GOOD TRIP

2025

COMPLEX PROJECTS
Bodies and Building Milan
AR3CP100

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Good Trip proposes a cancer care center for Quadronno district in Milan.

Good Trip seeks to investigate hospital architecture through the lens of pleasure. The research questions normative models of healthcare and the perpetuating bigness in medical institutions. Advances in medical sciences and technology along with population boom-inflated demands in healthcare facilities in the nineteenth century have since aerated bigness and perpetuated genericness in hospital designs across European metropolis. In these derived hospitals, patients become bodies moved along Kafkaesque corridors, stigmatized and stripped off joy of living. Rejuvenated interest in hospitals post-Covid 19 and rising cancer incidences linked with the dawn of super-aged societies in Europe urge a radical redefining of cancer care buildings, from curing to caring.

Good Trip hopes to reflect on the injunction to pleasure that is imposed today in the hospital. The research speculates on a radical hybrid of an urban hospital to imagine how space and architecture can support healing and promote the joy of living in a non-institutional setting. Dwelling on material culture and anti-ageist studies, this research-by-design seeks to formalize pleasure in hospital's Third Place through intimacy, domesticity, and non-normative social engagement while reflecting on the hospital as both a healthcare and socio-cultural infrastructure within the city.

I.
RESEARCH PLAN

00
PROLOGUE

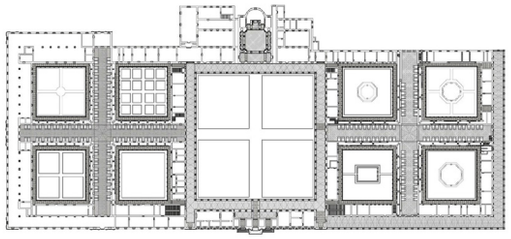

Fig. 1 Ospedale Maggiore, Milan, 1456-1465, Plan.

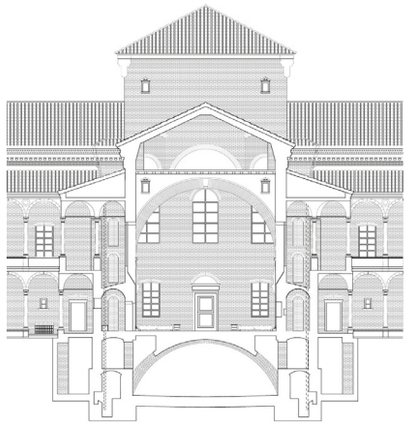

Fig. 2 Ospedale Maggiore, Milan, 1456-1465, Section.

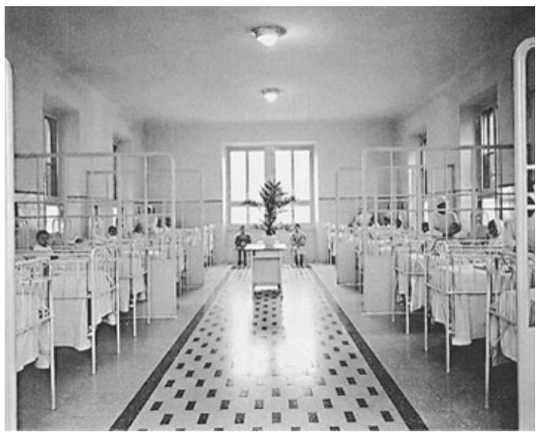

Fig. 3 ”Vittore Buzzi” Children’s Hospital with layout based on the pavillion type.

The history of Milan healthcare has been marked by various hospitals and health reformations that engender paradigm shifts in hospital architecture in the west. Michele A. Riva and Giancarlo Cesana, Professors at University of Milano-Bicocca, investigated the global panorama of medicalization of hospitals by tracing – through a “micro-historical approach” – Ospedale Maggiore in Milan since its establishment in the Renaissance.[1]

The fatal aftermath of the Black Death epidemics (1346–1353) and Europe’s rapidly growing medieval cities led to hospitals being instituted by the bourgeoisie in Europe. Amongst the prominent examples is Ospedale Maggiore in Milan, also known as Cà Granda (“big house”), designed in 1456 by Filarete.[2] The hospital represents the charitable largesse of sponsoring patrons to the sick and the poor and was the first of its kind to employ the crossward plan: a symmetrical composition according to the Renaissance principles, comprising of two main wings, each with four open courtyards. (figure 1) Rather than derived from the contour of the land, it was designed on the page, “siteless and idealized.” [3]

Hygienic concerns in the design of hospital ‘Maggiore’ set it apart from preceding religious healing temples. The hospital aimed to improve efficiency in healthcare by centralizing patients into a single bigger building, while implementing hygienic innovations. Filarete’s sections of the hospital reveal a new sewage system enabled by the privy running along the back of the patient bed and emphasis on room ventilation through large windows front of the bed. (figure 2) Anticipated the concept of the general hospital, which serves the sick in general to improve public health, the hospital initiated the centralization of healthcare in Italy and represented a new archetype for non-religious institutions all over Europe.

