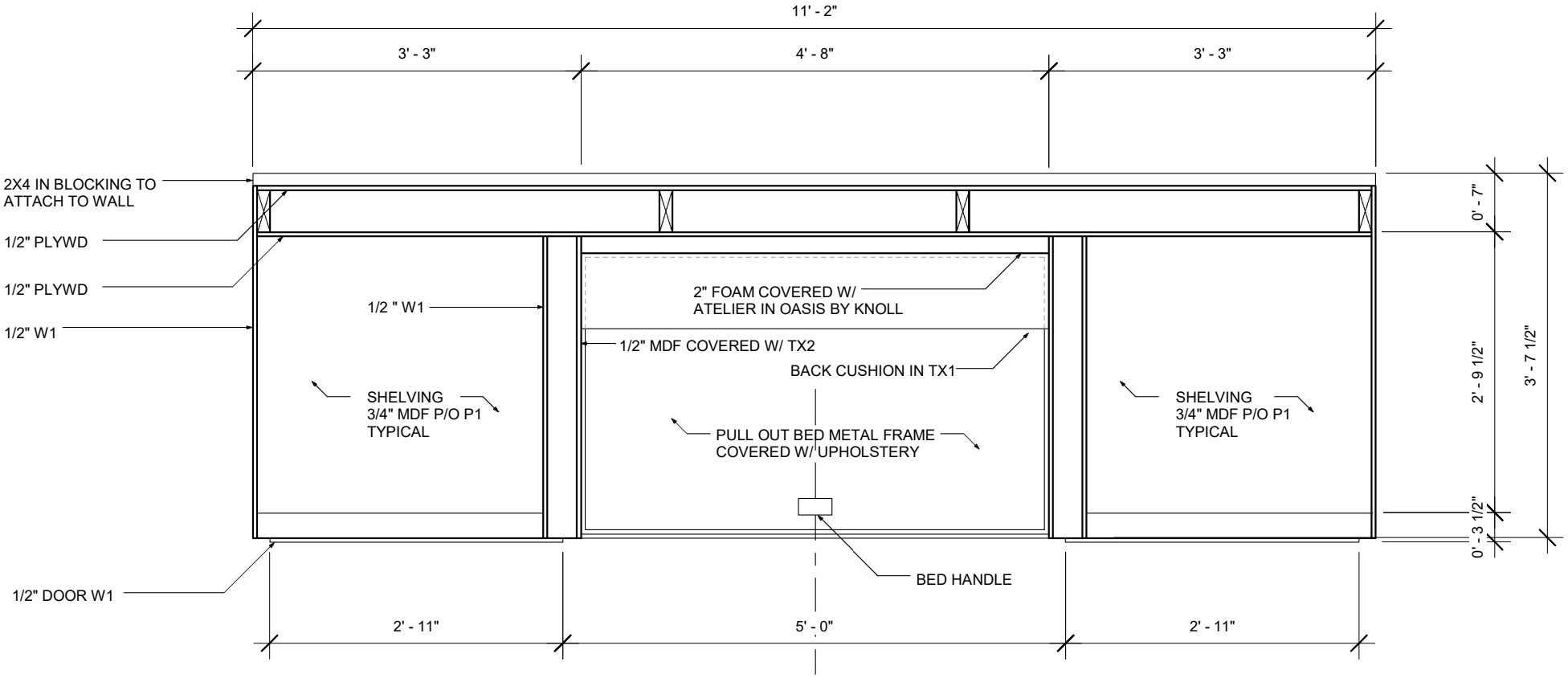
SCALE: 3" = 1"



SCH1 PULL OUT BE SCHEMATIC 1
SCALE: 3/4" = 1' - 0"

SCH 2 PULL OUT BE SCHEMATIC 2
SCALE: 3/4" = 1' - 0"

SCH 3 PULL OUT BE SCHEMATIC 3
SCALE: 3/4" = 1' - 0"



S3 MILLWORK SECTION - SEAT CUSHION REMOVED

SCALE: 3/4" = 1' - 0"

Appendix D– Access and Life Safety Requirements

The National Building Code of Canada 2015 (NBCC 2015) was reviewed and analyzed in order to ensure occupant safety for all users of Communitas House, and to ensure that the hospice's design is compliant with Canada's building bylaws and accessibility standards (National Research Council of Canada, 2015).

Part 3: Fire Protection, Occupant Safety and Accessibility

Section 3.1 General

3.1.2 Classification of Buildings or Parts of Buildings by Major Occupancy

3.1.2.1 Classification of Buildings

The proposed independent hospice facility is intended for use by one major occupancy. According to Table 3.1.2.1 the major occupancy classification is Group B (Division 3) : Care occupancies, hospices without treatment

3.1.5 Non-combustible Construction

3.1.5.1 Non-Combustible Materials

The proposed independent hospice facility utilizes the original brick, concrete and steel construction, a non-combustible material, to support its floors and roof assemblies.

