





# THE ARCHITECTURE OF HOPE

Charles Jencks

## THE TYPICAL SITUATION WITH CANCER?

Maggie's Centres, cancer caring centres now growing apace in Britain, arose from the experience of my late wife Maggie Keswick. They came from her struggle fighting cancer over many years. By 2008 there were six Maggie's Centres up and running and five in the pipeline, a completely unexpected situation. When Maggie and I had the original idea in 1993, we had contemplated only one small room with a big window looking out on to a green space – nothing like eleven buildings and a whole programme of cancer support.

Maggie was first diagnosed with what she called 'the dreaded disease' in 1988 and, after undergoing a mastectomy and radiotherapy, she considered herself cured. So when the affliction returned five years later she mistook the symptoms for an old backache, one that felt very much like those of her youth. She then followed the zigzag path that many do when they have intermittent pain, the wrong information and a misdiagnosis. For five months she went to one back doctor after another, one visit for an MRI scan that was misread, several appointments with her own doctor who told her what she wanted to hear (that she was alright) and then, in a traumatic meeting in June 1993, she was finally told the truth. The breast cancer had spread to her liver – that was the pain – and her bones. This prognosis was delivered in a Scottish surgery in the town of Dumfries near where we lived. We went in to see the oncologist who regularly came from Edinburgh, a pleasant doctor who, like those in the NHS, was hard working, and with little spare time on his hands. She later recounted the experience in a home movie made for her mother, and her wry irony sums up a situation that was to recur. It crystallized our thoughts:

*View from Maggie's Dundee: taking one's pains to nature, the architecture frames the River Tay and distant mountains.*

Charlie and I went to Dumfries and the doctor there said, 'I think you ought to see the doctor who comes every week from Edinburgh.' . . . So we waited in this awful interior space with neon lights and sad people sitting exhausted on these chairs . . . and the nurse said, 'Could you come in?' And then we saw this doctor from Edinburgh, and we said, 'Well, how long, how long have I got?' And he said, 'Do you really want to know?' And we said, 'Yes we really want to know.' And he said, 'Two to three months.' And we said, 'Oh . . . !' And then the nurse came up, 'I'm very sorry dear, but we'll have to move you out into the corridor, we have so many people waiting.' So we sat on these two chairs in the [windowless] corridor trying to deal with this business, having two to three months to live. And as we sat there various nurses who I knew came up and said, very cheerfully, 'Hello, dear, how are you?' 'Well,' managing a laugh, 'I'm fine.'<sup>1</sup>

She smiled at this ludicrous situation. Most revealing in her account was the plural usage. She and I and our two children were in it together. Cancer patients always need someone close by to help them negotiate the very difficult terrain, someone to 'care' for the myriad problems as they arise. As families with cancer know, it is an enveloping situation that affects all areas of life: how do you break the news to loved ones, how to get a loan, where to buy a wig when chemotherapy kicks in, and how to face death. These are the kinds of social and psychological situations that come with cancer, often drag on for months and are very good reasons for having a cancer *caring* centre beside every major hospital.

But there was not one next to the Western General Hospital in Edinburgh, the place where Maggie was to fight her cancer and go for weekly chemotherapy treatments for



the next eight weeks. Instead, we encountered a new version of that ludicrous situation. On every visit to recharge her chemo-drip we had to wait in this windowless box and avert our eyes from the other possible victims on death row, sitting opposite, just six feet away. All one could do was hide behind a well-worn copy of *Hello!*, another version of penitential cheer and 'have a nice day'. The weekly visit to this cramped cell became associated in Maggie's mind with the affliction and the chemotherapy. This was Architectural Aversion Therapy banded in by celebrity-tat, and it formed our resolve. As Maggie was later to write in *A View from the Front Line*:

... waiting in itself is not so bad – it's the *circumstances* in which you have to wait that count. Overhead (sometimes even neon) lighting, interior spaces with no views out and miserable seating against the walls all contribute to extreme mental and physical enervation. Patients who arrive relatively hopeful soon start to wilt.<sup>2</sup>



Page and Park, Maggie's Centre Inverness, 2005, a green copper transformation of the mounds to either side. The landforms and layout of the building are designed around the idea of mitosis, cell division. Architecture and landscape are thus related through content and form, as the building turns the vesica shape of the cell, and mounds, upside-down.

She goes on to mention the need for a private area, 'an old-fashioned ladies' room – *not* a partitioned toilet in a row,' which 'supplies privacy for crying, water for washing the face, and a mirror for getting ready to deal with the world outside again.' Such facilities would seem fairly obvious for a place where one confronts life and death issues, and indeed they are becoming more common near cancer wards. But the issue is deeper than an old-fashioned ladies' room, as I have heard on several occasions from patients who have used Maggie's Centres. They have told me, with considerable emotion welling-up close to tears, that the centre provided a place for them to go – away from their family, their business, the hospital – and have a good cry.

The ambiance of Maggie's, the calm dignity, the sympathetic attitude of the carers in this environment, all made the difference in their fight with cancer. Their gratitude was palpable. Maggie's gave them a place to confront their myriad problems one at a time, and share such experience with others so afflicted. The special kind of architecture was humorous and thoughtful, provoking but informal, contemplative and risk-taking. It allowed them a self-transformation over time from someone in a state of crying shock to a clear-eyed acceptance of their plight. It encouraged the kind of transformation, as I will explain, that Maggie herself went through.

Perhaps there is no typical experience of cancer. In Britain, one in three people now get it and, as life expectancy goes up, the figure is set to rise to one in two (as it already is in parts of Scotland). But there may be no typical situation because there are over 250 different types of cancer, each with its particular history and genetic profile. There are, however, several common circumstances that a patient faces, among them the mind-numbing field of choice and yet more problems to confront. Coping with any particular type of the illness is a traumatic experience, as well as a family and social problem. When one is faced with this life-threatening disease the first question is often the one that Maggie asked: 'Well, how long have I got?' Or, 'Will I live?' The aim of the centres is to transform such questions into 'the will to live, or live better'. Self-transformation is at their heart.

## THE POWER OF THE HYBRID BUILDING

This book is primarily about the architecture of Maggie's Centres, not about cancer, but it does not make sense to separate the two completely and, as I hope to show, the



metaphors that underlie them both have to be thought about deeply for they steer us in certain directions. We have created these buildings with patients in mind yet have also learned a lot from them as this strange building type developed. It is an unusual one today, radically mixed in functions and moods, a cross between several existing types.

Informal, like a home, a Maggie's Centre is meant to be welcoming, domestic, warm, skittish, personal, small-scaled and centred around the kitchen or place to make coffee and tea. The centrality of food and drink allows people to enter and exit without declaring themselves, try things out, listen or leave without being noticed. You can insinuate yourself in the kitchen on any number of pretexts without having to sign up to anything, or fill out an NHS form. This primary role of informality I have termed 'kitchenism' to give it a kitsch and memorable tag, but it is just one more function and mood in a set of contrasting ones. For instance, there are places for different kinds of group meetings: for therapy sessions, lectures and physical activity – artwork, encounter groups, relaxation, and tai chi. This kind of generic space is more of a public background than domestic foreground.

Then there are private spaces where economic and psychological questions are discussed: small, intense rooms

that may look out on a tiny courtyard, or have a striking set of paintings, or a collection of stones, or the kind of artifacts one finds in a home. These rooms do not look like Freud's inner sanctum with its consulting couch, but they may be the place where one confronts fundamental issues or asks existential questions that follow on from 'How long have I got?' The spiritual and occasionally religious significance of what happens here may be recognized in the ambience. Finally there are the gratuitous spaces: the gardens, the architectural gestures, or sculptures, or collections of nick-nacks that exist for themselves. As Philip Johnson once opined, 'architecture is the art of wasting space', a quip that did not endear him to hardcore functionalists. The point is that architecture, like the other arts, must follow its own internal logic in places, and do so to create its special quality. And this architectural delight or humour or sensuality affects people in Maggie's Centres; it supports more attitudes than simply the functional ones. It makes the long haul of healing and dealing with cancer a direct part of the rest of life, of everyday culture, not a rarefied or taboo experience. Patients tell us that the architecture makes their smashed egos

*Maggie's Fife, Kirkcaldy, 2006. The space turns its back on the black car park and opens on to a green oasis.*





expand again, makes them feel important and light-hearted. I have heard this enough to start believing them.

If one focuses on the variety of functions then the typical Maggie's Centre can be seen as a kind of *non-type*. It is like a house which is not a home, a collective hospital which is not an institution, a church which is not religious, and an art gallery which is not a museum. At least four different building types are combined in this hybrid, and the amalgam makes them more effective in carrying forward their work. Why? For one thing it creates a sense that everyone is in it together, patients and fundraisers, carers and those who drop in for tea, staff and doctors. This informal continuity, the mixture, overcomes the sense of isolation that usually divides a business into the centre and periphery. Beyond such immediate benefits the blend of functions has also made them of more interest to architects and students, especially in a period when many building types have been reduced in scope to a single use.

Surprisingly, architects now come to us and ask to design one, perhaps because of this mixed usage. They do not ask in order to make money, since the building is usually small, a mere 300 square metres (and sometimes they donate their fees). Moreover, their interest is not just a question of wishing to be associated with celebrity-architects (though this cannot hurt). Rather, I believe, it is the challenge of a meaningful and caring commission in the Age of Shopping.<sup>3</sup> They deal here with an emergent building type that is not quite a museum, church, hospital or home but has aspects of each.

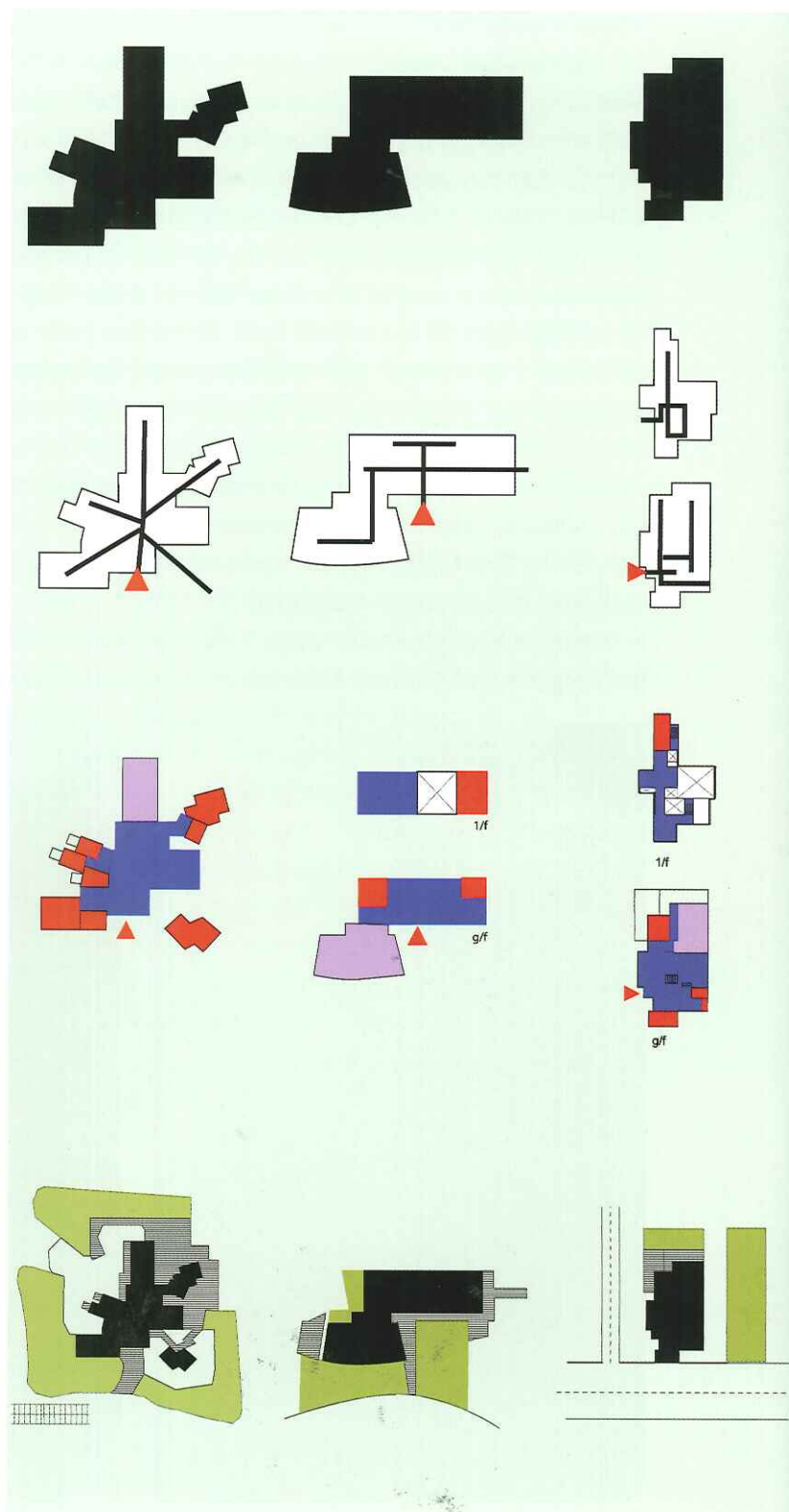
In this sense, maybe Maggie's Centres are typical of another trend, and one that particularly affects hospitals themselves. This tendency is for large institutions to morph themselves into hybrid buildings, and that is because people are now spending so much time in them. The trend is ubiquitous. If we are living longer, and all diseases of aging are on the rise, then the hospital will naturally evolve towards more humane and varied building types. Most obviously it will become like the hotel, less obviously like the small village with a shrine (or a gallery), and places of entertainment. These trends are already visible in Holland, America and Japan.