Not until the final decades of the eighteenth century did Milan hospitals begin to forge a new relationship with its medicalized inhabitants, transforming from charity-based institutions into civic institution. Enlightenment policy attributed social progress to improving children’s health.[4] From orphans to ‘the incurables’, sick children with chronic mental or physical disability were displaced from foundlings and transferred to a new hospital built solely for them in Abbiategrasso in the outskirts of Milan.[5] To be cured, they must be taken on a trip out of their routine. Emerged along with this new marginal group of patients were new doctors whose education emphasized clinical observations.

1
Riva, M. A., & Cesana, G. (2013). The charity and the care: the origin and the evolution of hospitals. *European Journal of Internal Medicine*, 24(1), 1-4. https://doi.org/10.1016/j.ejim.2012.11.002

2
ibid.

3
Murphy, M. P., Murphy, M. P., Mansfield, J., & Group, M. D. (2021). *The Architecture of Health: Hospital Design and the Construction of Dignity. Cooper-Hewitt Museum,* 52

4
Ben-Shalom, O. *Medicalizing Milan: Hospital Reform and Urban Identities in Enlightenment Italy. Harvard Mellon Urban Initiative.*

5
ibid.

6
ibid.

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ibid.

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ibid.

Population boom in the most industrialized city of Italy in the latter half of nineteenth century further reconfigured the hospital. Ospedale Maggiore's 288 beds proved inadequate to serve its sick citizens, compared to the 1000 beds in the concurrent Hôtel-Dieu in Paris.[6] The need for more beds resulted in the expansion of the hospital to another area and the adoption of the Nightingale pavilion model that dominated western hospitals.

Constructions of 'specialists' hospitals and research-driven hospitals post-WWII was the keynote of this era where medical sciences and technology took over architecture in the hospital. In the span of a century, several specialized hospitals were found targeting specific patient groups: pregnant women (Obstetrics and Gynecology Institute "Luigi Mangiagalli", 1906), children (1915, "Vittore Buzzi" Children's Hospital), or tumor (1928, National Cancer Institute).[7] (figure 3) This mushrooming of specialized hospitals caused a controversy in the medical milieu that emphasizes all-round competence. Meanwhile, Ospedale Maggiore was officially affiliated with the medical school of "University of Milan" and earned the national title of "Research Hospital" (IRCCS).[8] The Filarete building became a university campus, and the hospital was moved to a vast area across the street. This marked a full leap from charitable hospitals to full medical institutions.

The later half of twentieth century observed further developments of the vertical modern hospitals. The functional hospital came to life in this era with three primary massings – inpatient unit, outpatient unit, and public amenities – and its signature hospital corridor. Among many of those in Milan is Clinica La Madonnina in Quadronno district, designed by the Soncini brothers. The hospital typifies the mood of the time with a rational modern take to hospital architecture including individual patient's room with adjoint loggias facing a healing garden. (fig. 4) Here, the hospital is no longer a horizontal urban campus, but a radical medical condenser made for curing.

Fig. 4 Clinica La Madonnina in Quadronno with loggias overlooking healing garden.

01
INTRODUCTION

“Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.”

– Susan Sontag, Illness as Metaphor.

1.1 Thesis topic

Hospitals are grim reminders of our mortality. From a panoramic view, hospitals as civic institutions that provide care and cure for the sick reflect how a society treats its ill citizens. The expectation of a healthcare infrastructure like hospitals to induce ease, comfort, and wellbeing is a tautology, yet it is not always the case in practice. Hospitals are mired in the complex and absurd, defined by rules and constraints of the ever-evolving medical system. In other words, hospital architecture has become a wild goose chase for constant restructuring and expansion to avoid obsolescence.

Once almshouses for the poor, hospitals evolved from charity-based institutions to the modern machine à guerir, to healing centers for chronic illness. (figure 5) As stringent design briefs overtook the direct role of architecture and healthcare, the medicalization of architecture since the nineteenth century stripped patients of pleasure and dignity. As portrayed in Sontag’s metaphor, the hospital functions like a kingdom of the sick with its strict border control at the entrance, further segregating the two kingdoms. After all, the modern hospital is supposed to be a quiet, functional, and sterile sanctuary for curing and healing.

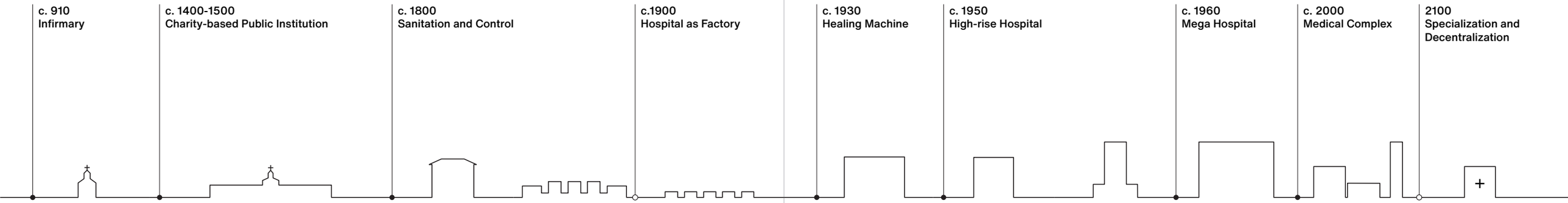

Fig. 5 Timeline of hospital typologies.