3.1.17 Occupant Load

3.1.17.1 Occupant Load Determination

The occupant load for each floor within the proposed independent hospice facility, based on Table 3.1.17.1., are as follows: 10 square meters per person (107 square feet) Therefore, maximum occupancy for Communitas House is 194 people.

Section 3.2 Building Fire Safety

3.2.1 General

The proposed independent hospice facility occupies two storey and faces one street.

3.2.2. Building Size and Construction Relative to Occupancy

3.2.2.10. Streets

As the proposed independent hospice facility's South facade faces Crescent Park Drive, it is considered to face one street.

3.2.2.44. Group B, Division 3, up to 3 Storeys (Non-combustible), Sprinklered

A Building classified as Group B shall conform to the following:

a) Be of non-combustible construction
b) Sprinklered throughout
c) floor assemblies that are fire-separations with a fire-resistance rating not less than 1hr;

d) load-bearing walls shall have a fire-resistance rating not less than that required for the supported assembly.

3.2.4. Fire Alarm and Detection Systems

3.2.4.1. Determination of Requirement for a Fire Alarm System

As the proposed independent hospice facility has an automatic sprinkler system, the building requires the installation of a fire alarm system.

3.2.4.3. Types of Fire Alarm Systems

The fire alarm system at the proposed independent hospice facility shall be a single or 2-stage system.

3.2.4.10. Fire Detectors

The proposed independent hospice facility does not require fire detectors, as all floor areas are sprinklered throughout. However, elevator shafts require fire detectors, as they are not sprinklered.

3.2.4.12. Smoke Detectors

Smoke detectors need not be installed in sleeping rooms and corridors serving the sleeping rooms within the proposed independent hospice facility where smoke alarms are installed in accordance with Article 3.2.4.21.

3.2.4.21. Smoke Alarms

The proposed independent hospice facility requires smoke alarms to be installed within each sleeping room and in a location between the sleeping rooms and the remainder of the suite.

3.2.7. Lighting and Emergency Power Systems

3.2.7.3. Emergency Lighting

Emergency lighting within the proposed independent hospice facility must be provided to an average level of illumination not less than 10 lx at floor or tread level in: -

a) exits;
b) principal routes providing access to exit in open floor areas and in service rooms
c) corridors used by the public;

d) corridors serving sleeping rooms in a care occupancy, except corridors serving sleeping rooms within individual suites of a care occupancy

e) public corridors.

3.2.7.4. Emergency Power for Lighting

The proposed independent hospice facility requires an emergency power supply that is designed and installed, that upon failure of the regular power, it will assume the electrical load automatically for a period of 1hr.

3.2.7.8. Emergency Power for Fire Alarm Systems

Fire alarm systems of the proposed independent hospice facility require an emergency power supply that is capable of providing supervisory power for not less than 24hr, and immediately following that period, emergency power under full load for not less than 1hr.

Section 3.3 Safety Within Floor Areas

3.3.1. All Floor Areas

3.3.1.1. Separation of Suites

Each suite in the proposed independent hospice facility shall be separated from adjoining suites by a fire separation having a fire-resistance rating not less than 1hr.

3.3.1.3. Means of Egress

Access to exits within floor areas within the proposed independent hospice facility shall conform to Subsections 3.3.2. to 3.3.5., as well as each suite that contains more than one suite shall have an exterior exit doorway, or a doorway into a public corridor.

3.3.1.4. Public Corridor Separations

Public corridors of the proposed independent hospice facility shall be separated from the remainder of the storey by a fire separation.

3.3.1.5. Egress Doorways

The proposed independent hospice facility requires a minimum of 2 egress doorways in all floor areas that are sprinklered throughout and the travel distance to an egress doorway is more than 25m (82ft), or the area of the room or suite is more than 150m2 (492ft2) for individual suites and 200m2 (656 ft2) for suites other than sleeping rooms. In suites where two exit doors are required the minimum distances between those doors comply with those listed in Table 3.3.1.5.B, for buildings that are sprinkled throughout.

3.3.1.9. Corridors

The minimum width of a public corridor is 1100 mm (3.5ft). All of the corridors within the proposed independent hospice facility are 1377mm (4.5 ft) wide or greater. Additionally, there are no dead end corridors longer than 6m (20ft) within the proposed independent hospice facility.

3.3.1.13. Doors and Door Hardware

All doors within the proposed independent hospice facility that open into or is located within a public corridor or other facility that provides access to exit from a suite provides a clear opening or not less than 800mm (32in), and do not open onto a step. Additionally, all doors at the proposed independent hospice facility are operable by one hand, are openable with not more than one releasing operation, and are installed no more than 1200mm (4ft) above the finished floor.