*Comparative plans. The formal types vary from pinwheel to spiral to donut, but all are hybrid to an extent. The circulation, second row, underlines this variable organization and in all cases one enters into the public space that pivots on the kitchen-sitting room. The bottom row shows the importance of landscape and site for the overall plan. Like open plan houses of the 1880s, the free-wheeling space is layered with surprising vistas and light that comes in from many angles, in sharp contrast to the contained and private rooms. Drawings by Lily Jencks.*

Pinwheel  
Maggie's Hong Kong  
Estimated 2010  
Gehry Partners

Pinwheel  
Maggie's Edinburgh  
1996  
Richard Murphy

Pinwheel spiral  
Maggie's Glasgow  
2002  
Page and Park





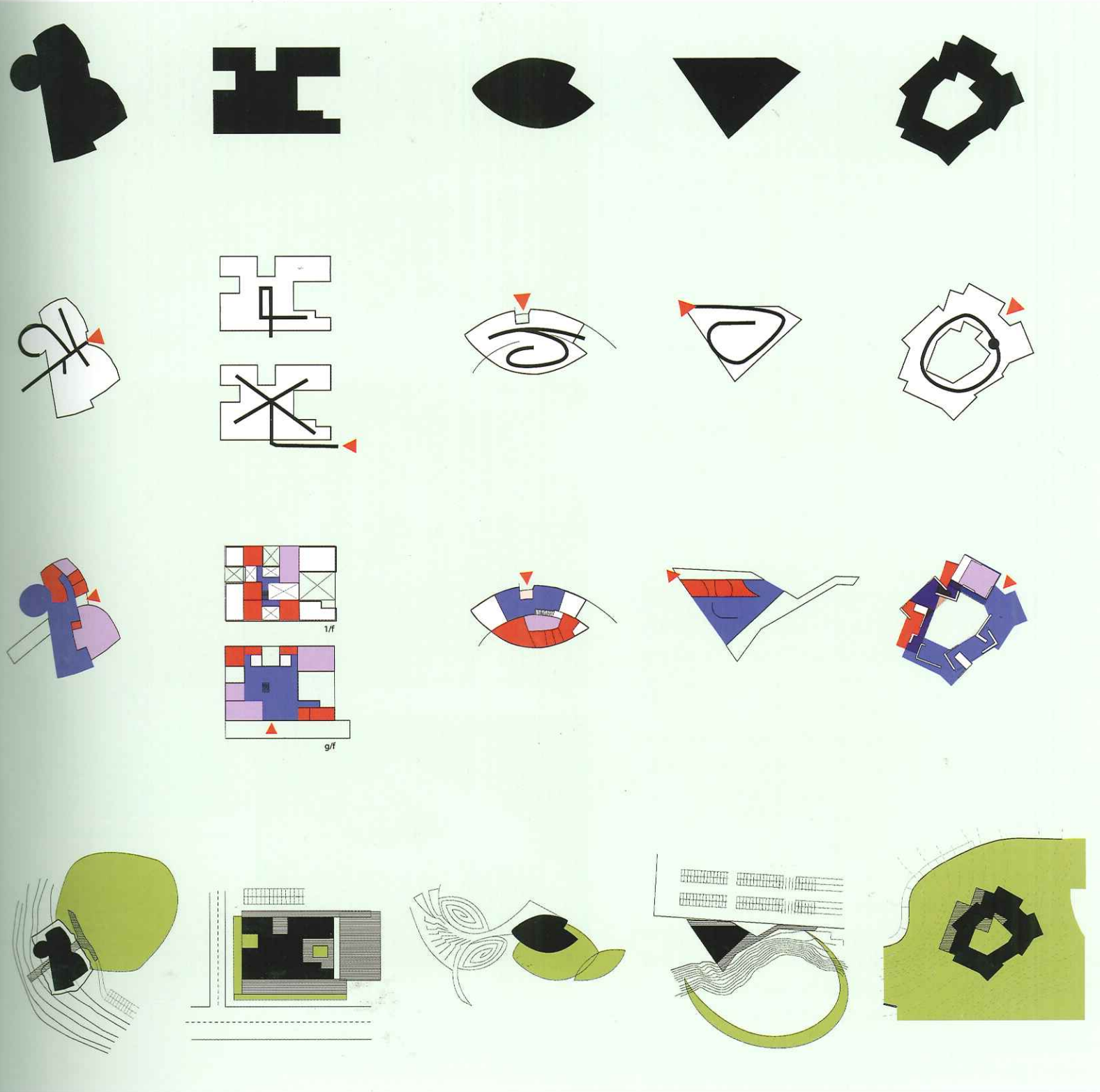
Pinwheel spiral  
Maggie's Dundee  
2003  
Gehry Partners

Pinwheel spiral  
Maggie's London  
2008  
Rogers Stirk Harbour  
& Partners

Central spiral  
Maggie's Inverness  
2006  
Page and Park  
Charles Jencks

Central spiral  
Maggie's Fife  
2006  
Zaha Hadid Architects

Central doughnut  
Maggie's Gartnavel  
Estimated 2010  
OMA



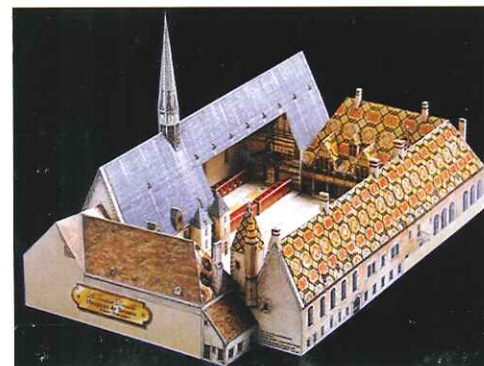
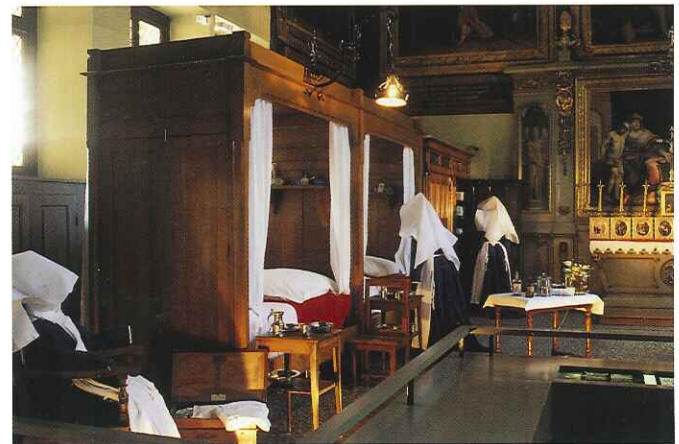


## THE ROLE OF ART

When Maggie and I first set off on our architectural trips in the late 1970s, many years before her illness, we marvelled at such unlikely conjunctions. In the distant past, however, they did exist. There often was a seamless continuity between health and architecture in Europe and Asia, but this tradition seemed to be lost. The loss can be verified by picking up the standard textbook on hospital building today; it shows little record of the past interplay between culture and health.

One building that confirmed this truth, and opened our eyes to the power of the hybrid, was the Hospices de Beaune, built in 1443. We visited it while looking at medieval churches in Burgundy, a hospice that gives its name to that superb red wine. From afar the building looks like an ordinary monastery huddled around a courtyard, but then as one gets closer it turns into something entirely unexpected. The first transformation is the dazzling roofscape, a convincing work of Op Art, about five hundred years before the fact. The pitched roofs and dormer windows dancing over the internal garden are in red, yellow and black tiles. These buzz and vibrate as interlaced zigzags. Maggie saw this covering as a rich garment, equivalent to the sparkling fabric in one of Gustav Klimt's paintings where pattern pulls everything together – bodies, clothing, architecture (significantly, in the 1960s she had designed somewhat Art Nouveau clothes, shimmering with strong colours). Moreover this roof fabric contrasted nicely with what was below, the half-timber Gothic and the garden with its traditional fountain of healing.

Even more startling was the interior of the church, a structure as big as the hospital opposite, religion transformed. Where one usually found side-aisles opening on to a central nave, or chapels with their saintly relics, we now found *beds* – four-posters, swathed in red. Pillows were turned at an angle to face the high altar, obviously to take part in High Mass. Dark red velvet curtains, warm enclosures for whatever might go on, a mixture of the spiritual and the sensual that is often a religious metaphor, set the mind off on an expedition. Would not pilgrims and even the sick make the connection between the dark red wine, of the same name, and the beds? Was the mixture not saying that ill health is a normal part of life, and the hospice a place to find something entertaining, humorous,



*Hospices de Beaune, model and view of the courtyard and beds in the chapel. Set up by Nicolas Rolin in 1443, as the foundation document states it was meant 'to serve and house the sick poor.'*





Rogier van der Weyden, Beune altarpiece, The Last Judgment (detail).  
 Note the way the red Christ and the writhing figures dramatize suffering,  
 a clear allegory for the patients who believed the saviour's pain had a  
 moral significance for them.



sexy? It reminded me of another Johnson quip, of his seeing Chartres Cathedral, as a fourteen year old, when a funeral was going on: 'It was so beautiful I didn't know why I wasn't dead.'

Beauty, optical tricks, mixed use, the magic of surrealism: it had to be an intentional compound. As if to clinch the case, we came upon the jewel of art that also pulled pilgrims here, as much as the building or promise of wine. This was Rogier van der Weyden's altarpiece, a polyptych of *The Last Judgment*. This sermon in paint was obviously aimed at those sick who came to be saved, one way or the other. A classical judgment scene with the archangel Michael weighing souls, it focuses on Christ as the supreme arbiter glowing in a blood-red costume against an explosive golden sky. Those worthy Christians clamber out of their graves, while the damned stumble topsy-turvy, with all sorts of enumerated pain, into their customary and eternal torment. As if this graphic suffering were not enough for a hospice, the polyptych is fronted by Saint Sebastian skewered by his usual afflictions and emaciated as any patient on his last legs. The attendant figures, whether the patron Nicolas Rolin or his heavenly representatives, are wringing their hands in prayer. No question this is symbolic realism with a vengeance, quite different from the abstract or anodyne painting that, in today's hospital, is not meant to disturb the patient.

Whatever effect it was meant to have, the lesson was clear: art, just as much as a fountain and garden, played a central role in hospitals. In the West this generous tradition was not uncommon. Other centres of healing have a similar mixture with superb architectural settings created by Brunelleschi in Florence and Filarete in Milan. I have also seen the way architecture is used as a decent and challenging ambience in Malta, Bruges, Ghent, Santiago and Winchester, enough places to know there is an alternative tradition of hospital building that awaits appropriation by contemporary architects.