Drawing by author. Data from Wagennar, C., The Architecture of Hospitals (Rotterdam: NAi Publishers, 2006), 206-213

1.2 Problem Statement

Medicalization, Genericness, and Bigness

Hospitals lack pleasures. The modern hospital, unrestricted to the context of Milan, relies predominantly on medical rhetoric to problematize and resolve architectural, urban, and environmental problems.[9] Specific resolutions sought to remedy specificities of the so-called "design brief" result in the extreme genericness of the sterile medical machine. Tailored solutions pertaining to treatments of illnesses engender contradictory results, marginalize sick bodies, and segregate various demographic groups.

The stringent adherence to design briefs to accommodate medical technologies also led to bigness in the hospital. A relentless chase for spatial expansion further contributes to early obsolescence as architecture shifts the focus to ultimate efficiency and innovation while detaching itself from the patient's experiences. On this topic, Borasi analogizes the hospital — subject to medicalization — to a "'sick' body" and proposes the notion of demedicalization of architecture.[10]

The bidirectional nature of medicalization refers to a phenomenon of incremental development over the last century while implying the possibility of a reversal. Successful demedicalization has occurred in some cases within the medical sphere, for instance, related to homosexuality and masturbation.[11] In the architectural discourse, the radical hybrid model of Maggie's Center for Cancer exemplifies this notion by yoking together non-medical programs to create a new environment for more pleasurable forms of cancer care. "They are in a way monumental, and precious, like a church that isn't a church, a gallery that is not in a museum, or a house that is not a home." [12]

> "Above all, what matters is not to lose the joy of living in the fear of dying."
>
> – Maggie Keswick Jencks, cancer patient and co-founder of Maggie's Center

Population ageing and the marginalized

Rising cancer incidences coinciding with population aging[13] engender a demographic redistribution with implications for specialized hospitals. Italy has the highest old-age dependency ratio in Europe, predicted to rise to 66.5% by 2050, against a European average of 52% in 2050.[14] (figure 6) Urban ageing phenomenon corresponds to the rising cancer occurrence and mortality in Italy, with over 377,000 new cases diagnosed annually, making cancer the second leading cause of death in Italy.[15] Rising cancer incidences in the context of superaged Italy and the thinning of family support networks translate to an overdue need to revise and reconfigure facilities specific to this patient group.

Furthermore, spatial segregation persists in the general hospital, where palliative care, or end-of-life care, is embedded in cancer care departments, tucked away at the end of cavernous hospital corridors. Amongst many examples are the oncology unit at McGill University Health Center in Montréal or even in the more recently constructed St. Olav's University Hospital in Trondheim, Norway.[16] In such settings, being sick or being old, sometimes at once, amounts to the marginalized, segregated environment for strictly curing efficiency.

Cancer care: a dichotomy of needs

The consequences of cancer gravely affect the experience of joy in people living with cancer physically and mentally. Loss of bodily functions, inability to maintain social roles and to engage in routine activities, and psychosomatic symptoms are among the impacts of cancer and its treatment regimens.[17] Occupation therapy exemplifies one of the medical approaches to facilitating the experience of joy and improving the life quality of people with advanced state cancer based on eudaimonic well-being.[18] Nevertheless, architectural approaches are