3.3.1.17. Capacity to Access to Exits

The proposed independent hospice has a Group B, Division 3 occupancy and therefore the corridors servicing the facility have a minimum required width, which shall not be less than 18.4 mm per person. The occupant load calculation results in required widths well below those outlined in sentence 3.3.1.9.

3.3.1.18. Guards

The proposed independent hospice facility requires a guard not less than 1070mm (3.5ft) high around the exterior balcony perimeter. Additionally, openings within the guard shall not allow the passage of spheres larger than 100 mm (4 inches) in diameter. The guards shall also be designed so that no member, attachment or opening located between 140 mm (5.51 inches) and 900 mm (35.4 inches) above the level protected by the guard facilitates climbing.

3.3.1.19. Transparent Doors and Panels

a)The design and construction of transparent doors and panels at the facility must be readily apparent through the attachment of non-transparent hardware,

b) be constructed of laminated tempered safety glass or wired glass.

c) visibility of fully glazed transparent doors, sidelights and panels shall be enhanced through the inclusion of mullions, markings or other elements that are visually contrasting, are at least 50 mm high, extend the full width of the door, sidelight or panel and are located between 1350 mm and 1500 mm above the floor.

3.3.2. Assembly Occupancy

3.3.2.3. Fixed Seats

Non-fixed seats at the proposed independent hospice conform to the National Fire Code (NFC).

3.3.3. Care, Treatment or Detention Occupancies

3.3.3.3. Corridors

The proposed independent hospice facility does not have any dead end corridors that serve patient sleeping rooms. Additionally, the exit corridors at the proposed facility exceed the 1650mm (5.4ft) minimum width for care occupancies that do not require the movement of patients or residents in beds.

3.3.3.4. Doorway Width

The clear width of a doorway that opens onto a public corridor shall be 850mm (2.8ft) for individual suites at the proposed independent hospice facility.

3.3.3.5. Compartments and Fire Separations

Walls between individual suites at the proposed independent hospice facility are constructed as fire separations with a fire-resistance rating not less than 1hr. Additionally, floor assemblies within individual suites need not be constructed as fire separations.

Section 3.4. Exits

3.4.1.2. Separation of Exits

Each floor area in the proposed independent hospice has access to two means of egress, which are separate from one another.

3.4.2. Number and Location of Exits from Floor Areas

3.4.2.1. Minimum Number of Exits

Every floor area of the proposed independent hospice facility is served by at least two exits.

3.4.2.3 Distance between Exits

The least distance between 2 exits from a floor area shall be one half the maximum diagonal dimension of the floor area, but need not be more than 9 m (30 ft) for a floor area having a public corridor or one half the maximum diagonal dimension of the floor area, but not less than 9 m (30 ft) for all other floor areas.

3.4.2.5. Location of Exits

Exits within the proposed independent hospice facility are located so that the travel distance to at least one exit is not more than 45m (148ft), as the facility is sprinklered throughout.

3.4.3. Width and Height of Exits

3.4.3.2. Exit Width

The minimum aggregate required width of exits serving floor areas intended for a care, treatment or detention occupancies shall be determined by multiplying the occupant load of the area served by 18.4 mm per person. In the case of the proposed hospice facility, this results in 18.44 mm multiplied by 194 (max floor area occupancy) =3567mm (140 in) aggregate exit width. If no more than one exit is required, every exit shall be considered as contributing no more than one half of the required exit width, with a minimum exit width of 1100 mm (44 in)

3.4.3.4. Headroom Clearance

Except as permitted by Sentences (4) and (5), every exit shall have a clear height over the clear width of the exit of not less than 2050mm (6.7 ft) and the headroom clearance for doorways shall be not less than 2030mm (6.6 ft).

3.4.4. Fire Separation of Exits

3.4.4.1 Fire-Resistance Rating of Exit Separations

The fire-resistance rating of exit separations at the proposed independent hospice facility is 2hr for each exit.

3.4.5. Exit Signs

3.4.5.1 Exit Signs

All exit doors will have exits signs conforming to sentences 3.4.5.1 (1-5).

3.4.6. Types of Exit Facilities

3.4.6.1. Slip Resistance of Ramps and Stairs

The surfaces of all landings and treads in the proposed independent hospice facility have slip resistant finishing.

3.4.6.2. Minimum Number of Risers

The proposed independent hospice facility does not have any interior flights of stairs with less than 3 risers.

3.4.6.3. Maximum Vertical Rise of Stair Flights and Required Landings

The flight of stairs at the proposed independent hospice facility does not have a vertical rise greater than 3.7m (12.1ft) between landings. A landing is also provided at the top and bottom of each flight of interior stairs, and where a doorway opens onto the stairs.

3.4.6.4. Dimensions of Landings

The width of the landing is the same width as the stairway of the proposed independent hospice facility, where the length of the landing is no more than 1100mm (3.6ft).

3.4.6.5. Handrails

The stairway at the proposed independent hospice facility has a handrail on at least one side that conforms to sentences 3.4.6.5. (2-12).

