Title: Liminal Hospital Spaces; Corridors to Well-Being?

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Abstract:

Hospital design has progressed from the favoured pavilion ward layout of Florence Nightingale's 1856 recommendations, to observation of the similarities between *office buildings* and *single block* hospitals and more recently the recognition of the transient corridor space. Yet still, people's experiences and expectations highlight similar feelings of powerlessness and vulnerability when in positions of the patient, family, friend or caring bystander. This paper discusses the importance of liminality in hospital corridor/waiting areas, and how through design intervention(s), such as temporality of shadows, voice and scent, could aid personalisation of such transient spaces to engage those that pass through, sit and wait, with interior elements that enhance feelings of well-being.

The paper explores the semiotics of architects and designers within hospitals as a series of functioning units and blocks. It discusses the corridor and public spaces as contributors of communities *that deliver care* as opposed *to cure*. A combined methodology is used based on an abductive logic using an interpretivist approach to construct knowledge through mixed data collection. A series of observations, conversations and suggestions, galvanised through sketching, engage the curious, to explore potential of design triggers to humanise such spaces. Therefore design interventions become intrinsic interlocutors with its community of patients, family, friends, health professionals and staff. Hence design, creates opportunities of enhanced experiences, involved in continual narratives to well-being.

The findings conclude the importance of corridor/waiting areas, or *non-spaces*, as vital areas, which underpin our experiences, where incidental *social space* becomes design drivers aiding feelings of well-being.

Keywords: Liminal, Hospital, Patient Experience, Incidental, Transient

INTRODUCTION

Hospitals are depicted as being shelter and refuge for the needy, and by definition be 'hospitable' places, yet too often they are places that leave negative connotations in our minds, emotions and memories, as they are truly not a destination of choice, but by necessity. Hospital environments are spaces that we all at some point in our lives come into contact with either in the primary sense as a patient, or secondary as the patient's family, friend or supporter; and for others this is also their place of work, so for them the hospital takes on a double persona.

Hospital design has progressed from the favoured pavilion ward layout of Florence Nightingale 1856 recommendations (McDonald, 2012), to Forty's (1980) observation that "hospitals have reverted to large single blocks, whose closest resemblance is to office or industrial buildings". Hospitals of such nature have all the necessary elements, units, destinations, but unfortunately haven't been able to adjust or adapt to keep up with changes in modern medicine processes. The older hospital buildings, due to historic placements and financial stresses, struggle to manage new developments within the units,

and capitalise on new diagnostic, working methods of bringing different units closer together. So these units remain separated and inevitably patient experiences can feel disjointed, displaced and bewildered when seeking to navigate effectively on every visit.

Often our experiences inevitably are characterised by a series of waiting points, that determine our journey through diagnostic/testing – consultation – cure, or, diagnostic/testing - consultation – care and then looped back through the cycle of consultation, managed care with diagnostic testing interjected when necessary. Marsh (2006) reflected on how architects and designers can be seen as treating the hospital as a series of functioning units and blocks, yet overlook "that successful hospitals are as much communities that deliver care for chronic illness as [they are] factories that cure acute ones". To this end it is the nexus of corridor/waiting areas, these "non-spaces", as described by Auge (1995), where predominance of time can underpin our experiences, and where incidental "social space" discussed by Lefebvre (1974), become design drivers aiding feelings of well-being.

The recognition of the transient corridor space is discussed by Iedema, Long, Carroll (2010), where their work examines "the social space and experiential place…pursued in the work of Hall (1966) and Goffman (1959), both of whom underscored the importance of identifying the *interactive* affordances of spatiality…Goffman proposed that spaces are experienced as being either public 'frontstages' or more private 'backstages," (Iedema 2010). They catalogue work by Irvine (1979), where it is discussed that "backstage spaces may be seen as being less inscribed with conduct regulations and institutional prerequisites than are front stage spaces." Iedema et al (2010) applies this distinction and labelling in terms of the hospital as being the following: "backstage spaces would include transit spaces such as stairwells and corridors that create connections among frontstage spaces such as consultation rooms, wards, meeting rooms, operating theatres, entrances, offices, and so forth." They then go on to reflect how "connecting spaces, such as stairwells and corridors, are to some extent 'in between' or 'liminal' spaces (Turner 1957)."