Maggie and I had stumbled on another stunning hybrid of healing and culture in Greece. This was the large amphitheatre at Epidauros, famous in architectural history for its near-perfect acoustics and semicircular geometry. White limestone seats curve out to embrace a wild and lush landscape, the epitome of the Greek contrast between beauty and nature to which it is impossible not to respond

– especially when a Greek tragedy is being performed in the waning light. Only later did we discover that it was the most celebrated healing centre in the classical world. There was a large sleeping hall, 160 guest rooms for the sick, a sanctuary, and mineral springs and fountains. Thus health, theatre, art, gardens and culture – the hybrid building task – went back to at least the sixth century BC. It shows a very different idea of what a hospital might be today.

But let me clarify a possible misunderstanding. It was not as if we had the idea of these exemplars as a model for a cancer caring centre. And their mixture of functions, while a necessary condition of their success, is not a sufficient explanation any more than the hybrid building explains the achievements of Maggie's Centres. It is only one suggestive hint in a complex puzzle. To find other reasons for their accomplishments one must return to the way Maggie fought cancer because that story illuminates the caring component of these centres. The term 'fight' is of course a metaphor, like President Nixon's 'war on cancer', a global battle declared in 1971 and still, like the Hundred Year's War, a protracted struggle. The question might be: Is it a good metaphor, or something like the war on terror? Is it a political trap that keeps one from seeing how cancer is a part of life?

## INESCAPABLE INFORMATION AND HOPE

The story is one of constant surprise and shifts of fortune, zigzags of diagnosis and explanation, human mistakes and information overload. All this is germane to the later Maggie's Centres.

We were lying in bed two weeks before Christmas 1987, when I felt a small lump in Maggie's left breast. Naturally we were both alarmed by this; breast cancer was in her family and a cousin had recently succumbed to the disease at the age of fifty-three. So she went for a check-up, a breast scan, and the good news came back that the mammogram showed nothing serious. The following January, just as I was leaving for Los Angeles to teach, I felt the lump again and it seemed to have grown harder. I urged Maggie to go back to her doctor and have a different kind of test. After another week, while I was at the start of the UCLA term, the bad news came that the biopsy showed cancer. She urged me not to return to London, insisting that her doctor said a simple 'lumpectomy' would suffice, because her lymph



nodes under her arm were apparently cancer free. Taking a small lump out of the breast was a relatively easy operation and, if done well, not disfiguring. So I stayed on the West Coast of America and we talked daily on the phone.

After this operation, however, it turned out that the surgeon had 'missed the margins', and there would have to be a bigger, deeper cut. Again I offered to return to her bedside, and our two children who were then seven and nine, and again she asked me not to. Her close friend Marcia Blakenham would be at her side (and Marcia was later to play a big role in helping us start the centres). Having consulted a doctor friend, Adeline Mah, I told Maggie she must bring the cancer tissue or at least its genetic analysis to Los Angeles, because this city has one of the great collections of cancer hospitals. Americans are notoriously good at diagnosis, litigation is at least helpful in this regard, and Los Angeles is an excellent place to get the most advanced treatment and very good advice – lots of it. When Maggie arrived in late January, and we had gotten through the emotional moments of her zigzag experience, we set off to one major hospital after another. My contacts at UCLA and Bob and Adeline Mah had opened a lot of doors, and produced the names of the leading specialists, the 'oncologists' (a word I had not heard before which was soon to become very familiar).

The genetic analysis of her kind of breast cancer was grim. Hers was a virulent type luckily, however, caught at an early stage. The 'stage and type' of cancer are the two basic axes on which one determines the statistical outcomes and the longevity of life, but these verdicts, of course, are only probabilities. During the next two months I stacked up a pile of articles from the popular and medical press, and we began to understand the complexity of cancer, its 250 variants, and the corresponding number of possible paths of navigating through its jungle of choice and outcomes. I kept this growing pile and still do today because it offered the most potent orientation any patient can ever find: the hope of a cure.

Such hopeful information was also inescapable. Even if one wanted to avoid it, or was in denial, the news resurfaces in the mainstream press. If the 'Big C' is a nasty and devious

*The Pile of Hope. Articles in the popular and professional press occur with regularity, often promising an imminent breakthrough. For the patient they become impossible to ignore.*





enemy, there always seem to be 250 new treatments on the horizon, drug breakthroughs with exotic sounding names, each targeted at a particular opponent. Depending on your frame of mind on the day of treatment these bizarre labels can either make you feel sicker, because they are associated with pain and nausea or, by contrast, much more confident about the promises of high technology. For instance, today Glivec and Tasigna can bash back chronic myeloid leukaemia. If you were going for the latest breast cancer drug four years ago it might have been Herceptin, or more recently Anastrozole. You might discover that Sutent works three times better for most kidney cancers than Interferon; Nexavar is a hope for advanced liver cancer, Avastin for bowel cancer – but what about the unpronounceable Cetuximab and Erbitux? One begins to wilt under the onslaught of such labels – or is it bloom? The anti-poetic verbiage of drug companies seems part of a cancer conspiracy to keep doctors on top, a new style of Anti-Art.

Yet because of this information onslaught the patient becomes aware of a counter idea, that of a nascent community, the global army of doctors and researchers heroically massed up against the adversary. A secret alliance might exist, a kind of Freemasonry without the baggage, a coalition united in struggle, with patients drawing strength from each other and the idea that the world's top intellects have been mustered to the cause. This hope has some basis. Online websites are springing up with names such as PatientsLikeMe, blogs and live chat rooms that allow people from many countries to share personal information on drug breakthroughs and side effects for particular illnesses.<sup>4</sup> Almost the second thing a patient will do after diagnosis is to look for allies in the war, and go to the web to find them.

Even if not sought, such news searches one out. Open a quality newspaper and the science reports will feature the breakthroughs that may occur in the next five years. Open a tabloid and the personal victories and defeats will be recounted. One cannot avoid this part of the cancer wars, both scientific and sensational; it assaults the eye of the afflicted, their friends and family. Hence my 'pile of hope' grew into the assorted types of possible cure: hormonal, surgical, radioactive, genetic and cardiovascular (in some cases you can shut down the blood supply to a tumor and stop its growth). There are the many types of chemotherapy,

some of which are very effective (but because it affects the whole body, one top oncologist has described it mordantly 'like saturation bombing, where you kill the enemy, hopefully, before the patient'). There is freezing the cancer out (cryogenics), and one can possibly use the particular cancer itself as a vaccine to alert the immune system, or kick it into action (immunotherapy). These eight weapons each bring the promise of a further innovation in the near future, and there are many more than eight. Wonder drugs proliferate in the media, and the vulnerable mind. Hope has a thousand avenues of inquiry and rare is the cancer patient, fighting for life, who remains unaware of this opening territory. But the information can also be a curse. When Maggie flew back and forth from Los Angeles to London, to see John and Lily, she began to collect opposite opinions. The American doctors, predictably more aggressive, suggested removal of the breast, 'mastectomy' (another word that was to become familiar), along with chemotherapy, whereas the British suggested just a lumpectomy and radiotherapy. This divergence of experts meant another crisis, another jump into the information thicket, and the strong motivation to hack one's singular path through the jungle. I read through medical journals, and then asked an oncologist at Los Angeles' Cedars-Sinai Medical Center for the statistics on mastectomy versus lumpectomy, for Maggie's particular type and stage of cancer. Naturally there were not many articles that fit our situation, but one Italian study of the 1980s came close and it showed a small statistical difference. If I remember rightly it pointed to something like a 10 per cent difference in outcomes after ten years, in favor of mastectomy.

For me this difference was enough, and I said, 'Maggie, if you had a recurrence and you didn't have the operation, you would always blame yourself and be furious. As far as I'm concerned the physical difference would not matter to me . . .' And so she went against her British doctor and took the American route. Later she wrote how relieved she was 'to find I could survive amputation and not feel diminished; my Amazon chest is a battle scar, an affirmation.'<sup>5</sup> The Amazon comparison is a recurrent trope among mastectomy patients. Like those heroines, whose arrow-shooting was more accurate after the removal of one breast, they were proud of making their difficult choice in the war on cancer. Maggie finally had the operation, back



in Britain, much against her doctor's advice. Then, as if to balance the national books, she chose what the British advised, radiotherapy. Today for her kind of breast cancer chemotherapy, with lumpectomy, is the favoured option.

Options, choice, information overload – these are the truths facing cancer patients and they are always accompanied by hope. Wishful thinking is an intelligent and normal attitude. It gets one through the pain and thousand uncertainties, as it does in warfare. Thus it became one reason for her mistaking the metastasis for an old back pain. Like virtually all cancer patients at some stage in their ordeal, she did not want to know what might be lurking in her body; half her brain was in denial to the wishful part. As it turned out this late diagnosis did not matter, since the cancer had already spread and earlier detection would not have made much difference. But the new diagnosis, the death sentence of two to three months, did have a shocking effect on Maggie, perhaps made all the greater because for four years she thought she was cured. The greater the hope, the bigger the crash.

### ‘THE MOST DIFFICULT THING’

Whatever the case, when Maggie got the bad news she basically curled up in bed and started to die, willed herself to get through it with dignity and as fast as possible. She got thinner, smaller, whiter, immobile, and did not want to see anyone. Then, after two weeks of this inward shrinkage – I can't think of what else to call it – something happened spontaneously to both of us. We said something like, ‘Well if we're going to die, let's go down fighting’ – a joint decision. Through my previous contacts I had heard of a philanthropic library in Michigan which had all sorts of cancer literature, and dispensed advice freely. I telephoned from Scotland and explained that my wife had terminal cancer. The woman who answered said, ‘What is the stage and type?’ When I supplied the answer she typed it into her computer and went on, ‘I have eleven medical articles, and four books – what's your credit card number?’ Incredible, an instant global service – the Information Angel of Detroit!

In three or four days the technical papers and books arrived, and Maggie picked up the one called *Options*.<sup>6</sup> She devoured this over the next weeks, getting as much sustenance from its words and examples as she did from the blood transfusions. As she selected a list of options to

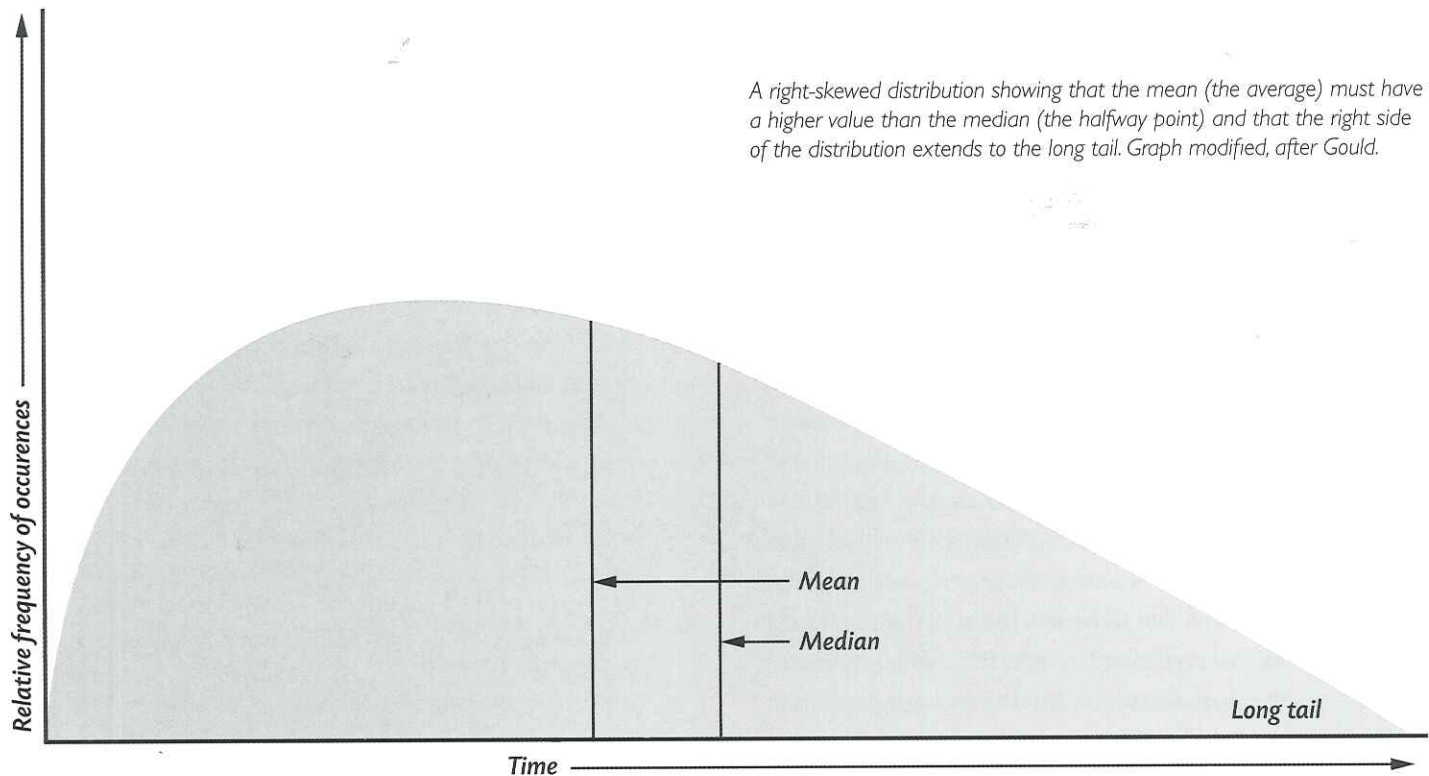
try – some exotic, some extreme, some mainstream – her colour and old fighting spirit returned. Imagination and hope had played a role, sparked off by the information that possibilities outside the mainstream existed. Liver transplant? Risky trials in Pittsburgh? Coffee enemas in California, extreme drugs, alternative supplements, radical diets – there were a thousand options varying from harmless quackery to an unproven stimulus to the immune system. Later Maggie wrote what sounds like an odd comment on her sudden change of mood:

Eventually, the most difficult thing was deciding to give up the certainty of death for the uncertain prospect of a stay of execution: if I got into the fighting mode, and it failed, would I ever get back to this precariously balanced acceptance?<sup>7</sup>

How strange. It would not occur to me *not* to fight. But as I reflect on her situation and words they now make sense. Her previous withering in bed was a tough *conscious decision* to reconcile herself to death, a psychic balance achieved through great willpower and hard mental work. To point out the obvious, terminal cancer is not just a physical condition but something that demands you either take an active decision to fight or hurry to its conclusion. The sudden change of heart may have been a random event on both our parts, but the new conscious decision to fight was definitely inspired by the book *Options* and the other literature we received from Detroit. As Maggie wrote of another article I gave her, one by the scientist Stephen Jay Gould on his own cancer, ‘The Median Isn't the Message’ – ‘knowledge is power.’ The knowledge, in Gould's case, was not to confuse the median of the statistical curve, where half the people die, with your own cancer (see illustration overleaf). So the lesson was to see if your background, personality and orientation can place you far to the right of the curve, to its tail, and gain more time.<sup>8</sup>

This apparently simple idea has several parts which have to be unpacked, slowly. Information about possible cures interpreted the right way leads to knowledge, and that inspires hope, which can lead to action and then remission. Each link in this five-part chain is crucial, and is important to the kind of work that Maggie's Centres do when they help patients navigate the information web, and its thousand circuitous avenues marked ‘possible’ cures. It is





the chief reason that I believe 'Maggie's Centres Can Make a Difference' (see page 38). The right knowledge is power and can help you live longer. Maggie outlived her death sentence of three months by surviving two years and one month. She survived that long because she was given the hope through reading and consulting experts, and that led to her trying what was then an exotic high-dose chemotherapy, as well as many other things. Together these many factors – hope, the will to fight, the knowledge of statistical curves, finding out about chemotherapy breakthroughs, exercise, good eating, relaxation therapy – beat the grim reaper. Or, to put it more exactly, multiple factors held off the inevitable for eighteen months.

That experience, and the role of information in it, was a fundamental reason why we set up the cancer caring centre in the first place.

However, I ought to mention the downside of this onslaught by information, especially because Maggie does:

My husband read and rang everything and everybody who knew about breast cancer, in America, in Britain, in France and in Germany. I found this quite exhausting but also that it was necessary to him as his way of dealing with my illness. Friends rang us with news of remissions achieved by the administration of shark cartilage, carnivorous plant extracts, laying on of hands, hydrotherapy, diet, regimes of pills, oxidation. In his

extremely well-balanced book *Choices in Healing*, Michael Lerner likens cancer to a parachute jump, without a map, behind enemy lines.<sup>9</sup>

Her article and the cancer caring centre and books like Lerner's were meant to provide a beginner's guide to enemy territory, but in the end everyone has to construct their own route through the tangled jungle. Every week that we drove to Edinburgh for her treatment I would present Maggie's doctor Robert Leonard with a new set of potential treatments and breakthroughs, reams of articles. These were gleaned from the popular and professional press. The information overload was, no doubt, as exhausting for him as for Maggie. But through this weekly trial we became closer, united in common battle and, I suppose, Leonard became more committed to our cause than he might have been to someone who was passive. In any case, from these encounters both he and Laura Lee did become friends, and then major participants in setting up the centres. Indeed, Laura became the Director, then the CEO, of Maggie's Centres.

Another inspiration in our zigzag journey was the example of Susan Sontag, whom we had contacted previously. In 1975, she was diagnosed with stage-four (advanced) metastasized breast cancer when she was forty-two and given a 'hopeless' prognosis. She had fought the death sentence by challenging accepted



opinion, researching various global options, driven by her indomitable will to live. As her son David Rieff describes this spirit, she would do anything and everything to go on: 'Dying was not an option. The simple truth is that my mother could not get enough of being alive. She revelled in being; it was as straightforward as that.'<sup>10</sup> Sontag read every relevant thing she could until she found one hopeful looking route, and that led to France and the French physician, Lucien Israël. He was using experimental immune therapies combined with chemotherapy. The English edition of his book, *Conquering Cancer* (1978), promoted a message that was unacceptable to the medical mainstream – that 'disseminated breast cancer . . . can be controlled and perhaps cured'. Although Susan Sontag succumbed twenty-six years later to a different cancer, by using Dr Israël's very mixed 'cocktail' she beat her original one. Her willingness to try anything promising, her fearless zest for life, her writing on *Illness as Metaphor*, were all exemplary to Maggie and me.

Through intermediaries Sontag recommended we try a drug called Taxol, derived from the Pacific yew tree, and Tamoxifan. The latter did indeed help Maggie for several years.

This exchange of information is typical. Cancer patients can learn as much informally through contacts and reading as they can through the medical profession, for the simple reason that doctors often do not have the time to help, or to explain the myriad possible drugs. The notion of self-help, essential to Maggie's Centres, was based on incidents typified by our contact with Sontag. When we started planning a caring centre in Edinburgh, I helped Maggie with the article 'Empowering the Patient'. This followed Sontag and others in giving more choice and agency to the sufferer. However, Maggie did not warm to the Americanism 'empowering'. It smacked of the 1960s. So she confined it to final section of her article where she alludes to Sontag's indomitable spirit (and her own). She concludes:

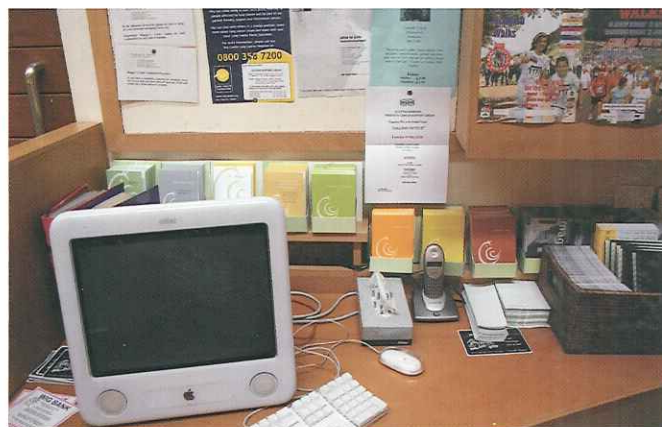
Above all what matters is not to lose the joy of living in the fear of dying. Involvement in one's own treatment is an empowering weapon in this battle. I believe it will be proved in time to make a difference in mortality. . . . But if the next AMAS test shows positive again and the map we've made so far no longer works, there are still other

things to try – and most of them work maybe 20 per cent of the time. Choosing the less expensive (no point in bankrupting my family), those that least disrupt how we want to live, and as many as possible, I mean to keep on marching, down the tail of the statistical curve and on, into the sunset, and then, when eventually I must die, to die as well as possible.<sup>11</sup>

Her prediction came true. Though in considerable pain the last week, she did die as well as possible, meeting friends and carrying forward responsibilities. Even the day before she expired she was planning to look into that '20 per cent' chance of beating the odds. Hope, new knowledge, a breakthrough? Maggie told me that the year from April 1994 to 1995 was the 'best of her life', at least when it came to feeling well and motivated.<sup>12</sup> She worked so hard to eat well and follow a healthy regime that, except for the hidden cancer, she was in good shape. Moreover this was the year that she and I and Laura Lee and others were planning a cancer caring centre for the stable block next to the hospital in Edinburgh. This goal also gave her strength. In the end, she did indeed 'go down fighting', but with the anticipation that something she started might 'come up'. They did, the many centres that bear her name.

Being modest, she might have been displeased with the designation of the buildings. (She said once, looking at a tabloid headline of the then Prime Minister, 'How could *that woman* have stolen my name?') But a self-help institution should be focused on the patient. To give them the right impetus, and not hijacked by professionals, I argued that

*Information module at Maggie's Edinburgh: since the complex information on cancer is often misinterpreted, patients can be coached here as they surf the web. The information area, or bay, is now part of our building brief.*







Maggie's logo, top left, for a cancer caring centre with a bird in a house. My designs tried to incorporate her idea into a classical logo and then were turned into various versions of the CCC logo. This ended with the Bird-CCC which became, along with the word Maggie's, the final logo. Kono design worked this up for many different contexts.

the centres should be named after Maggie. In our research we had come across something like 500 informal, small cancer groups that had been set up spontaneously in Britain. Patients were already leading the way. What they needed in the self-organizing of their groups was a place to meet and a professional carer to steer them. Maggie's phrase for the new building, 'Cancer Caring Centre' also needed a change, I thought, because it was so impersonal. Hence I rechristened it with her name and redesigned her birdcage logo incorporating the three 'C's of her title into the shape of a bird.

Her name and the logo have given the centres the warm identity of a patient, and become a rallying sign for those committed to self-help.

## METAPHORS BEHIND ARCHITECTURE

The Maggie's Centre buildings that are finished, and contemplated for the future, are discussed below by Edwin Heathcote and the architects. This later treatment allows me a few remarks on how they came into being, and some of their qualities, without having to explain them.

The reader will be aware of a paradox. So far, I have been using Richard Nixon's unfortunate metaphor. We are in a 'state of war' with a disease, cancer is 'the enemy', and the path to surround and 'kill it' is through a 'jungle of tangled avenues.' No doubt part of dealing with cancer is a very painful fight that has to be conducted like a military campaign, especially when it involves surgery and chemotherapy. Every week, when I drove Maggie for four hours to and from Edinburgh to get her chemotherapy, we had to stop the car several times because of her back pain, and sickness. This part of the treatment is like trench warfare where one never knows if the chemical bombs are working. But, at other times the cancer is unnoticed, a normal part of life and often dealt with best in a kind of nonchalant denial, as if it were happening to someone else. Both attitudes and metaphors – war and normality – are necessary.

Susan Sontag wrote in *Illness as Metaphor* that cancer is just a disease and not a curse or a punishment. It is not a judgment on your lifestyle and it is highly curable if a good treatment is followed. Her main point is that, 'The most truthful way of regarding illness – and the healthiest way of being ill – is one most purified of, most resistant to, metaphoric thinking.' This sounds bracing. How ironic then, as her critics relished pointing out, that she could never resist this kind of thinking herself, especially when so strongly on 'the attack' against it. Metaphoric thinking is as inevitable as any other kind of thought, and we cannot expunge it anymore than could Sontag. But her strictures carry an intelligent warning, especially in architecture.