3.4.6.8. Treads and Risers

The stairs at the proposed independent hospice facility conform to sentences 3.4.6.8. (1-10).

3.4.6.11. Doors

The distance between a stair riser and the leading edge of a door during its swing shall be not less than 300mm (11.8in) and all exit doors shall be clearly identifiable.

3.4.6.12. Direction of Door Swing

With the exception of doors serving patient and caregiver rooms, all doors in the proposed independent hospice facility open in the direction of exit travel, and swing on vertical axis.

3.4.6.14. Self-Closing Door Swing

Within the proposed hospice facility, an exit door that is normally required to be kept closed is provided with a self-closing mechanism and will never be secured in an open position.

Section 3.5 Vertical Transportation

3.5.3. FIRE SEPARATIONS

3.5.3.1. Fire Separations for Elevator Hoistways

The vertical service space used as an elevator hoistway in the proposed independent hospice facility requires a fire separation with a fire-resistance rating of 2hrs and conforming to Table 3.5.3.1., as it services a Group B, Division 3 occupancy.

Section 3.7 Health Requirements

3.7.2. PLUMBING FACILITIES

3.7.2.2. Water Closets

The number of water closets provided for patients and caregivers exceeds the one per 10 persons of each sex specified for care and residential occupancies. Two additional unisex washrooms are provided for the assembly occupancies of the hospice.

3.7.2.3. Lavatories

a) At least one lavatory shall be provided in a room containing one or 2 water closets or urinals, and at least one additional lavatory shall
be provided for each additional 2 water closets or urinals.
Level 3, Level 4, and Level 5 of the proposed office each require 4 water closets per gender, which requires 2 lavatories per gender

washroom.

b) Wash fountains in circular form are permitted to be provided in lieu of lavatories required by Sentence (1) provided each 500 mm (20 in) of circumference is considered to be the equivalent of one lavatory.

c) Any shelf or projection above a lavatory shall be located so that it will not be a hazard.

d) Lavatories required by Sentence (1) shall be equipped with faucets that

i) Operate automatically, or

ii) Have a manual control that

iii) Complies with Clause 3.8.3.8.(1)(b),

iv) Does not require the application of continuous force to maintain water flow, and

v) Where metered, provides at least 10 s of water flow.

3.7.2.8 Grab Bars

Grab bars shall:

a) be slip resistant and free of any sharp or abrasive elements
b) be mounted on surfaces that are free of any sharp or abrasive elements,
c) be able to resist a load of not less than 1.3 kN applied vertically or horizontally
d) be 30 mm to 40 mm in diameter, and
e) where mounted on a wall, have a clearance of 35 mm to 45 mm from the wall

Section 3.8 Accessibility

3.8.2 Application

3.8.2.8 Plumbing Facilities

At least one water-closet stall or enclosure in a washroom required to be barrier-free shall comply with Subsection 3.8.3. A barrier-free washroom shall be provided with a lavatory that complies with Subsection 3.8.3.Where mirrors are provided in a barrier-free washroom, at least one mirror shall comply with Subsection 3.8.3. Where showers are provided in a building, at least one shower stall in each group of showers shall comply with Subsection 3.8.3.

3.8.3 Design

3.8.3.2 Barrier-Free Path of Travel

The unobstructed width of a barrier-free path of travel shall be not less than 920 mm (36 in). Interior and exterior surfaces that are within a barrier-free path of travel shall:

a) Have no opening that will permit the passage of a sphere more than 13 mm (1/2 in) in diameter, b) Have any elongated openings oriented approximately perpendicular to the direction of travel, c) Be stable, firm and slip-resistant,

d) Have a cross slope no steeper than 1 in 50,

e) Be beveled at a maximum slope of 1 in 2 at changes in level between 6 mm (1/4 in) and 13 mm (1/2 in), and

f) Be provided with sloped floors or ramps at changes in level more than 13 mm (1/2 in).

The width of a barrier-free path of travel that is more than 30 m (100 ft) long shall be increased to not less than 1500 mm (60 in) for a length of 1500 mm (60 in) at intervals not exceeding 30 m (100 ft).

3.8.3.6 Doorways and Doors

Every doorway that is located in a barrier-free path of travel shall have a clear width not less than 800 mm (32 in) when the door is in the open position.
Power door operators shall activate automatically or through the use of controls that :

a) Are located in a barrier-free path of travel,
b) Are marked with the International Symbol of Access,
c) Are located clear of the door swing and no more than 1500 mm (60 in) from the door swing,
d) Comply with Subclause 3.8.3.8.(1)(a)(ii): Are operable from a height between 150 mm (6 in) and 300 mm (12 in) as well as between 900 mm (36 in) and 1100 mm (44 in) above the floor, and
e) Are operable by touching or approaching any part of their surface with a fist, arm or foot,

3.8.3.8 Controls

Controls described in the this section shall

a) where located in or adjacent to a barrier-free path of travel, and unless otherwise stated,

i) be mounted 400 mm (16 in) to 1200 mm (48 in) above the floor,

ii) be adjacent to and centered on either the length or the width of a clear floor space of 1350 (54 in) mm by 800 mm (32 in), and b) be operable

i) with one hand in a slosed fist position, without requiring thight graspin, pinching with fingers, or twisting of the wrist, and ii) unless otherwise stated, with a force not more than 22 N.

