

# **Design and Dignity** by Ian Clarke

## **Introduction**

This short essay is written not by a philosopher or researcher; rather unusually for a journal such as this, it is written by an Architect, practicing full time and somewhat more used to drawing than writing. It reflects some thoughts about design and dignity that have emerged over twenty years of experience in the design and delivery of settings for care at the end of life.

Its central thesis is that well-considered design has a significant role to play in the promotion of dignity for patients, relatives and staff in hospitals, and that dignity is no longer one of the so-called 'soft issues' or 'intangibles', with the inferred secondary importance conventionally attributed to it in healthcare planning. Instead it extends far into the more fundamental aspects of human experience of our healthcare systems, and ultimately into its therapeutic effectiveness, core quality and economic efficiency. In the era of consumerism and increasing choice, it is becoming an increasingly high profile economic issue, particularly in countries where the euros follow the patients.

The author is consultant architect to the Design and Dignity component within the Irish Hospice Foundation's 'Hospice Friendly Hospitals Programme'; its target being direct and measurable improvement of the quality of experience associated with the end of life care in Irish Hospitals, where more than 30,000 people die each year. However, this essay goes beyond that pressing and immediate issue. It proposes not only that the design of the environment can directly influence the quality of that experience, but also that the issue of dignity is important in all healthcare contexts, not just in end of life care. The common and valuable factor is the human experience, rather than the position of the individual on the clinical trajectory.

## **What is dignity in the context of design?**

Dignity, like comfort, is something that is easier to grasp intuitively by considering its opposite. Of comfort, Sir Terence Conran the renowned designer wrote; 'Comfort is one of those concepts that comes more sharply into focus when looked at the other way round – we all know what discomfort is... rooted in the physical, but not exclusively of the body, discomfort signals any kind of imperfect fit between ourselves and our surroundings' (1). Considered in this reverse-engineering way, many examples of indignity in hospital may spring to mind, and they revolve around the central aspect of its meaning as defined in the Oxford English Dictionary; dignity is about respect, of the self and of others. Design must both positively enable dignity and then positively maintain and reinforce it.

In the healthcare setting dignity is frequently coupled with privacy, but unfortunately that coupling has developed the inferred assumption that by providing privacy we also solve the whole problem of indignity. That may of course be true in a simple context such as using a private toilet cubicle rather than a commode on an open hospital ward, or providing a private relatives room and viewing facilities as part of a hospital mortuary. However essential those things may be, there remains more to understanding dignity in hospital than privacy at a time of basic need. This essay does not therefore set out simply to catalogue the nuts and bolts of design improvements which may bring about increased dignity in hospitals. In the context of end of life care they have been thoroughly set out in the Design and Dignity Guidelines

launched last year by the Irish Hospice Foundation. Rather it sets out to touch upon some of the core human issues which underlie the importance of design for dignity, issues which have conventionally not been thought within the remit of bricks and mortar. The most important of those issues, in terms of design, may be expressed thus; *the architecture shall not confront the patient with his or her own incapacity, or ultimately, demise.*

### **A change in expectations**

With increasing general affluence over past decades, in common with hunger engagement at close quarters with serious illness or injury seems to have become less usual or expected in our lives that it was in former times. In a consumer-oriented culture, for the majority it is now almost an alien experience, a sharp contrast with the affirmative expectations of everyday life. Thus it is that today healthcare buildings often form the setting in which we address this sharp contrast.

As Florence Nightingale told us in 1859: 'Surgery removes the bullet from the limb, which is an obstruction to cure, but nature heals the wound' (2). In today's hospital construction projects, be they a simple refurbishment or a whole new building, we are indeed building capacity for the 'surgery', but the question is are we providing enough capacity for 'nature' to do its work too? It is proposed here that providing for the healing 'nature' which Florence Nightingale described involves amongst other things providing for dignity as a core component of the effective healthcare environment. It involves building in, through intelligent design, a latent potential for positive quality of experience on a moment-to-moment basis for patients, their visitors, and the people who work in hospitals. That positive quality of experience provides a sense of respect; that is it provides dignity.