In the late nineteenth century and throughout the following one, architects and planners used the metaphor of cancer to describe the proliferating growth of cities, their disease-ridden slums, and decaying buildings. Inevitably with the Modern Movement, and Le Corbusier, the solution became the surgical one – 'to cut it out' – and the replacement became the obvious one: the pervasive hospital metaphor. Modernists fell in love with the white cube, symbol of purity, and soon the blank, sanitized box became





*Maggie Keswick and Charles Jencks at the École des Beaux Arts, Paris, 1981.*

the solution for modern art display.<sup>13</sup> Maggie and I spent a good twenty years bemoaning the results of this fumigation, 'the vacuum-cleaning period of architecture', where every building had to be sterilized in appearance and as hygienic as an operating theatre, even later with its purified guts hanging out (as in its late-modern incarnation).

As an alternative post-modern architecture, like the post-modern medicine we were advocating in 'Empowering the Patient', was meant to be richer in breadth and metaphor. To the neutered and disinfected city it brought new ornament, symbolism and humour. In fact, the emergent post-modern movement had brought us together in the first place, when Maggie was a student at the Architectural Association in London, where it provoked a heated debate even between us. Incidentally, it crystallized her thoughts on the importance of Chinese gardens, and their difference from Japanese gardens in metaphor and meaning. We enjoyed the exchange of opinion on these subjects, wrote articles together and often went on lecture tours as a pair, she talking on the Asian garden while I spoke on contemporary architecture.

During the early eighties my focus was on post-modernism across the arts, a particularly hot subject in Paris, where we were a double bill at the École des Beaux Arts. Thus shared interests and overlapping careers meant that sometimes we worked as a team.

One of the post-modern seminars Maggie and I organized was on the subject of a book by the linguists George Lakoff and Mark Johnson.<sup>14</sup> In *Metaphors We Live By* (1980) they showed how cunningly persuasive this mode of thought can be. Everyday metaphors of the body, and human relationships, pervade all thinking, not just rhetorical speech, and drive us in certain directions. They insinuate themselves into language like vermin, like the war on cancer, like the advertisement of which we are unaware.

Such ideas and developments were the background for our choice of an architect in 1994. However, we accepted architects of all persuasions and welcomed multiple





*Richard Murphy, Maggie's Centre Edinburgh, 1996, exterior and garden design by Emma Keswick. Note the George Rickey sculpture, left, with its L-shapes rotating gently in the wind.*



metaphors for a building, even mechanistic ones, aware that the symbolic aspect of the post-modern argument had been won. Pluralism now reigned, or at least a wide market choice of styles and approaches. We interviewed and examined five architects, but after some thought rejected the large professional office in favour of Richard Murphy. He had a small office of three draftsmen, and a reputation as a disputatious character, but several important commendations.

Murray Grigor, our friend, had recommended him as a designer who excelled at small conversions. Murphy had written a sympathetic book on the Italian architect Carlo Scarpa, the master of interweaving new and old buildings, so already he had celebrated in writing those qualities we sought. Finally, he had converted the kind of dour stone building that we had been offered next to the Western General Hospital. Ours was an old stable block made from heavy greywacke, the kind of stone that tends to turn black with age and soot contributing to the nickname for Edinburgh, Old Reekie. Murphy threaded this tough fabric with coloured steel and glass brick so the contradictory



materials enhanced each other; like Scarpa he made a subtle art of rehab. It was 'post-modern complexity and contradiction': the hybrid building.

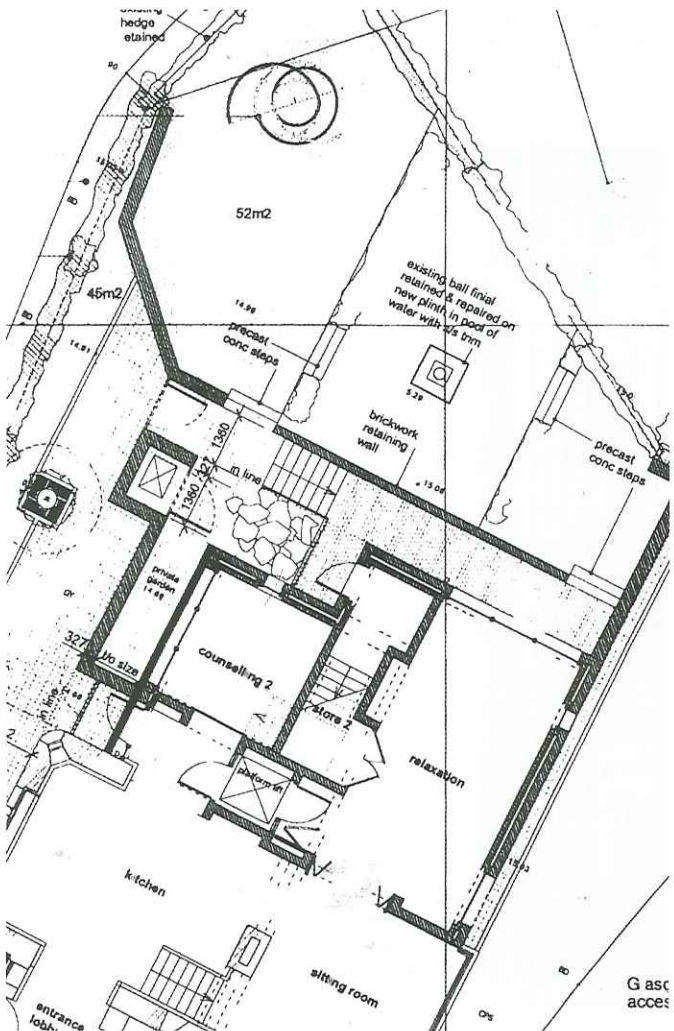
As Richard and Maggie worked on plans, and she developed her 'Blueprint for a Cancer Caring Centre', there were differences of opinion. I took the role of representing the architect and said that it was her job to be the taskmaster, an insistent functionalist. This duality of roles worked quite well. The result in the first centre at Edinburgh is a set of intimate spaces, with light and views penetrating in unexpected places. Conceptually it has the tight layered space of a Chinese garden (about which Maggie had written extensively) crossed with high-tech jewelry.<sup>15</sup>

Later, after Maggie died, Marcia Blakenham and I continued her role and asked the architect for more light, more dynamic colour and more juxtaposition. We drew a central skylight and suggested bright hues. Richard was annoyed. What good architect is not put off by modifications

of his view? But he responded with counter-schemes, and thus the dialectic between architect and client continued. Later, Marcia and Laura Lee added informal furnishings – deckchairs and polychromatic pillows – and the light-filled space started to feel like a cheerful version of a Queen Anne Revival home c.1880, something by Norman Shaw or early Frank Lloyd Wright. Window seats were crammed on to stair-landings, pocket-sized offices open out on to shared rooms, a dripping fountain takes up most of a tiny courtyard space. In the 1880s, had they bothered with 'isms', they might have called it 'inglenookism'. Most Maggie's Centres have these tight, surprising corners and ambiguous overlapping spaces, like a late-Victorian house. They are good for informal chats between patients or with an oncologist.

The next centre was also next to a major hospital, again a converted building, and once more a sequence of tight and informal spaces. David Page and his team converted a nineteenth-century gatehouse which opened on to Glasgow

*Maggie's Centre Glasgow, 2001–3, conversion of the Glasgow University Gatehouse by Page and Park Architects. This was an old entry to the campus with mannerist contrasts: big gables versus small walls.*







Page and Park, interior of the Glasgow Centre showing the spiral of space, starting from kitchen, top left.



University and the Western Infirmary. It is a beautiful site that fronts the side of a rolling green park with a lot of mature trees, some steep hills and a brook at the bottom. Maggie's Centres have always sought a site with some planting and dramatic landscape as close to the big hospital as possible, and here we were lucky to get it. As the plan reveals, the Queen Anne Revival layout allows semi-public space to flow around the entry and stairway. One enters unobtrusively and turns into the kitchen for a snack and then continues, on a spiral route, to more private spaces for consultation or the offices on the top floor. Again, the way all the staff, carers and patients are brought through the same, multi-use space works to unify the team. Such things as office work and fundraising become less abstract, an integral part of the 'war on cancer.'

As with the Edinburgh building, art and some prints by Eduardo Paolozzi, who was a close friend of ours, punctuate the space. These works give the feeling of having been chosen for a particular context, which they have been, by Marcia Blakenham. For the back garden, I was asked to design a DNA sculpture and, like the building itself, it is an oversize structure in a small space. It has that big-smallness that was current and enjoyed when the gatehouse was designed in the late-nineteenth century.

It is my hope that works of art and landscape become as important to the programme as the architecture, that they become an essential part of the brief. Partly this is happening and evident in the next building we commissioned, the one in Dundee designed by Frank Gehry, an old friend from Los Angeles. On the outside, mediating between the large hospital and the small centre, is a landform and labyrinth that the garden designer Arabella Lennox-Boyd has conceived (see overleaf). The unicursal maze, with only one path leading to the centre, is based on the one at Chartres, where the symbolic goal for the pilgrim is Jerusalem or the Heavenly City. At Dundee the labyrinth is walked as a form of contemplation for the patient, a journey of twists and turns leading to a possible cure. The earth berms to either side give the health pilgrim, if one can call cancer patients that, a psychic enclosure as turf frames the sky.

Such cosmic framing is similar to the way that, inside the building, Frank Gehry outlines a view of the mountains and River Tay. He borders this heroic prospect with a square window topped by a visor. It is the culmination of

the meditation room placed in a tower above the library. In the sense that a picture window isolates the vista, like a painting of nature, this part of the architecture can be seen as a self-conscious work of art. It cues one to the other works hanging on the walls. Among them are Christy Love's *Photo of a caravan with a trompe l'oeil forest scene*, Grayson Perry's *Politician*, and Tarka King's *Scots Pine*, 2003. None of these works attempt to deal with cancer or the healing subject – life and death. None aspire to the condition of the Rogier van der Weyden at the Hospices de Beaune. They are striking and amusing set pieces, not paintings of the first and last things. Arabella Lennox-Boyd's garden outside is the big, involving work that engages the patient, the labyrinth that asks to be walked.

My own view, not widely shared, is that every Maggie's Centre should have at least one challenging piece that addresses the fundamental issues patients face. If artists do not take risks and attempt to deal with life and death in their art, how can we expect the patients to try to make that 'most difficult choice' of self-help, or to fight instead of give in?

'Hospital Art', to name the genre that Grayson Perry has criticized so directly, should not be, in the first instance, functional.<sup>16</sup> Anodyne painting and sculpture, the bane of public art, is to be avoided. As Perry points out, when art is commissioned for a hospital it must be accepted on its own terms as a provocation not as a consolation. Some of the most challenging works of the past were painted for the ill, and one can even find solace of a kind when suffering is forcefully presented in art.

Gehry's building, by contrast, is friendly, even cheerful. With its crinkly roof inspired by a Vermeer ruffle and its squat tower recalling a lighthouse, the architecture conveys a quizzical power. This welcoming image was enough to make it a local icon and also the object of a first class postal stamp. At the opening, Bob Geldof referred to the swelling bulge of the tower as 'Gehry's self-portrait as a dumpling' – an affable metaphor. Patients and staff find the unusual forms engaging not threatening, the roof beams splayed at odd angles something to contemplate during group sessions in the kitchen. Good architecture has the role, as T.S. Eliot said of poetry, of becoming 'a superior form of distraction', a higher kind of visual music.