Consequently the paper's objective discusses the importance of liminality in hospital corridor/waiting areas. How through using design intervention(s), such as the temporality of shadows, voice and scent, could aid personalisation of such transient spaces. Therefore engaging those that pass through, sit and wait, with interior elements that enhance feelings of well-being.

METHODOLOGY
A combined methodology is used based on an abductive logic where it is instigated through observing a 'surprising fact', and as Van Maanen et al. (2007) argue there are many moments these could be uncovered within the research process, therefore the abductive approach allows for a continual interplay between these discoveries and theories.

The paper utilises the interpretivist approach to construct knowledge through mixed data collection. The ethnographic research has applied James Cliffords (1997) theorised methodology approach of 'deep hanging out', within a number of observations at different hospitals. Hence allowing comparisons to occur within a variety of corridor/waiting areas capturing some opportunistic liminal waiting moments. During these visits sketching was utilised as a catalyst, for opening up conversations and suggestions as people's curiosity was peeked, and acted as a neutral external factor to focus upon in these stressfully charged encounters.

FINDINGS

At this point it is pertinent to state that in reflection, having a neutral external factor as sketching enabled more 'social spaces' to occur, as people started grouping closer to the activity in order to join the discussion and see what was being created. Then discussion(s) on the environmental design factors in such waiting areas sparked a series of suggestions, always backed by acute memories and experiences of waiting, be it the one of the present or the past. However it often it became a comparative about the worst areas to find yourself waiting in, bringing back heightened emotions of these transient spaces, where a pause became a wait, became an event, became a memory. Sometimes these memories were of a positive nature, but most often people remembered the ones of negative occurrences.

People's suggestions and comments brought up interesting reflections whereby primary physical exchanges were their fundamental priority, such as the human factor. The interaction with the person behind the reception was for many, seen as being of utmost importance in offering reassurances in the first instance. This also backs up many observations when accessing the hospitals corridors system, whereby within even a short length of time the number of patients, patient supporters and visitors, whom on seeing a member of staff, determined through dress/uniform, would reaffirm with them where it was they were heading, and if they were heading in the right direction. Therefore on entering their final destination, it seems little or no surprise that they still needed that guarantee from the person behind the desk. This could gain sympathies and understanding from the view that they have experienced heightened feelings of powerlessness and vulnerability, which could be argued that the present signage hasn't adequately assured people on their journeys.

There were lengthy conversations over the seating, discussing what level of comfort could be delivered in the style and function choices of appropriate chairs, dependent on waiting type and times. Again looking at key physical touch points to connect people with their environment, it could be argued that more cold hard seating does little to offer gentle comfort to those waiting. Fundamentally when short waits become lengthened, then the lack of such comfort only heightens people's feelings of alienation, whereby they feel divorced and unconsidered in such seating choices. Therefore looking at all scenarios for each waiting area, offering different waiting experiences, could aid decisions for seating selection to aid perceived levels of comfort for the occupiers.

Then came primary visual factors of distraction such as the use of TV's, magazines, artwork, posters and information leaflets. As well as the need of familiarising oneself with the placement of toilets and refreshment, if indeed the waiting times increase. Therefore knowing your surroundings can be key in settling some of the worries encountered in new environments. Again the reassurance of knowing where things are located, such as toilets, can be almost primal in acknowledging our physical needs, which for some can become more frequent when under such emotional, physical and mental stresses.

These were then followed by primary exchanges of the other senses such as sounds; as noise levels were also perceived as being higher. Similarities could be made between such waiting areas at times reflecting an historic library setting, whereby its occupants talk in hushed tones for greater privacy; as for many the openness and hardness of hospital waiting areas only succeeds in amplifying any sounds/voices within it. This lack of perceived privacy again could be argued as another factor detaching its occupants from the environment, and therefore hindering positive patient and visitor's experiences.

Other heightened senses are smells within the environment, this in turn could induce unease, as the sterilisation can at times imply the need to clean as you pass through it's passageways. This again was compounded by the numerous hand sterilisers that litter the corridors and waiting areas, where there can be an uncomfortable trade off between being seen as clean, by being treated as unclean. The question to many though is how often do these constant reminders get used, as they seem to remain lifeless, something to forget as you pass through.