### **Quality and quantity**

Assessment of quality has become a central issue in modern healthcare projects, be they still on the drawing board or already constructed. Much effort has been placed on devising a robust and appropriate assessment methodology. In the UK this has resulted in a number of variants based around the Design Quality Indicator (DQI). This sets out three primary assessment criteria; *build standard, functionality and impact*. These are of course the very same criteria identified by the Roman architect Marcus Vitruvius Pollio two thousand years ago, *firmitas, utilitas, venustas*, translated as *firmness, commodity and delight*. The proposition here is that a holistic approach to hospital design must conceive that *impact* is a core part of *functionality*, not a largely separate aspect. Functionality alone (the plan is rational, the circulation efficient, etc) is not in itself enough. The impact of the design on people using the building must also be positive in the experiences it generates within them, if it is to be truly effective.

There has been considerable research commissioned internationally into the impact of building design upon patient health outcomes, towards the development of a robust scientific evidence base as an information facility to inform future projects and assess emerging ones. In the USA Professor Roger Ulrich (3) has proposed three key dimensions related to the patient experience and the important issue of the level of stress they induce. These are the stress of illness itself, stress generated by engagement with the healthcare system, and stress generated by the environment in which healthcare is delivered. These may be considered as overlain and unified by the consideration of the human perspective and experience.

## Why is the experience of a care setting important?

Considered from the cultural perspective, there are many well known aphorisms which reflect the impact and value of the design of our environments. Winston Churchill remarked that 'first we mould our buildings, and then they mould us', and it is said that any society is reflected in the architecture which it builds for itself. Providing for personal dignity in the environments we design reflects upon us and our values.

Considered from the scientific perspective, our understanding of our surroundings and the bearing that they have on us relies upon the receipt of stimulation. This may be in the form of external energy- light for example in the case of vision; or it may be internal – a thought for example in the case of our comprehension, thought being an internally-generated stimulus. Both bring about an emotional response within us, either in a managed or instinctive way. The emotional response is important because it is unavoidable, has impact on how we feel and is significant to wellbeing on a moment-to-moment basis and thus in the longer term. For example, over very short timescales, the innate human sympathetic response - 'flight or fight' - emerges directly from it, whereas over longer timescales whole patterns of behaviour and ways of thinking may be informed by it. Critically, in the short time-lag between stimulus and the response to it is recognised to lie the capacity to moderate, temper or even choose the response, with its consequent effects. This simple fact lies at the root of widely used psychological therapies, such as cognitive behavioural therapy. It also lies at the root many approaches to personal empowerment and effectiveness, such as those of the renowned American author on management and human performance Dr Stephen Covey. Emotional response matters, and we have the opportunity to turn this to significant advantage by promoting design which actively facilitates positive experience, rather than considering it as a fortunate but ultimately arbitrary by-product of our built environment.

In our culture there are several elements of the human experience which are conventionally considered to be limited to the intangible fields of personal mood or inter-personal relationships. These include concepts such as intimacy, trust, empowerment, compassion, empathy and coping. In a caring society we consider these qualities to be important in times of illness or distress, as either the sick person or as the provider of care. We know how these feel and that they are significant, but one would seldom see such words used with practical meaning in a healthcare design brief. Where they do occasionally appear they are often described as 'soft issues' or 'intangibles', unhelpful turns of phrase which carry the incorrect inference that they are somehow vague or weak and therefore unimportant and not relevant to the bricks and mortar of hospital building. It is proposed here that this mindset is wrong. Like comfort, it is proposed that such issues have distinct and strong environmental implications, and therefore fall within the remit of design. Again like comfort, such implications are particularly highlighted when consideration is given to their various opposite characteristics in reverse-perspective; they then come more sharply into focus:

Intimacy:

Separation, loneliness, out of contact, coldness

*How can a large hospital be made to feel more intimate and less isolating for the individual? Does it have to feel like a large machine or an impersonal institution? Could it feel more personal by the way it is designed?*

Trust: Instinctive unease, anxiety, sense of confrontation or threat

*How can a hospital be made to feel more easy to find your way around, like a simple village or town, rather than an unfamiliar labyrinth with blind corners and no views out, reliant on signage like a motorway? Can design do something about this?*

Empowerment Restriction, imposed debilitation

*How can the design of the environment help recovering patients gain confidence and motivation to get back on their feet, to want to move beyond the bed or chair bit by bit under their own steam as they recover and engage with the world again?*

Compassion: Detachment, aloofness, lack of support

*How can the design of the environment provide support to a patient's sense of self, to feel at the centre of care and not just today's object of surgery, therapy or nursing? Can design be of impact here?*

Coping: Not managing, suffering, loosing out.