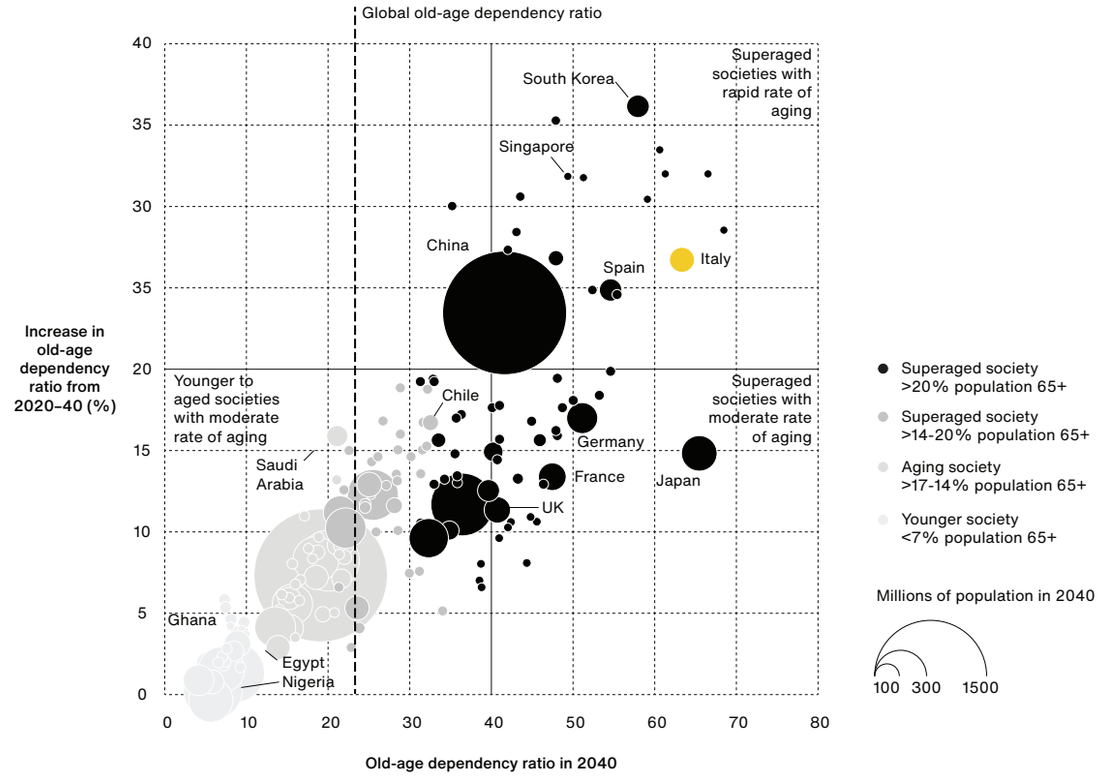

Fig. 6 Italy as a superaged society

rare. Minimal research has been conducted to improve the built environments specific to cancer care where the typical treatment regimen is primarily outpatient.

More than 80 percent of all cancer care, including high-dose chemotherapy and high-tech radiation diagnostics, is delivered in ambulatory-based settings, typically at infusion centers.[19] As a result, insights gained from studies on inpatient settings of regular hospitals may not be relevant to these outpatient environments. For example, while evidence-based design attributes single-patient rooms to reduced infections and enhanced patient healing in hospital settings, such configurations in infusion centers may limit patients' ability to call for help from nurses. Curiously, the first cancer center, the New York Cancer Hospital, has a centripetal open ward with ventilation ducts and nursing tables in the center. (figure 7) The strict restriction on patient freedom to control windows in single patient rooms due to infection control in regular hospitals also applies loosely to the case of cancer treatment, where the contrary could be proven more beneficial.

Longer waits, long-hour treatment sessions, more frequent trips to the hospital – typically ranging from three to six months – and the hospital itself, altogether render the traditional oncological departments stigmatizing and obsolete. (figure 8) What makes pleasure above all more relevant in this context is its dichotomy of needs – between choice and control, privacy and kinship, tranquility and positive distractions. Such contrast needs result in an intensified duality of emotions experienced by cancer patients where joy can be twofold in the backdrop of pain. For instance, the transformative empowerment of fake wigs brings pure pleasure by creating a sense of normalcy. As such, a focus on providing private comfort in non-residential outpatient facility and positive distractions within the hospital's third places will faciliate an architecture of pleasure, while reflecting on a non-normative model of healthcare.

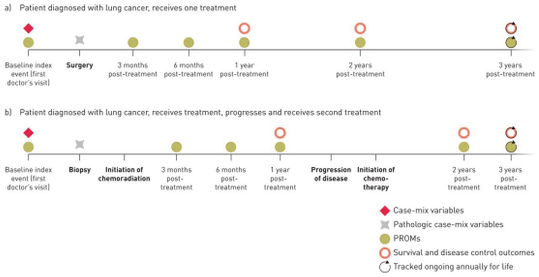

Fig. 8 Sample timelines illustrating cancer treatment paths for patients treated with different modalities, including a) surgery or b) multiple treatments with definitive chemoradiation followed by chemotherapy after disease progression. PROMs: patient-reported outcome measures.