What we did not contemplate when commissioning the building is that architecture could give Maggie's Centres

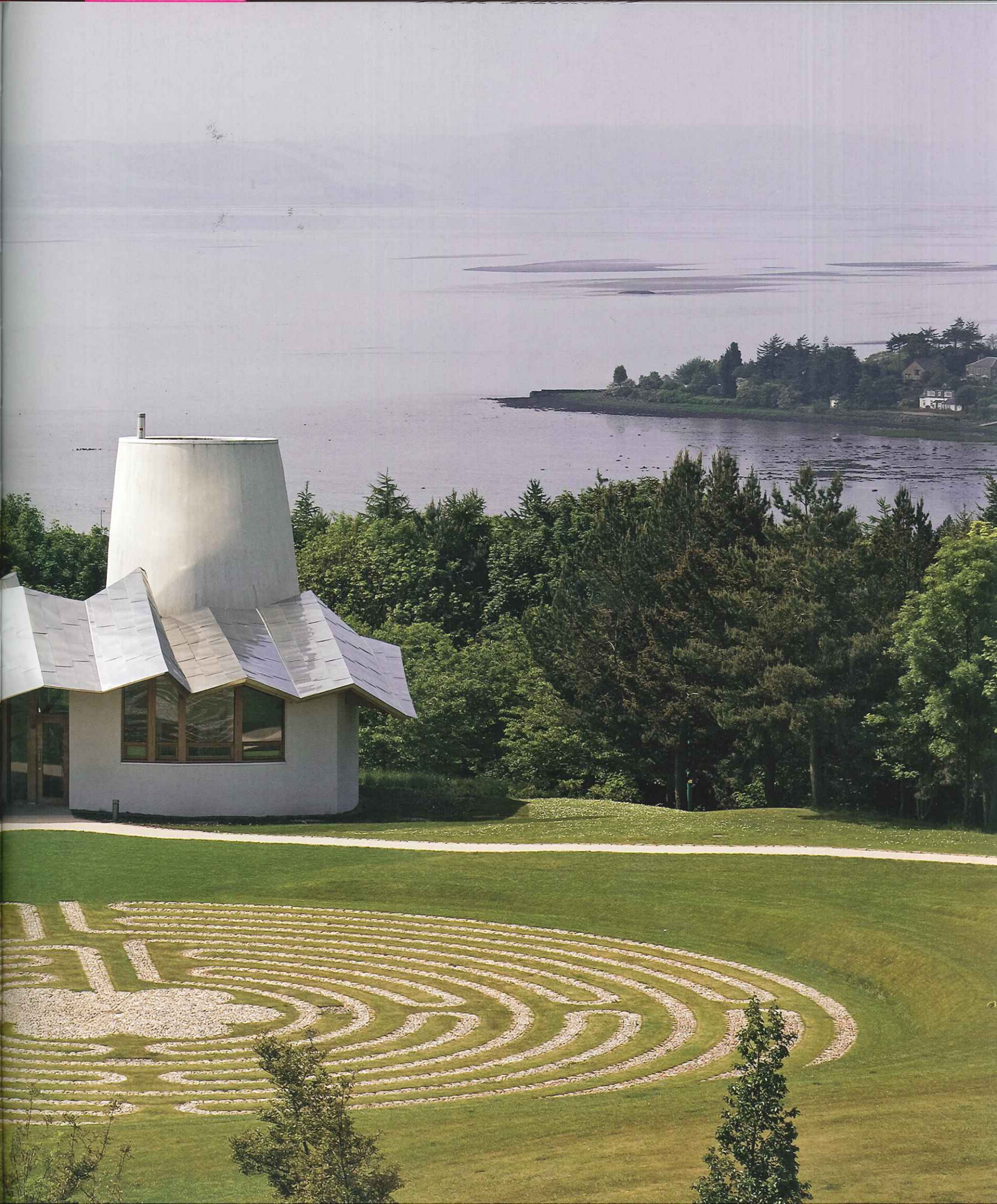




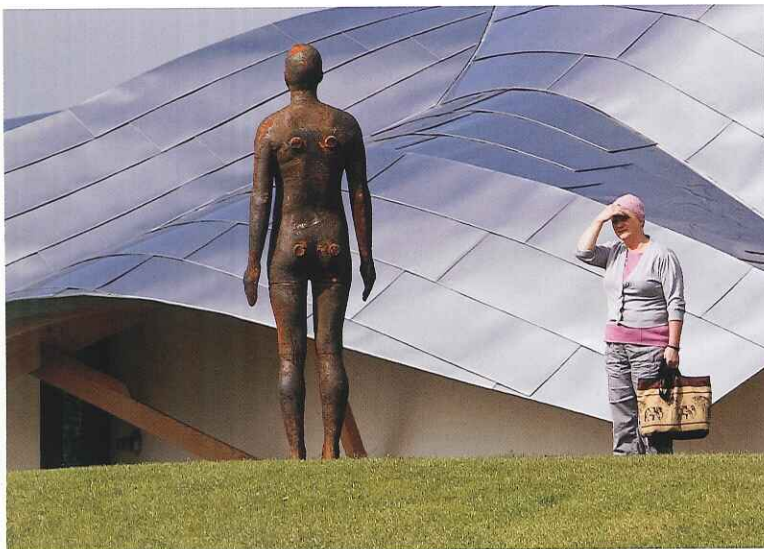
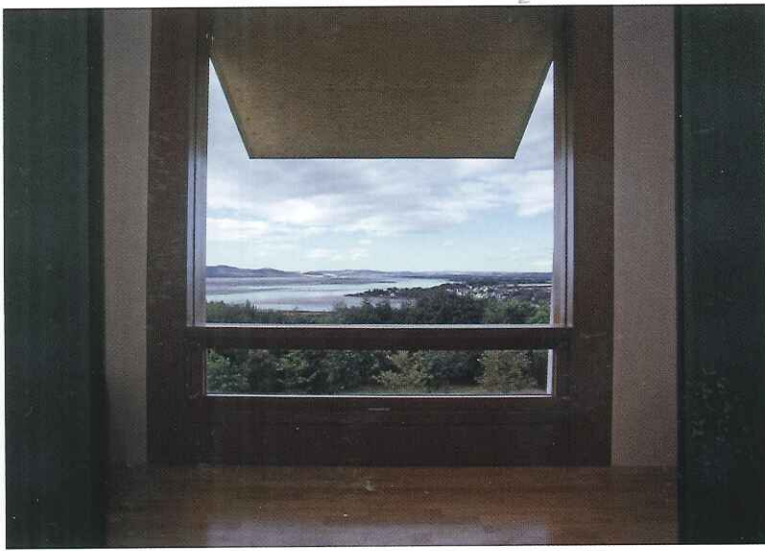












PREVIOUS PAGES Arabella Lennox-Boyd, Dundee garden labyrinth and landform (2008). TOP LEFT Dundee meditation room: nature framed. The visor and window frame signal the view, rhetorically. LEFT MIDDLE Christy Love's Caravan with a trompe l'oeil forest scene. LEFT BELOW Antony Gormley, Another Time, cast iron (2008). ABOVE Grayson Perry, Politician, etching (2003) and Tarka King, Scots Pine, oil on canvas (2003).





*Gehry being photographed at Dundee media feeding frenzy: as his expression implies, the medium here is the message.*

a media presence and play a significant role in funding. Presently we must raise about £6 million per year to run our six centres and initiate new ones. Architectural presence has helped in this task considerably, and none more so than Frank Gehry's. As a result of his New Guggenheim in Bilbao, which opened in 1997 to world acclaim, Gehry had become the architect of the moment. So when the design for his first British building was announced in 1999, and an exhibit on it was held at London's Soane Museum, the national media amplified the job into an event as weighty as the New Scottish Parliament. The result was more column inches and magazine spreads than could be justified by building a mere 300 square metres. No one complained but, except for Derek Douglas, the then Chairman of Maggie's, no one had predicted it.

Given the subsequent history it may be hard to believe but we did not set out to commission celebrity architects. Most of them, nine of the first twelve, were old friends

such as Frank. Our families sometimes went on vacations together. In the intervening period, from the time we first met them to the time of their commission, these associates – in particular Zaha Hadid, Rem Koolhaas, Daniel Libeskind – had become famous. Only Richard Rogers and Kisho Kurokawa were well known before we met them and even in these cases they were close enough to be frequent dinner companions. So, what looks to the outside world as a policy of architectural head-hunting is, in reality, the consequence of finding that when an architectural historian grows old enough some of his acquaintances have become notorious. One would not be a very good critic if this were not the case. Still, it is gratifying that Gehry's fame and exemplary architecture amplifies our message.

What remains a mystery is that, given the powerful role that architecture has played in furthering our goals, I cannot understand why other British institutions have not followed the lead. Possibly it has something to do with the unique way our building task lends itself to architectural expression. Is it that iconic architecture is only justified



for such jobs as a cancer caring centre? Or buildings that may have a public and spiritual role? Whatever the case, by commissioning well-known architects a competitive situation has developed. This means that each designer knows that the bar has been set fairly high by the previous work. Competition keeps these architects on their mettle. It is probably also assumed by them that the media will quickly note any falling off in effort or skill. Already, I'm sure, with so many high-flyers, the press is dying for us to crash.

If these small buildings are mini-icons, and multiple metaphors, then it raises the question of content. To what do the metaphors allude, to what iconography do the icons relate? All the buildings taken as a group are colourful and basically upbeat: the war on cancer is not the primary note they strike. Their domesticity and slightly unusual shape suggest they might be the friendly clubhouse of an obscure religious sect dedicated to golf. However, the metaphor of 'normality' (which some people may have problems seeing as a rhetorical trope) is also very strong. Tea and cushions – 'kitchenism' – is the recurrent keynote. It displaces the fact of cancer from the exotic and horrific into the everyday and accepted.

## MIXING METAPHORS: CANCER AND BUILDING

When asked by Page and Park to design a garden for Maggie's, I alluded to all sorts of natural developments: at Glasgow to DNA and RNA, the unfolding of information in the cell. At Inverness I have used forms that relate to mitosis, to cell division and the proliferation of cells, to the balance and communication between cells. Obviously these metaphors are germane in the war on cancer, and probably also in the back of the patient's mind when wrestling with its causes. But there are further reasons for them, in the age of the iconic building. Given what is called the 'Iconic Arms Race' in architecture, I think it is important to develop an explicit iconography that transforms the discoveries of the natural world, one that can provide suitable icons for expression today.<sup>17</sup> Such shapes relate to the cosmos and, as long as they are creatively mapped on to other metaphors and uses and not merely illustrations of science, they can be fitting and powerful. At the Maggie's Centre in Inverness, we have

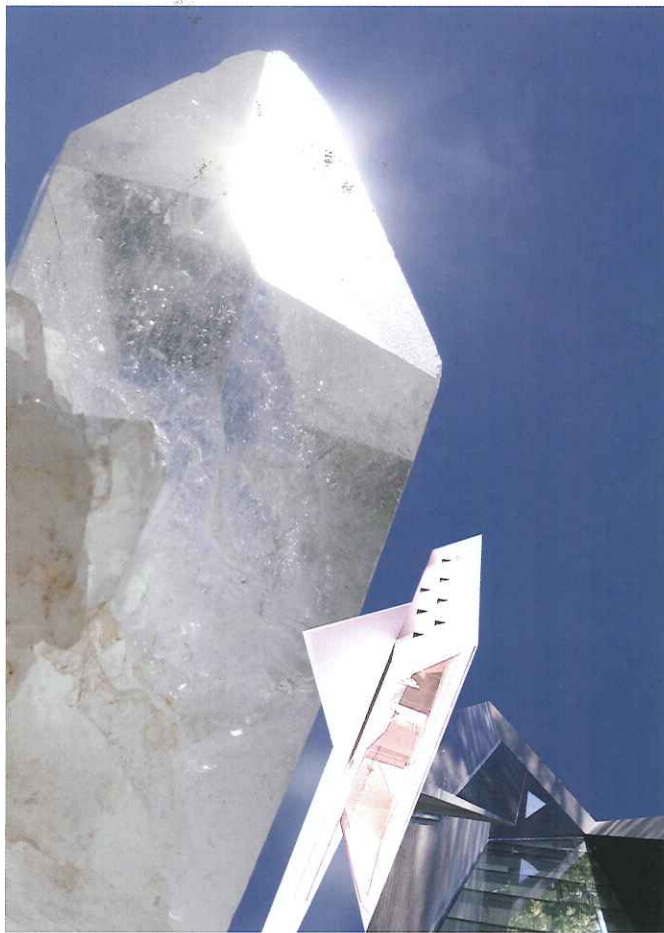
shown a cell at the huge scale of a green building. It is splitting into two parts to become two turf mounds that have white flashes connecting their centres, understated metaphors of the real signals that keep cells in balance and healthy.