3.8.3.11 Water Closet Stalls

At least one water-closet stall or enclosure in a washroom required to be barrier-free shall

a) Be not less than 1500 mm (59 in) wide by 1500 mm (59 in) deep,

b) Have a clear floor space of 1500 mm (59 in) by 1500 mm (59 in) in front of the accessible stall, c) Be equipped with a door that

i) Can be latched from the inside with a mechanism conforming to Clause 3.8.3.8.(1)(b)

ii) Is aligned with either the transfer space adjacent to the water closet or with a clear floor space not less than 1500 mm (59 in) by

1500 mm (59 in) within the stall,

iii) Provides a clear opening not less than 850 (33 in) mm wide when it is open,

iv) Is self-closing so that, when at rest, the door is ajar by not more than 50 mm (2 in) beyond the jamb,

v) Swings outward, unless there is sufficient floor space within the stall for the door to swing inward in addition to a clear floor space of at least 800 mm (32 in) by 1350 mm (53 in), Where it has frontal access, provide a knee clearance not less than i) 760 mm (30 in) wide,

vi) Where the door swings outward, is provided with a horizontal, D-shaped, visually contrasting door pull not less than 140 mm (6 in) long located on the inside such that its midpoint is 200 mm (8 in) to 300 mm (12 in) from the hinged side of the door and 800 mm (32 in) to 1000 mm (40 in) above the floor,

d) Have a water closet located so that the distance between the centre line of the fixture and the wall on one side is 460 mm (18 in) to 480 mm (19 in),

e) Be equipped with an L-shaped grab bar that

i) Is mounted on the side wall closest to the water closet,

ii) Has horizontal and vertical components not less the 760 mm (30 in) long mounted with the horizontal component 750 mm (30 in) to

850 mm (33 in) above the floor and the vertical component 150 mm (6 in) in front of the water closet,

f) Be equipped with either one grab bar at least 600 mm (24 in) long and centred over the water closet, or two grab bars at least 300 mm (12 in) long and located either side of the flush valve, that

i) Are mounted on the rear wall, and
ii) Are mounted at the same height as the grab bar on the side wall or 100 mm (4 in) above the top of the attached water tank, if applicable,

g) Be equipped with a coat hook mounted not more that 1200 mm (47 in) above the floor on a side wall and projecting not more than 50

mm (2 in) from the wall, and
h) Be equipped with a toilet paper dispenser mounted on the side wall closest to the water closet such that

i) The bottom of the dispenser is 600 mm (24 in) to 800 mm (32 in) above the floor, and ii) The closest edge of the dispenser is 300 mm (12 in) from the front of the water closet.

3.8.3.12 Universal Washrooms

Every regularly occupied storey that is accessed by a barrier-free path of travel shall:

a) Have a universal washroom that is served by a barrier-free path of travel,

b) Have a door complying with Article 3.8.3.6. that

i) Has a latch-operating mechanism located 900 mm (35 in) to 1000 mm (39 in) above the floor that complies with Clause 3.8.2.8.(1) (b) and is capable of being locked from the inside, and released from the outside in case of emergency, and

ii) If it is an outward swinging door that is not self-closing, has a door pull not less than 140 mm (6 in) long located on the inside so that its midpoint is not less than 200 mm (8 in) and not more than 300 mm (12 in) from the hinged side of the door and not less than 900 mm (35 in) and not more than 1000 mm (39 in) above the floor,

c) Have one lavatory conforming to Article 3.8.3.15.
d) Have one water closet conforming to Article 3.8.3.13. and clause 3.8.3.11.(1)(d), with a clear floor space at least 900 mm wide that is parallel and adjacent to the open side of the water closet,
e) Have grab bars conforming to Clauses 3.8.3.11.(1)€ and (f),
f) Have a coat hook conforming to Clause 3.8.3.11.(1)(g),
g) Have a toilet paper dispenser conforming to Clause 3.8.3.11.(1)(b),
h) Unless a counter is provided, have a shelf located not more than 1200 mm (47 in) above the floor, and i) Be designed to permit a wheelchair to turn in an open space not less than 150 mm (6 in) in diameter.