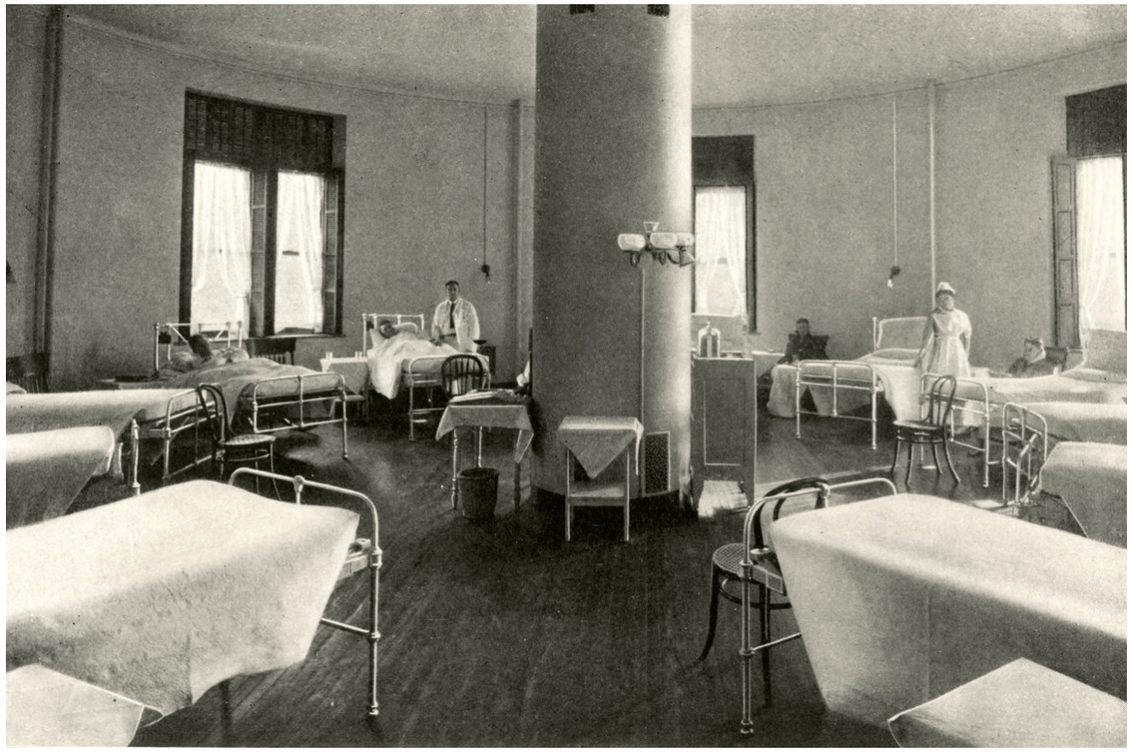

Fig.7 New York Cancer Hospital as the first cancer center in the world, 1887, employed radial plan to prevent dirt and germs from accumulating in corners.

1.3 Research question

Should hospitals exude pleasure? This is precisely not a question one ponders when thinking about the architecture of hospitals, even more so in cancer hospitals. In Lütjens Padmanabhan's words, architecture can be joyful or sad, relaxed or tense, sympathetic or moralistic, personal or aloof.[20] Hospital architecture, I argue, is no exception. Hospitals, commonly perceived as a site of sorrow and pain, can also be a site of pleasure and joy.

Joy differs from pleasure in that pleasure is derived from an external source, while joy arises from within when we bring our full awareness to the experience. (source)With this distinction, the research theorizes on the architecture of pleasure in a hospital for cancer to investigate whether the building, as a tangible, external environment embracing the body, can encourage the joy of living from within the self. The research question is as follows:

Can architectural pleasure in the urban hospital foster healing and joy in people living with cancer?

This research question is subsequently broken down into two sub-questions:

How to uncomplicate the complex structure of treatment areas for patients?

How to formalize pleasure in hospital's third place (corridor, waiting lounge, etc.) for people undergoing treatment and staffs?

What is the role of material cultures in the everyday life of hospital corridors, emblematic yet often demoralizing and disorienting?

Fig. 9 Ceci n'est pas un hôpital, concept collage.
Drawn by author.