When Zaha Hadid's design was opened in Fife, in 2006, there was an outcry among a few architects who saw in the black angular shapes the metaphor of war and pain, Darth Vader and death. Richard Murphy gave us advice on how to design a proper Maggie's, and *Building Design* carried four letters from aggrieved architects.<sup>18</sup> Such reaction is understandable and even welcome, for a building task that is potent and not settled. Who is to say how it should be treated? In this case much of the criticism came from those who had only seen the photographs and did not perceive the other metaphors. First of all the black asphalt-like surfaces are a continuation of the adjacent car park, but it is continuity with an important difference. The black material has a much warmer quality than macadam, containing a silver fleck, and this makes the feeling more intimate and friendly. Second, the overall

*Aerial view of Inverness Maggie's showing mitosis of cell division – the building splitting – and two cells communicating and in dynamic balance.*







*Maggie's Fife. Zaha Hadid speaks about the importance of a folding surface and the green hollow on to which her building opens. Other metaphors which are equally plausible are a crystal and a flying wedge, but the building's drama depends on strong contrasts. Like a geode, a hard black surface suddenly turns into a glistening interior which sparkles with light and the stunning views of nature.*

shape is very much a mixed metaphor as the flat planes of the car park are folded into an origami version of a flying wing. This hovers over a surprising and contrasting green dell. The interior also has maximum contrast with the black, and it is this light-filled whiteness put into direct contact with nature – the trees and the hollow below – that becomes the basic experience of the patient. Again, as in all the centres, there are multiple metaphors in play – origami, minimalist wedge, quartz crystal – but it is the relationship of the building to its natural setting that is the strongest.

For several other centres nature has also become a referent. In *The Iconic Building*, I argue that the hidden code of iconic buildings often refers to nature and the cosmos, and the challenge is to make this implicit metaphor at

once enigmatic and, at points, explicit. While discussing the centre designs with architects the question of veiled versus overt symbolism often comes up. Wilkinson Eyre is working on a 'treehouse' for Oxford and Piers Gough is designing a 'house in the trees'; here the location and some of the details are obviously green, but the angular geometry of the former and Palladian layout of the latter resist a single reading. Kisho Kurokawa, an old friend of mine for more than forty years, finished designing a 'whirlpool galaxy' for Swansea, something we worked on together just before his untimely death in December 2007. Foreign Office Architects in Newcastle and Rem Koolhaas in Glasgow are designing centres that defer to the gardens above them, or they wrap around. The landscape becomes, through contrast, the primary subject. From this brief summary it is clear that when they become iconic Maggie's Centres do refer to nature in oblique ways, and this can be highly suitable, even if initially unsettling, as in the Fife centre.

But it is the peculiar metaphor of 'risk-taking normality' that should be stressed. Return to the war on cancer and put oneself in the position of a cancer patient. Should one give in or fight, take an active interest in therapy or blithely ignore it? Is the best policy to try every complementary stratagem that one likes and is not too expensive, as Maggie advised, or just wait while the doctor gets on with the therapy? In terms of survival statistics, there is evidence for the extremes: it pays to fight and it pays (after primary treatment) to ignore the condition.

Yet the attendant psychological problems of cancer, as we were aware, are deeper than this simple antinomy. In fact, the affliction puts one into a classic double-bind and that again suggests that a mixed metaphor may be a good one. Consider the case of 'normal life'. The assumption is that everyday health means we are without illness, whereas a deeper look reveals that everyone has cancer but their immune systems and apoptosis, not to mention anti-oxidants and other things, deal with it first, before it runs away with the cells. Consider, secondly, that even when fighting cancer actively, the patient has long periods of normality, of forgetting the condition and simply 'living with it'. This second attitude has become a conscious metaphor, and saying, of Maggie's Centres. It is not too far from the first truth, that we all already have



it. Or the third one, an ironic epigram: 'Cheer up, if you live longer – as we are doing – and long enough, you will die of cancer. You should be so happy!' In short, cancer is normal to aging, to the mistakes in DNA replication over time, indeed to life.

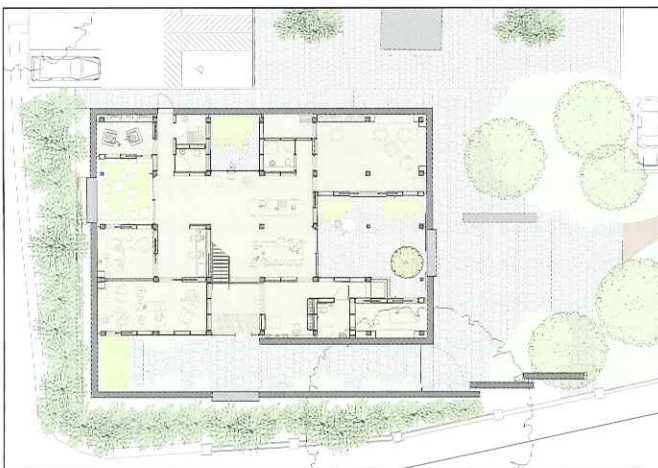
But if one has this 'disease', then it is also very easy to blame oneself even if, like Susan Sontag, one knows that this is wrong. How extraordinary, how human. In spite of her writing against *Illness as Metaphor*, and striking out for years against the self-blame, her son David Rieff came upon the fateful, self-contradicting words in her diaries: 'I feel my body has let me down . . . And my mind too . . . I'm

responsible for my cancer. I lived as a coward, repressing my desire, my rage.'<sup>19</sup> How could the writer who inveighed against metaphor, and expostulated that cancer is just an illness not a judgment, end up writing that?

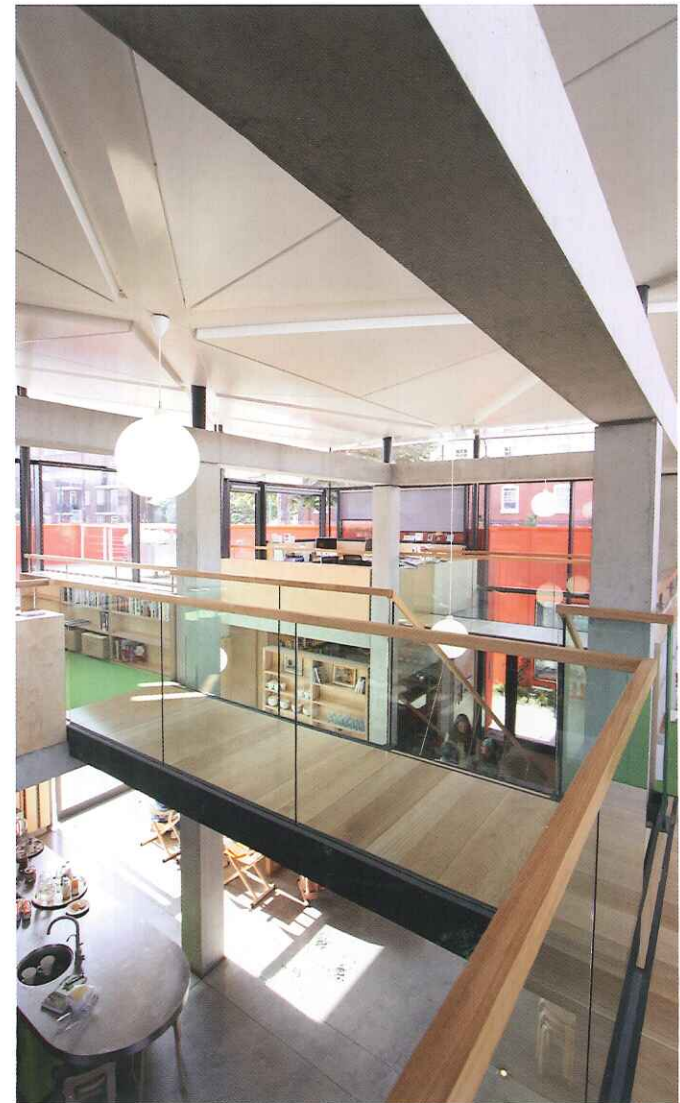
In a classic double-bind you are damned if you do something and damned if you don't. When you have cancer you are bound to know today that effort and state of mind and the immune system can play a big role in the outcome. So, if you do not try hard enough to fight the disease then you are perhaps guilty and being judged if the cancer 'wins'. At the same time, if it is a statistical illness in which conscious action usually plays no difference – and patients



*Richard Rogers with Ivan Harbour, London Maggie's Centre, 2008. The exterior at a busy street intersection leads to an inward-looking wall building with a hovering canopy of a roof. Dan Pearson's garden surrounds the walls and penetrates them. The plan shows the spatial cells as a horizontal and vertical grid of nested cubes that extend to double and triple in size.*



*View through spatial layers and columnar grid opening across floors, a layering known to architects in the 1960s as 'labyrinthine complexity.'*





in total denial appear to do better than those in the middle – then perhaps you are guilty if you do fight it, and add to the stress. Double-bind? I do not know for which side of this dilemma Sontag was blaming herself.

Given this complexity and the attendant contradictions in advice, the policy of Maggie's Centres is again one of self-help, letting the patient decide without any pressure which path to take. Probably for many it will be a zigzag route varying from the war metaphor to blithe denial, periods of painful struggle and forgetful normality. It is these intermittent attitudes which the buildings have to reinforce in style and use.

*Looking back at the entrance porch protected by a high wall from the heavy traffic. The cars and buses, however, are also beautifully revealed as quiet silhouettes as they pass behind the frosted window to the right. A masterpiece of poetic detail.*



Richard Rogers designed the London centre aware of such contradictory requirements. Next to a large NHS hospital and crammed into a busy urban site, this wall-building turns its back on the cars just as a Pompeian house shut out the noise of the street. The orange-red colour, a good stimulant for those feeling weak, is probably also an echo of Chinese red since the designers were aware of Maggie's book on *The Chinese Garden*. These Asian gardens also are the focus of introverted courtyard houses with very high walls and, on the inside, they are a Chinese puzzle of square rooms. No doubt this is an inspired model to follow in a cancer care centre for they too used to promote a complex mixture of functions, just like ours, varying from the domestic to t'ai chi. Architects, however, will see in the plans more than Chinese precedents: for instance, the kind of space that was called 'structuralism' in the 1960s, epitomized by Dutch architects and Aldo Van Eyck's Children's Home. Van Eyck characterized such layered space as having a desirable 'labyrinthine complexity'.

The point of these simple square spaces is that they overlap on each floor and across floors, thus allowing the veiled communication so essential to the centre's activities. They let one insinuate oneself into meetings, to overhear when deciding whether to join a group, or to be private when consulting a specialist. Opening on to glimpsed vistas, and Dan Pearson's gardens, the framed squares attract the eye beyond the horizon. On the one hand, their normality is emphasized in the wood and concrete, tough and everyday but, on the other hand, their beckoning views gently stimulate one to move ahead, into the unknown.

As metaphor the building is a simple 'garden-pavilion' surmounted by a roof with cut-out holes. These openings, with their lightweight louvres in white, give a very attractive dappled light. This makes the hovering planes of steel into the equivalent of filtering branches, the canopy of a tree. It may be a mechanistic image of nature, but then having chemotherapy is rather a mechanistic way of dealing with cancer. Call the latent metaphor by that cliché 'tough love', or whatever oxymoronic figure of speech comes to mind adequate to the mixture: the high orange wall, the steel tree and the labyrinth. It is certainly a mixed metaphor, everyday and realistic, and in some odd ways inspiring.



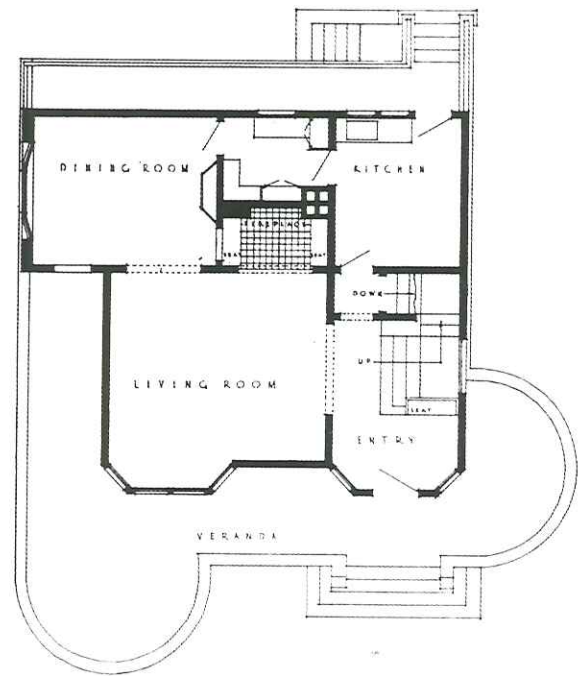
## CAN MAGGIE'S CENTRES MAKE A DIFFERENCE?