3.8.3.13 Water Closets

A water closet for a person with physical disabilities shall

a) Be equipped with a seat located 430 mm (17 in) to 460 mm (18 in) above the floor,

b) Flush automatically or be equipped with a flushing control that

i) Is located 500 mm (20 in) to 900 mm (35 in) above the floor,

ii) Is located no more than 350 mm (14 in) from the transfer side, and iii) Complies with Clause 3.8.3.8.(1)(b),

c) Be equipped with a seat lid or other back support, and

d) Where it has a tank, have a security attached tank top.

3.8.3.15 Lavatories and Mirrors

A barrier-free washroom shall be provided with a lavatory that shall:

a) Be equipped with faucets complying with Sentence 3.7.2.3.(4),

b) Be located so that the distance between the centre line of the lavatory and any side wall is not less than 460 mm, c) Have a rim height not more than 865 mm (34 in) above the floor,

d) Have a clearance beneath the lavatory not less than

i) 760 mm (30 in) wide,

ii) 735 (29 in) mm high at the front edge,

iii) 685 mm (27 in) high at a point 200 mm (8 in) back from the front edge, and

iv) 230 mm (9 in) high over the distance from a point 280 mm (11 in) to a point 430 mm (17 in) back from the front edge,

e) Have insulated water supply and drain pipes where these pipes are exposed,

f) Have a soap dispenser that i) Is automatic, or

ii) Complies with Clause 3.8.3.8.(1)(b) and is located not more than 1100 mm (43 in) above the floor, within 500 mm (20 in) from the front of the lavatory, and

iii) Have a towel dispenser or other hand-drying equipment located close to the lavatory, not more than 1200 (47 in) mm above the floor in an area that is accessible to persons in wheelchairs.

Where mirrors are provided in a barrier-free washroom, at least one mirror shall be:

a) Mounted with their bottom edge not more than 1000 mm (39 in) above the floor, or

b) Fixed in an inclined position so as to be usable by a person in a wheelchair.

3.8.3.17 Bathtubs

Bathtubs required by sentence 3.8.2.8.(11) shall:

a) be located in a room with a clear floor space not less than 1500 mm in

diameter

b) be not less than 1500 mm long

c) have a clear floor space not less than 750 mm wide adjacent to its entire length

d) be capable of being accessed along its full lengrh with no tracks mounted on its rim

e) have faucets and other controls that

i) conform to Clause 3.8.3.8.(1)(b) and

ii) are located on the centre line or between the centre line of the bathtub and the exterior edge of the bathtub rim, at a maximum height of 450 mm above the rim,

f) Have three grab bars

i) That conform to Sentence 3.7.2.8.(1),

ii) That are not less than 1200 mm long,

iii) Two of which are located vertically at each end of the bathtub, with their lower end 180 mm to 280 mm above the bathtub rim, and

iv) One of which is located horizontally along the length of the bathtub at 180 mm to 280 mm above the bathtub rim,

g) Have a slip resistant bottom surface, and

h) Be equipped with a handheld shower head with not less than 1800 mm of flexible hose that can be used in a fixed position at a height of 1200 mm and 2030 mm

3.8.3.21 Spaces in Seating Area

a) Spaces designated for wheelchair use shall be

i) Clear and level, or level with removable seats,

ii) Not less than 900 mm (35 in) wide and 1525 mm (60 in) long to permit a wheelchair to enter from a side approach and 1220 mm (48 in)

b) long where the wheelchair enters from the front or rear of the space,c) Arranged so that at least 2 designated spaces are side by side,

c) Located adjoining a barrier-free path of travel without infringing on egress from any row of seating or any aisle requirements,

d) Situated as part of the designated seating plan, to provide a choice of viewing location and a clear view of the event taking place.

Appendix F – MAID Request Form and UHN Framework

Medical Assistance in Dying
PATIENT REQUEST RECORD (Manitoba)

Please read this form carefully. Please feel free to ask any questions, now or at any time during your interactions with your health care providers. The physicians and staff at the Winnipeg Regional Health Authority are here to assist you. This document shall form part of your health care record and will be retained in accordance with the policies and procedures of the applicable Regional Health Authority where you are receiving treatment and may be shared with regulatory authorities.

PATIENT INFORMATION		
Last Name	First Name	Second Name(s)
Personal Health Identification No.(PHIN) and/or Manitoba Health No.	Birthdate (YYYY/MM/DD)	Gender: ☐ Male ☐ Female ☐ Other - specify:
Patient's Home / Residence Address		
Medical Diagnosis Relevant to Request for Medically Assisted Death		

PATIENT REQUEST (must be initialled by patient or proxy in front of the two independent witnesses as listed on page 2)
If the patient requesting medical assistance in dying is physically unable to sign, a proxy (another person) may do so in the patient's presence, on the patient's behalf, and under the patient's express direction. *The proxy cannot be either of the witnesses listed on page 2. The proxy must be least 18 years of age, understand the nature of the request for medical assistance in dying,* ***NOT*** know *or believe that they are a beneficiary in the will of the patient making the request, or a recipient, in any other way, of a financial or other material benefit resulting from the patient's death.* **See proxy signature box next page.**

By initialling and signing below, I confirm that:

Initials	I am at least 18 years of age. I am eligible for health services funded by a government of Canada.
Initials	I am capable of making decisions with respect to my health.
Initials	I request medical assistance in dying. I make this request voluntarily and without pressure from others.
Initials	I am informed that my medical condition is grievous and irremediable.
Initials	My medical condition causes me enduring suffering that is intolerable to me and which cannot be alleviated by any treatment acceptable to me.
Initials	I understand that the purpose and goal of requesting medical assistance in dying is to assist in bringing about my death.
Initials	I understand that, after I sign this request, I may change my mind at any time and in any manner and that I may withdraw my request for medical assistance in dying.