*(How can the design of the environment bring out the greatest latent potential in patients to manage for themselves and foster an early return to the normality of life? Can architecture address Antonovsky's view of health involving the sense of cohesiveness, meaningfulness and comprehensibility, ie 'Salutogenesis (4)?)*

The way forward? I suggest that it is to adopt a mindset more centred on the human experience when developing the briefs and designs for new healthcare buildings, and less centred simply on a processing mindset; *the care pathway is different from the physical pathway*. Is positive experience not part of true 'functionality' as well as the established issues of clinical adjacencies, infection control and the other important operational issues? This would certainly be quite a rebalancing, a change from most conventional ways of thinking that have been adopted in the past where the remit seems to have been quite different. Of course there have always been a few exceptions and exemplary schemes, but we should aim to make them more the norm than the exception. This could apply equally from the small scale of the local surgery upto the largest hospital. Architects, developers, constructors and clients should all

practice empathy: they should sit in the patient's chair (literally and metaphorically), and they should have certain goals in mind.

### **Goals towards improved quality of experience**

It is proposed that a significant goal in the design of healing environments is the promotion of *the quality of being for the occupants on a moment-to-moment basis*. Satisfaction moment to moment helps to promote satisfaction in the longer term, for both patients and staff. That quality will of course have a different weighting of its component characteristics depending on many factors related to the individual, and including for each patient issues specific to their condition and particular stage of care. Patients will need different things, because they will cope in different ways at different times, and so choice and flexibility are therefore imperative. However, it is suggested that a number of core characteristics are common to most situations, enabling presence in hospital to feel rather more *on the individual's own terms*. These include:

1. The reduction of the well recognised adverse direct stimuli on the patient from the immediate environment, for example including glare or unwanted noise. This is part of Professor Roger Ulrich's 'environmental stress', and the design of the environment can support the potential for this through detailed consideration of configuration of the care environment and its material components very locally to the patient. What would happen if the conventional bed-space could be considered more as a sanctuary for the patient, a 'bed-place', and rather less as simply a soft workbench for care delivery?.

2. The reduction of stress created in patients as a product of their own reaction to engaging with their environment. For example this includes anxiety caused by disorientation or perceived isolation, by feeling out of territory or by unwanted invasion of privacy or dignity. The design of the environment can support this for example by making the journey through the building feel like one through a characterful village: incorporating distinct and legible 'places', with importantly the essential thresholds or buffers between them which assist in our knowing where we are and what sort of behaviour is appropriate in our progressive journey, from the scale of the public entrance right down to the individual bed place. Why can we not get away from the ubiquitous 'no-place' hospital corridors that we are so used to, which often feel like monotonous human vectors, or motorways, simply terminating at the patient bed almost as if it were an arbitrary destination?.

3. The promotion of potential for a dynamic multi-sensory relationship between the patient and their surroundings, rather than a passive one. Current thinking suggests that sensory perception is not limited to the passive receipt of sensory information, but includes the opportunity to actively seek it through an iterative, two-way multi-sensory transaction. We sense the world not by soaking up information, but also by taking physical actions to interrogate it. The design of the environment can support or deplete the potential for this in many ways, including the selection of materials and the provision of views to the outside world, and the admission of natural light. Much of the material patients encounter at close quarters is synthetic, characterless and ephemeral: from dressings and care consumables down to the disposable tea cups: any opportunities for contact with more natural materials which carry more substance and meaning is valuable.