02
RESEARCH
FRAMEWORK

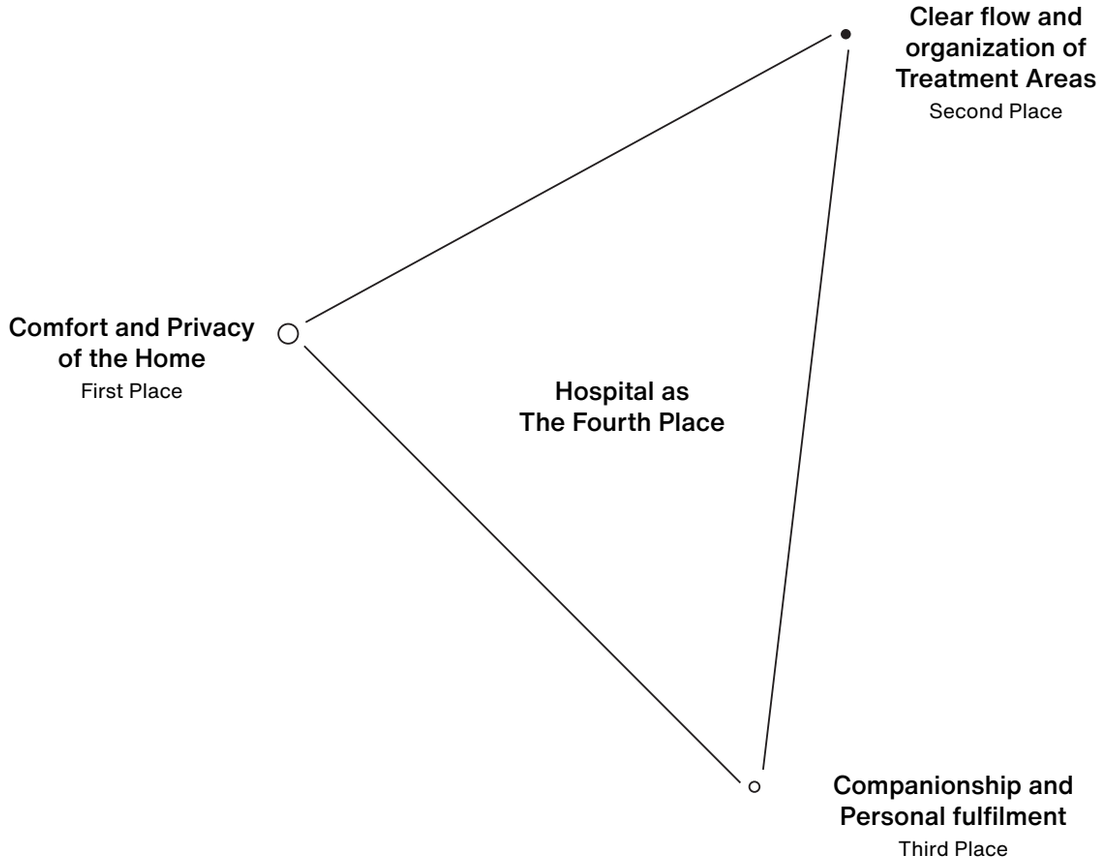

Fig. 10 Hospital as the fourth place, theoretical framework diagram.

2.1 Theoretical framework

Pleasure has a slightly slippery definition. Although pleasure is often associated with leisure, spaces built for leisure are not necessarily pleasurable, and vice versa. The architecture of pleasure will be investigated and later substantiated through the theories that follow.

The Third Place, The Fourth Place

To formalize pleasure, the research will investigates the notion of the third place in the hospital and speculate on the hospital as the fourth place. Sociologist Ray Oldenburg theorized that the third place refers to informal social spaces which exist outside the structured environments of the first place (home) and the second place (work), "where people gather primarily to enjoy each other's company."[21] If the hospital were a city, its third place would translate to interstitial spaces between the treatment room and the patient room. Foyers, waiting lounges, front elevators, staircase landings, corridors exemplify Oldenburg's concept. These spaces, contrary to being socially engaging, also contribute primarily to the negative connotations associated with hospital visits as an unpleasant and demoralizing experience.

The hospital, however, is not quite the third place in and of itself. While being the workplace for staffs, the hospital does not translate to a socializing or decompressing space from a patient's perspective. Neither is the hospital a workplace nor a home for those who have fallen ill—one only hopes to be discharged as soon as possible. When the definition of the third place still stands, the hospital as a special type falls through the cracks. Could hospitals, then, be theorized as the fourth place?

In a paper discussing a typology of places in the knowledge economy, Morisson elaborates that the fourth place is a superimposition of certain elements pertaining to the first, second, and third place.[22] Station F in Paris typifies this new type as an innovation center combining restaurants, bars, a post office, FabLab, working desks, and shared apartments residence. In the fourth place, the frontier between social and private dynamics, work and leisure, becomes blurred. In the same vein, the hospital, as the fourth place, is borne out of the injunction on pleasures due to consequences of illness and treatments. In this context, with the 'social' label disrupted, the fourth place lays a framework for conceptualizing the hospital influenced by superimposition of places and a dichotomy of needs in cancer care – between choice and control, privacy and kinship, tranquility and positive distractions.

"Maybe the ideal hospital is not a question of design outline, but more about sensitive concepts such as human interaction or well-being?"

– Phylum H ©Brunet Saunier Architecture

Henri Lefebvre's Jouissance

Henri Lefebvre's theorization of jouissance distinguishes between the ideas of "enjoyment of architecture" and "architecture of enjoyment," of which the latter indicates a space that encourages and stimulates pleasure, rather than simply admiring beautiful architecture.[23] While both sentiments can coexist, the latter gives rise to more intense emotions. He contrasts abstract space, shaped by capitalist interests like office buildings or institutions, with lived space of quotidian experiences. Whereas abstract space is cold, rational, and alienating, designed to control behavior and limit freedom, lived space challenges traditional boundaries, routines, and expectations by enabling spontaneous encounters. The terrazza ("roof terrace") as a cinematic key space depicted in post-war

and contemporary Italian films exemplifies this place of hedonism that invites both encounters and contemplation, such as terraces seen in Sorrentino's La grande bellezza. [24]

Bernard Tschumi's The Pleasure of Architecture

Tschumi's concept of pleasure in architecture embraces disjunction and tension between forms and functions, where pleasure arises from the interplay between space, event, and movement.[25] Tschumi argues that architecture should provoke, stimulate, and even contradict, creating spaces that foster dynamic interactions rather than static, predetermined uses. Through this approach, Tschumi proposes that unexpected and transgressive encounters within space evoke a unique form of pleasure tied to human engagement and sensory experience.

"As beautiful as the chance encounter of a sewing machine and an umbrella on an operating table."

– Lautréamont, Les Chants de Maldoror

One can draw a parallel with Lautréamont's metaphor, which captures one crucial principle of surrealism: the enforced juxtaposition of two completely alien realities to challenge an observer's preconception of reality. This juxtaposition evokes a sense of the uncanny to challenge conventional aesthetics and reflects Lautréamont's desire to disrupt logical thought and provoke new ways of seeing and experiencing. Relating this notion to architecture, spaces with surprise and surreal qualities will offer delight rather than sadness, for "pleasant surprise beats most forms of entertainment, particularly when it results in a positive change of mind."[26] As such, compared to the fixity of required treatment rooms or patient rooms, third place in hospitals enables opportunities for this type of contradictory spatial experience and invites reappropriation from the user.