PATIENT SIGNATURE FOR REQUEST (must be signed in front of two independent witnesses as listed on page 2)

I certify that I have read and fully understand the above request to received medical assistance in dying, and declare that I have voluntarily requested a medically assisted death and make this request free from external pressures.

Signature of Patient	Print Name	Date Signed

Last Name of Patient	First Name of Patient	Second Name(s) of Patient

SIGNATURE OF PROXY (if applicable) **(must be signed in front of the patient and the two independent witnesses listed below)**		
Signature of Proxy	Print Name	Date Signed
Address	City / Province	Postal Code

CONFIRMATION OF INDEPENDENT WITNESSES		
By initialling and signing below, I confirm that:		
Witness 1	**Witness 2**	
Initials	Initials	I am at least 18 years of age and understand the nature of the patient's request for medical assistance in dying.
Initials	Initials	The patient (or proxy, in the presence and at the express direction of the patient) signed this request in my presence and in the presence of the other independent witness.
Initials	Initials	I do not know or believe that I am a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or material benefit resulting from the patient's death.
Initials	Initials	I am not an owner or operator of a health care facility where the patient is receiving treatment or of a facility in which the patient resides.
Initials	Initials	I am not directly involved in providing health care services to the patient.
Initials	Initials	I do not directly provide personal care to the patient.

SIGNATURE OF INDEPENDENT WITNESSES **(must be signed in the presence of the patient (and proxy if applicable) and the other independent witness)**		
WITNESS 1		
Signature of Witness 1	Print Name	Date Signed
Address	City / Province	Postal Code
WITNESS 2		
Signature of Witness 2	Print Name	Date Signed
Address	City / Province	Postal Code

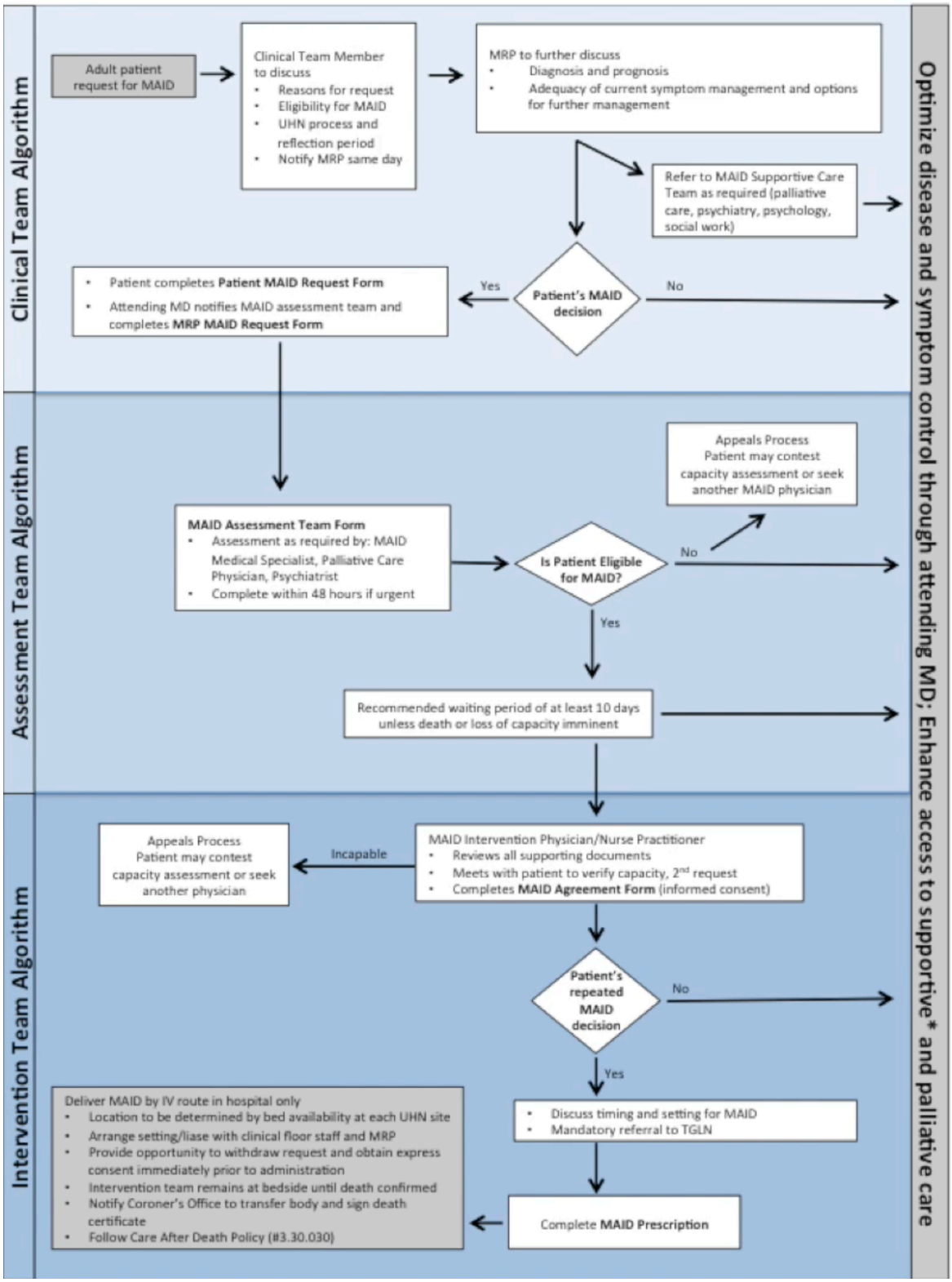
Last Name of Patient	First Name of Patient	Second Name(s) of Patient