4. The promotion of patient's sense of regaining autonomy, or the potential for it: Antonovsky's concept of Salutogenesis (4) identifies the psychological and physical sense of cohesion, meaningfulness and comprehensibility; in short the sense of coping which he proposes is amongst the characteristics of health. The design of the environment can provide the potential for this, by providing inbuilt support to a patient's latent capabilities, down to the smallest of scales. Consider the potential for a simple window seat in a patient bedroom as a stepping stone to the lounge down the corridor, and an invaluable place for a relative and nurse to spend a few seconds together. This is a half-full, rather than half empty approach to patient capability, no matter how residual that capability may be.

5. The promotion of the patient's sense of connectedness with natural world, and with something bigger and ultimately more dependable than the self. This provides a sense of greater meaning and groundedness than the immediate circumstance, which may be very adverse in the case of acute illness, in spiritual, material, sensory and environmental terms. This includes the sensory connection with natural environment in which the human race has evolved and its associated phenomena such as natural light, the ongoing cycles of day and night, the seasons and the weather. These have been amongst the inspirations for art and culture for as long as it has existed. In addition to the instinctive sensory familiarity of nature, it may itself have a spiritual dimension. The design of the environment can support the potential for this by providing a good sense of connectivity with the surrounding environment through all the senses, and the incorporation of well designed landscaping and gardens. The connection with something larger than the self also of course may include the dimension of religious faith.

6. The avoidance of exposure to the distress or grief of others. Distress is contagious. The design of the environment can support or deplete the potential for this, by providing appropriate levels of privacy and dignity. Clearly amongst other things this involves a greater proportion of single rooms and a relatives room on the ward, and better relatives facilities associated with mortuaries.

7. The promotion of the patient's sense of dignity and self-significance. For example this includes the reinforcement of personal identity, confidence and self-worth, of particular value whilst under the psychological duress of illness or injury. This is anti-anxiety and anti-depression. The design of the environment can support the potential for this in many ways. This issue is the central one and embodies all of the previous points as vehicles to its delivery.

8. Underpinning all of the above is the promotion of the opportunity for choice, which is a central issues to self-worth and wellbeing for everyone.

In conclusion, if we are prepared to consider a wider definition of functionality in our healthcare buildings, embracing more strongly the issue of the impact that the design of our healthcare buildings have on those who inhabit them, and by doing so embrace the issue of dignity, there

is an opportunity to deliver a great step-change in quality. In Churchill's words, 'we mould our buildings, and then they mould us'. It is up to us to inform the shape.

### **Notes and References**

1. Terence Conran: 'Easy Living', Conran Octopus, 1999, p 68 ISBN184091002X
2. Florence Nightingale. 1859. 'Notes on nursing: What it is and what it is not'. ISBN 0899666043, Buccaneer Books Inc, NY 1987
3. Professor Roger Ulrich, Director, Center for Health Systems and Design, Texas A&M University, College Station, Texas. Numerous publications too extensive to list but including those listed on this weblink:  
<http://archweb.tamu.edu/architecture/faculty/ulrich/mainframe.html>
4. 'Professor Aaron Antonovsky (1923–1994): the father of the salutogenesis' : Journal of Epidemiology and Community Health 2005;**59**:511.

## **Notes on the author.**

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Unified by a user-centred approach, the practice have a particular reputation for the design of hospices, including St Oswald's Hospice in Newcastle upon Tyne, UK (RIBA 'Building of the Year' 1989) and St Gemma's Hospice in Leeds, UK (NHS Patient Environment Award' 2003), amongst ongoing hospice work for clients throughout the UK including Marie Curie Cancer Care. In Ireland, they have provided an advisory role in the new Curraheen Hospital in Cork, and are design consultants to the Irish Hospice Foundation. Their work was included in the Commission for Architecture and the Built Environment (CABE)'s 'Healthy Hospitals Campaign' in 2004 ([www.healthyhospitals.org.uk](http://www.healthyhospitals.org.uk)), securing the largest proportion of votes in the public internet poll for visions of a future hospital environment. Ian Clarke is a member of the NHS Design Review Panel, and a CABE Enabler.

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