CONCLUSION
The hospital corridors/waiting areas to many, act as internal portals where we can become lost in thought, space and place. As the semiotics of these passive spaces become linked to liminal presence of the physical, mental and emotional state of those waiting or passing through. The internal corridors are the crucial pathways between the various areas within a hospital, becoming transient passages to engagement, but rarely require you to be engaged through your 'journey'. Signage is key in aiding people's navigation effectively, yet even the most signposted of journeys often lead to that first opening question on arrival... "Is this the place I need to be in?" Leading us to question whether no amount of signage could ever reassure you on your first visit, that you are in the right place. Again reiterating it is human interaction and contact that brings the personal touch to such moments of stress and emotion. Though this could be a worthy starting point for a design intervention to focus upon.

All of the conversations above look at the environmental factors that the semiotics of the space has heightened, and opens up the question of how design intervention(s) of temporal traits of identity; voice, scent and shadow, could look to personalise and humanise these sterile spaces. The design intervention(s) will look at engaging the environment as an interlocutor with its occupants, in order to help generate and aid narratives of comfort and peace, in such moments of transition and liminal waiting. This also responds to the levels of inhumanity within architecture and modern cities, discussed by Pallasmaa (2012), whereby looking at how our sensory systems suffer an imbalance within certain environments. Again these can further lead to feelings of detachment and alienation, as people become distant and somewhat removed from their environment, situation and presence. Pallasmaa states, (2012, p22) "It is thought-provoking that this sense of estrangement and detachment is often evoked by the technologically most advanced settings such as hospitals and airports." In turn this leads us to question, does this overwhelming knowledge of a technologically infused hospital setting only deepen our own and others sense of frailty? That in order to promote deeper senses of well being we could look towards a more organic, low-tech approaches within hospital corridor/waiting areas? However in today's technologically dependent society, could lead to design intervention(s) looking at hybridising the infusion of both low techs, with the more intuitive technological interventions to aid greater liminal experiences.

For many the importance of touch can ground our senses by connecting us physically to our surroundings and situation, yet touch is almost condemned within the hospital due to our nurtured fear and alarm over infection control. Again showing one of our most primal instincts in direct conflict within the hospital setting. So design interventions will need to engage peoples perceived level of contact, possibly through sensors, to help create a more tactile experience.

When considering sound within such environments, it can often be excruciating, as we become overtly conscious of our being there, without us wanting to be there. So avoidance of adding sound to the space and becoming a focus of attention is commonplace. People can be seen as trying to blend into the background, almost as a survival instinct of the personal. As for many our being there is often highly personal, as knowing the intimacy of ones self is in need of external interaction is then heralded, in such an open space. Therefore the slightest of sounds can appear amplified in such settings, only increased by the multiple hard surfaces, utilised for appropriateness of maintenance, function and cleanliness. Yet, unfortunately only enhances hard, cold and almost clinical sounds that further disconnect you from the space. Though Pallasmaa states (2012, p54) "sight is the sense of the solitary observer, whereas hearing creates a sense of connection and solidarity". So is the shared sound experience an unwelcome connection with the environment, that we are trying to avoid, or a binding mechanism, that can engage us in a more tacit interchange in such moments? Therefore a design intervention looking at voice could become more in tune with natural sounds, to allow disconnect with the immediacy of our stress filled experience, to sounds that offer more innate healing, connecting its occupants to sound imprints of tranquil moments.

When considering scent interventions, it is with the knowledge that scent is often the strongest memory trigger to our experiences. So when looking at hospital environments and its sterilisation regime, its no wonder that memories can feel overpowered by artificial cleansing chemical exchanges. Therefore, as in all the design interventions, there appears an opportunity to reconnect us to more naturally engrained connections, that subliminally allow us to escape our present physical environment, by relating to more memory rich, tactile moments.

In truth there isn't a cure for corridor/waiting spaces, just different levels of care that such design intervention(s) could offer to the various settings within one hospital. The study will now go on to design and create hybrid elements to encourage more physical, mental and emotionally charged frames of experience. These new corridor/waiting areas could then engender us all to being more receptive to positive messages, and design drivers to our personal and social well-being, when we find ourselves within a hospital.

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