Juhani Pallasmaa: The Eyes of the Skin

Pallasmaa's theory on multisensory experience in architecture offers another layer to the architecture of pleasure.[27] In The Eyes of the Skin, he criticizes modern architecture – renowned associated with the International Style perpetuating in hospital architecture to this date – for being too visually oriented and argues that tactile, auditory, and even olfactory aspects are crucial to creating good architecture.[26] Hospitals then shall offer a sense of comfort and pleasure through materials, textures, acoustics, and spatial configurations, including but not limited to visual tectonics.

Maggie's centers: A radical hybrid

For that a constructed building speaks more than any written words, Maggie's blueprint of a radical hybrid provides the last but the most crucial theoretical basis in this research. Maggie's Center meshes seemingly different functions together under one roof to evoke contradictory experiences and spontaneous pleasures. Absorbing programs of a day-care center like a kitchen, a library, and a garden, Maggie's is "a house but not a home, a museum that is not a museum, a church that is not a church, and a hospital that is not a hospital", everything all at once.[28] With this hybrid typology, patients have a choice to take risks in treatment, to take part in counseling or group sessions, or to take pleasure in retreating to their niches within the public sphere. Private niches within public spaces, or flexible spaces that invite appropriation without imposing, contribute to a hospital echoing a domesticated landscape of heterogeneity. Here, the hospital becomes a theatre of the routine every day, amplifying the joy of living without the hedonistic erasure of reality.

Psychedelic metaphor: a final note

The project title plays on the double entendre of "good trip", a colloquial term describing pleasurable experiences derived from psychedelic experiences used in treating patients with psychosomatic symptoms, including cancer-induced depression. Psychedelic journeys are inherently unpredictable, ranging from joyful to distressing; whether a trip is a "good trip" depends significantly on one's mental state, personality, expectations, and physical surroundings, also known as "set and setting." [28] Drawing a parallel of hospital architecture to a stage set for pleasure, Good Trip emphasizes the psychosomatic and physical aspects of cancer and its link to the physical environment. The title suggests a hope that a pleasurable space can foster better healing in cancer patients as a metaphor for psychedelics in treating cancer-induced depression. Perhaps, to take pleasure in a hospital visit is to embark on a good trip.

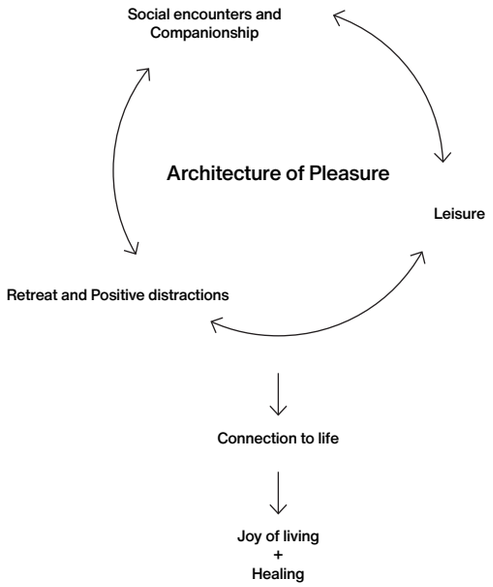

Fig. 11 Theorization of pleasure hinges on the dichotomy of needs in patients, theoretical framework.

2.2 Relevance to studio

As Peter Haneke has shown in his movie Amour, today, illnesses are often experienced by patients in the comfort but also the solitude of their own homes.[29] Cancer treatment, above all, can induce psychosomatic symptoms and aggravate negative thoughts in patients. For this reason, the project believes that, like the renaissance Ospedale Maggiore once was, the core of a healthcare facility should be to offer both private and collective spaces that celebrate simultaenously personal pleasure and public welfare. Rather than being a strictly functional clinical environment, the proposal involves a non-residential cancer center in Milan focusing on outpatient treatment, care, and support.

The research focuses on outpatient settings, which are more dominant in cancer care, as these may fail to support socio-spatial needs, such as privacy and control, more so than inpatient facilities. The complexity of cancer hospital under the umbrella concept of *flow* lies in the multiple spatial and programmatic needs of the bodies within buildings. The theorization of architecture of pleasure thereby hinges on the three primary relationships driving in this dichotomy of needs: between privacy and companionship, autonomy amd control, retreat and positive distractions. (figure 11)

Material position adds the last layer to the proposal. White-plastered walls are a norm for sanitation requirements in hospitals, whereas wood and textiles remain the moot point in the sterile environment. Strangely enough, one rarely questions whether such wall paint has carcinogen properties or not. To challenge this preconceived notion, the research hopes to study wood as the primary building material through the material culture lens. The research will study material floow by considering first its life cycle implications and then exploring potentials for Design for Disassembly relevant to the Material group's position.

03
RESEARCH METHODS

Fig. 14 Map locating existing cancer facilities in Milan and the assigned site in yellow. Drawn by author.