INFORMED CONSENT (to be signed AFTER the first independent assessment has been completed)	
By initialling and signing below, I confirm that:	
Initials	Further to my request for medical assistance in dying, I have discussed with a physician or nurse practitioner my diagnosis and prognosis, its nature and expected outcome, the potential complications of my medical condition and other related medical conditions, if applicable, including the treatments available for those conditions.
Initials	I have been informed by a physician or nurse practitioner about possible treatment options, as well as the options available to me to improve my suffering, including palliative care.
Initials	I have had the opportunity to discuss the process for and risks of medical assistance in dying, including the provision/administration of medications.
Initials	I understand that, if I no longer have the capacity to consent prior to the provision of medical assistance in dying, I will not receive medical assistance in dying, even if I have been previously deemed to be eligible to receive medical assistance in dying.

PATIENT SIGNATURE INDICATING INFORMED CONSENT		
Signature of Patient	Print Name	Date Signed

If the patient requesting medical assistance in dying is physically unable to sign, a proxy (another person) may do so in the patient's presence, on the patient's behalf, and under the patient's express direction. *The proxy cannot be either of the witnesses listed on page 2. The proxy must be someone who is at least 18 years of age, who understands the nature of the request for medical assistance in dying, and who does not know or believe that they are a beneficiary under the will of the patient making the request, or a recipient, in any other way, of a financial or other material benefit resulting from the patient's death.*

SIGNATURE OF PROXY (if applicable)		
Signature of Proxy	Print Name	Date Signed
Address	City / Province	Postal Code


Clinical Team Algorithm
Assessment Team Algorithm
Intervention Team Algorithm
Optimize disease and symptom control through attending MD; Enhance access to supportive* and palliative care
Adult patient request for MAID
Clinical Team Member to discuss
Reasons for request
Eligibility for MAID
UHN process and reflection period
Notify MRP same day
MRP to further discuss
Diagnosis and prognosis
Adequacy of current symptom management and options for further management
Refer to MAID Supportive Care Team as required (palliative care, psychiatry, psychology, social work)
Patient's MAID decision
Yes
No
Patient completes Patient MAID Request Form
Attending MD notifies MAID assessment team and completes MRP MAID Request Form
MAID Assessment Team Form
Assessment as required by: MAID Medical Specialist, Palliative Care Physician, Psychiatrist
Complete within 48 hours if urgent
Is Patient Eligible for MAID?
No
Appeals Process
Patient may contest capacity assessment or seek another MAID physician
Yes
Recommended waiting period of at least 10 days unless death or loss of capacity imminent
MAID Intervention Physician/Nurse Practitioner
Reviews all supporting documents
Meets with patient to verify capacity, 2nd request
Completes MAID Agreement Form (informed consent)
Incapable
Appeals Process
Patient may contest capacity assessment or seek another physician
Patient's repeated MAID decision
No
Yes
Discuss timing and setting for MAID
Mandatory referral to TGLN
Complete MAID Prescription
Deliver MAID by IV route in hospital only
Location to be determined by bed availability at each UHN site
Arrange setting/liase with clinical floor staff and MRP
Provide opportunity to withdraw request and obtain express consent immediately prior to administration
Intervention team remains at bedside until death confirmed
Notify Coroner's Office to transfer body and sign death certificate
Follow Care After Death Policy (#3.30.030)