3.1 Research methods

Clients

Client research focuses on two primary groups of users: those experiencing cancer and those who do not. This distinction emphasizes that the experiences of pleasure pertaining to these two groups may not manifest similarly but are both crucial within the scope of the research.

The former group consists of patients undergoing cancer treatment and those returning to hospitals for follow-up care. An understanding of patients' medical and social needs facilitates a better understanding of their spatial needs. Literary reviews on the flow of cancer treatment, the physical and psychological consequences of these treatments, the impacts of the built environment, and post-occupancy evaluations will help identify the nodes within the patient's care journey where unpleasant experiences are most prominent or even aggravated. Field investigations and interviews of cancer patients and caregivers can contribute to understanding how these user groups perceive pleasure and confirm the initial suspicion about the role of spatial autonomy and reappropriation in building pleasures.

The latter group involves hospital caregivers and visitors. Creating comfort and a sense of privacy while maintaining the patient-caregiver connection and patient-visitor kinship is among the key aspects of the pleasurable healthcare environment. For instance, patients' proximity to caregiver stations, visual and audible connections between caregivers and patients, or accommodation for visitors within infusion hubs are identified as factors contributing to feelings of safety and assurance through preliminary literary research.

Site

Site research addresses two primary aspects: contextual requirements for a hospital and relevant criteria for social infrastructure incorporating leisure programs. As the building site has been assigned in the Quadronno district of Milan, spatial mapping and environmental analysis will enable a better understanding of the site characteristics, including aspects such as environmental and sensory quality (orientation, light, air, views, noise pollution), accessibility (connections to urban green, connection to mobilities), and social interactions (leisure functions, concentration of demographics groups within the neighborhood and within the city). Based on the same criteria, contextual analysis and comparison of existing cancer hospitals within Milan and exemplary case studies in Europe, from treatment centers to research institutes to care-only centers, provide insights into how these elements contribute to or detract from pleasurable experiences.

Additionally, on-site surveys, behavioral observation, and qualitative heuristics[1] can capture how spaces intended for leisure, such as libraries and gardens, or their lack thereof, affect people's behaviors. Data gathered from these methods eventually allows for an assessment of site features that are relevant and applicable to the assigned site in Quadronno.

Program

Programmatic and spatial requirements will be investigated primarily through benchmarking of case studies and typology studies. As the research seeks to reconcile clinical treatment and supportive care under one roof, it is crucial to analyze the programmatic and spatial compositions of cancer treatment hospitals, cancer research institutes, and the hybrid cancer care model of Maggie's Cancer Centers. In the context of urban aging in Italy, other urban hospitals not exclusive to cancer, such as children's hospitals, rehabilitation centers, and senior daycares, provide insights into age-inclusive design and potential public amenities in hospitals beyond curing, such as leisure, self-care, and productivity.

Particularities of cancer treatment regimens necessitate further literary research and case studies into outpatient treatment areas like infusion centers where degrees of privacy manifest differently from a regular hospital, be it private hubs, semi-open infusion hubs, or informal infusion areas. A comparative analysis at the end will provide a comprehensive grasp of programmatic and spatial composition for the final proposal with patient's pleasure at its core.

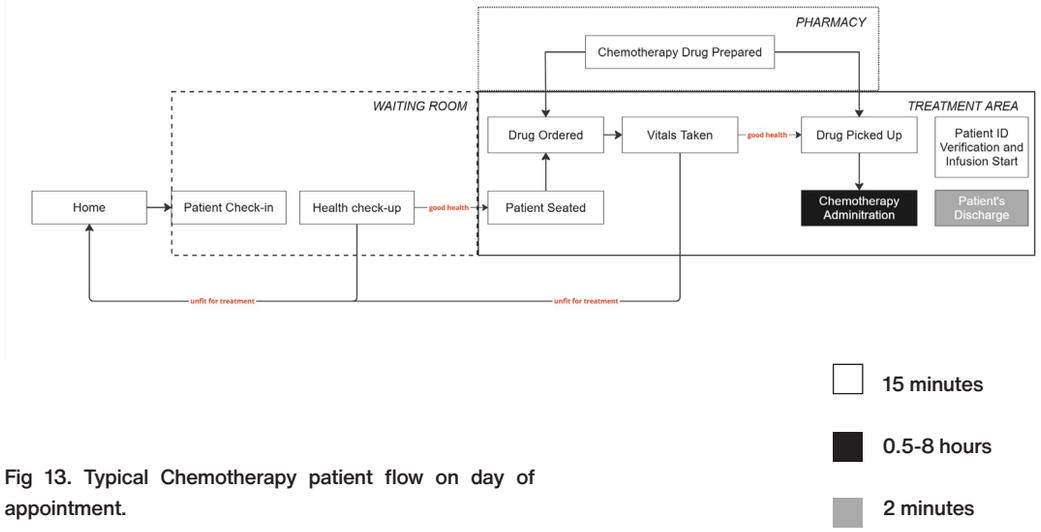

Fig 13. Typical Chemotherapy patient flow on day of appointment.

Fig. 14 Preliminary program case study

APPENDIX I

Endnotes

9
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