All these buildings constitute a genre with an emergent identity. They are experiments in an architectural petri dish, having the same programme but different outcomes. What do they have in common? They are seen and celebrated by some as small iconic architecture, little jewels for a worthy cause, and by others including me as a new hybrid building type with a semi-open plan.

This layout is reminiscent of 1880s domestic architecture in the UK and USA. If the American historian Vincent Scully were writing them up today he might call them after the category he invented, the Shingle Style, because of their similar semi-private spaces (not because of the wood). Frank Lloyd Wright developed this flowing space, centred around an inglenook and fireplace, and his early Prairie Houses show the kind of open and closed rooms that Maggie's Centres also develop. These spaces, like Wright's, combine semi-public living room with entry and stairs as a continuous sequence, but sliding partitions and visual and acoustic privacy are equally sought. To carry out their opposite activities Maggie's Centres require complex and contradictory spaces. The architects have provided such complexity, as much as the mixed metaphor, and these qualities have captured the public's imagination.

Also accounting for their success is interest in the big question, the query that modern hospitals raise, and that architects, the public and the paymasters are trying hard to fathom. It is what I will call the paradoxical question: what effect do Maggie's Centres have on health, and on survival? None at all, a little influence, or a big effect? This is a complex matter, raising many false hopes and not a few reasonable ones. With a book of our title it is important to clarify the several distinct issues, without trying to settle them once and for all. Why is the question partly undecidable? Because the architecture of hope is a projective enterprise involving future cultural efforts, and these are ultimately unpredictable. Nevertheless, certain aspects of the question are now clear, especially the negative ones, and they raise long-standing issues.

In the 1960s many post-modern writers pointed out that the fundamental goal of modern architecture – to change society for the better – was badly put and ideologically motivated. As with all professional ideologies, the modernist claim had the hidden purpose of increasing the power and



economic clout of its adherents, and it operated best when buried deep beneath consciousness. This failing, however, was understandable. Imagine architects or doctors committed to changing society for the worse! Indeed, the ideology of architecture improving society had evolved from Vitruvius through the Renaissance until, with the modernists, it became much more powerful, and underpinned by socialism.

The strong version of this professional attitude resulted in 'architectural determinism' – the belief that architecture and a city's layout determine a culture's daily life and people's behaviour. The idea only has to be put this baldly to appear dubious. Except in the extreme case of a prison, where the layout and the culture are both highly controlled, this strong





*Frank Lloyd Wright, Oak Park House and plan, 1893 (LEFT) and William Martin House, Oak Park, 1902 (ABOVE). Overlapping spatial cells combine entry, stairs and living room with a culmination in dining; other rooms are more private. This early modern spatial opposition was picked up by post-modernists to produce the complex hybrids so typical today.*

architectural determinism (SAD) was easy to refute, and so we did.<sup>20</sup> However, its distant cousin, weak architectural persuasion (WAP), is much more complex and hard to measure, one way or the other. Often framed in terms of the famous feedback loops of Winston Churchill – ‘first we make architecture then architecture makes us’ – WAP sounds irrefutable, especially because it does not specify any conditions. It is vaguely general. So let us mention the specific case.

In a hospital, which is highly controlled socially and functionally, and not a strong culture for the patients (because they lack agency), one might believe that the architecture does play an important role in determining the

behaviour. To clarify this idea, consider a contrasting case, such as a scientific laboratory, where technicians with strong agency are hard at work creating their experiments. There the architecture does not really matter very much, whether beautiful or ugly. Indeed, such scientists – like artists – often prefer a nondescript shed to anything designed.

So, in this spectrum from strong determinism to weak persuasion, from SAD to WAP, where does the architecture of Maggie’s Centres fit in?

It would appear to lie somewhere in the middle, because patients and carers enter these buildings and into self-help under their own volition. They are, however, still suffering from emotional pressures and likely to be vulnerable. Some of them are in tears, having lost confidence and even a sense of worth. Moreover, as I have stressed, the centres’ role is one of transformation, to turn the central question ‘Will I live?’ into the ‘will to live’, or one of our descriptive slogans, the idea of facing the dispiriting situation with equanimity: of ‘living with cancer’.

In this way and others I believe that Maggie’s Centres do make an important difference to patients, both in their quality of living with cancer and in the outcomes. This hunch is supported by many studies including those of David Spiegel. For Maggie too the connection between patient self-help and these hopeful outcomes was very important:

Above all [these books] emphasize the importance of the patient’s own involvement with their treatment; something born out by Bernie Siegel and the Simontons’ findings that ‘difficult’ patients do better than passive ones. By now most cancer professionals must be aware of the psychiatrist David Spiegel’s discovery (so surprising to himself) that, among his breast cancer patients at Stanford University, those who took part in group therapy lived some eighteen months longer than those who did not. Although not yet duplicated in other trials, from down here on the battlefield the results look pretty interesting.<sup>21</sup>

‘Eighteen months longer’ – impressive statistics even from a small sample – and such results continue to support our hunch and add weight to it. Yet some people are confused about what this kind of evidence means. It refers much less to the effect of architecture on health and much more to the work and ethos of what goes on with self-help groups, and the service inside the buildings. With Maggie’s Centres it is



the overall involvement of patients and carers that matters most – the culture more than the building – and the failure to understand this distinction has resulted in bewilderment.

For instance, the British design journal *Blueprint* ran a headline story on ten years of Maggie's Centres with the provocative title 'Can Architecture Beat Cancer?' and placed this question on a lurid red background. Selectively quoting me in the article and editorial to say 'that good architecture really can make you live longer', it made me into just the kind of determinist I had criticized for so long. When I was talking about Maggie's Centres, and referring to what we do, the magazine could only think that it was the architecture doing it!<sup>22</sup>

This was an absurd position, I answered. How could one believe architecture had such amazing powers? Even 'chemo, radio and the thirty or so other therapies that are mainstream practice (even some of today's wonder drugs) do not beat [cancer]'. No doubt the *Blueprint* headline story was intended to stir up controversy and sell magazines, but this itself illustrates my point. There is a lot of architectural passion invested in the hope that buildings can determine behaviour, and a lot of WAPs getting confused with SADs. Let's continue the Acronym-Speak. Since the NHS with its recent PFI programme is spending billions of pounds on hospitals and since architects are a caring as well as self-interested profession, there is a lot at stake. One understands why the feelings run high, but they obscure the heart of the question. Put aside the architecture for the moment, and ask the more focused question about Maggie's Centres: can their activities make a difference?

I believe they can, for five reasons.<sup>23</sup> Firstly, and most obviously, cancer caring centres can alleviate the death sentence, and thereby negate the negative effect of receiving one. It is accepted science that death can be hastened by willing to die, by knowing that it is inevitable and imminent. Thus those patients so affected, as was Maggie herself, can be helped for a stay of execution. This would probably be a small, but statistically meaningful, number of patients.

Secondly, it is also now standard science that excessive stress impairs the immune system. Since Maggie's Centres alleviate negative stress by teaching patients how to navigate through the problems that come with cancer, these sufferers will on the average do better than those who have no such training.

Thirdly, transforming behaviour will inevitably play some role. The positive feelings and complementary therapies that patients get at the centres encourage many of them to change their diet, to exercise and relax. In short, effective physical action may contribute to their longevity. Of course, they might have changed their lifestyle anyway, even if they did not come to a centre. But it is much easier to do so in a guided way, with the urging and example of others.

Fourthly comes knowledge, finding out possible new cures through other patients or by navigating the web with guidance. If many new therapies appear continuously, offering hope to a selected few, then it helps to know whether one is a possible member of this fortunate group and where one might go to take part in a new protocol. Maggie's Centres can help patients improve their understanding of these potential breakthroughs, and some of these will work, maybe only partially. In effect, this fourth reason for improved outcomes relates to primary care, the way the proactive patient looks for emergent drugs or synergetic treatments that are just being understood. Maggie's Centres can give informed opinions on these matters and, collectively, they are bound to make a difference over time.

Finally, a certain percentage of cancer sufferers will be helped by the placebo effect, or by the psychological effect of working in groups with other patients. With the placebo effect attitudinal differences can make a positive difference, as long as the therapies are believed in strongly by the doctor and patient. This effect remains controversial because, as I have mentioned, its reverse has also been shown: those who take no interest whatsoever in their cancer tend to do better than those partially involved with their therapy. It appears that having no interest and a great interest are both beneficial. Yet as David Spiegel's small study and others have suggested, it may be that the immune system is helped by positive attitudes and active participation. But, to reiterate, this is no reason for blaming patients or oneself for not wanting to participate; as Sontag wrote, cancer is not a judgment but an illness.

Whatever the truth, these five reasons lead to a belief in, not the proof of, the efficacy of cancer caring centres. The latter awaits a matched pair study we hope to run in the future.<sup>24</sup> Moreover, it is not necessary to untangle the complex relationships between body, mind and therapy to get statistically relevant samples. And that is the real point. All five effects are bound to work on some patients, in some



ways, some of the time, so that a significant number can be proven to have lived longer than those who did not attend the centres. There are many other good reasons for supporting such institutions, such as the way they improve the quality of life and help families cope with a stressful situation, but for me and Maggie a primary motive for their existence is the belief that they make a difference by extending life.

However, to say this is not to turn what I am, a WAP, into a SAD person. Architecture only plays a supporting role in the plot. It amplifies the message of the carers, the way the activities are performed, the feelings of the main actors, that is the staff and the patients (not the architects).

There is, however, a fascinating twist to the question of architectural effect. By a strange paradox there are a few cases where there is a negative case to be made for strong architectural determinism and, in an amusing confrontation with a doctor from the NHS, I stumbled upon it. The setting was a BBC debate on health and architecture. The physician and I, maddeningly for those listening to the radio, took exactly the opposite roles that were expected of us. I said that one should support good architecture for itself not because it would change patient care or determine behaviour, while the doctor pointed out the reverse. He argued that if a hospital creates a horrible or ugly environment then he and the nurses simply did not show up for work. What a surprise, to me. This negative lesson really is very SAD, and – touché – I hadn't thought of it. So, really bad architecture can make a difference, and lead to absenteeism. But such cases are rare and do not prove, in the words of *Blueprint*, that good architecture 'Can Beat Cancer'. Nothing like it.

What I think the Maggie's Centres do show is the more modest truth that weak architectural persuasion can contribute to the workings of a group when its symbolism and ambience support the central message of the organization. It does this by appealing to various moods, and here lies another surprise. By spending money on the architecture and art, Maggie's Centres say to the carers that we care about them too, as well as the patients. They do show up for work, with renewed energy each day. In this secondary sense the buildings support a positive mood, and then that affects the service we provide. In effect, the buildings are one important link in a positive feedback loop or, because they surround all our activities, the common colouring of all the links. In a few patients they might even inspire the Dunkirk spirit. Or, less actively, they simply provide



*Richard Murphy, Maggie's Centre Edinburgh: interior main room.*

a pleasant and diverting place to be, where one meets other patients in a similar predicament. With 250 different kinds of cancer there is clearly no single right approach for a caring centre. Perhaps the complexity of cancer explains the diversity of the expression and why Maggie's Centres are necessarily complex in form and metaphor.

## ARE THE DOORS CURVED? THE METAPHOR OF HOPE

What then is the overall effect of the architecture? It varies, of course, for each patient and carer who accompanies the sufferer, varies with the day and mood of the situation and, as I've just argued, cannot be completely isolated from the activities provided. But we have seen over the twelve years of growth a pattern of appreciation that deserves special emphasis. With their striking forms and friendly atmosphere, and the contrast to the normal NHS hospital building, the architecture sends a very clear message to the vulnerable that they matter, that their illness is important to us and to society. It gives recognition, as did such hospitals as the Hospices de Beaune, that illness, struggle and death are integral to living well, and nothing to hide.

Because of the depression that accompanies the diagnosis of cancer, this message needs saying, even in an age of frankness. Often the patient feels a sense of failure, and wonders 'Why me?' In spite of the fact that one in three have cancer, it is still hushed up at social and business events, an affliction that would be considered ill-mannered to announce at the dinner table, or unwise to admit at the conference table. At the very least a low-intensity taboo surrounds the subject, an understandable desire to not mention it.



Hence, when one walks into a light-filled welcoming space that says ‘cheer up, have you hugged your architect today?’ – or some offbeat equivalent that these non-standard buildings provoke – the atmosphere disarms the immediate mood. It displaces depression for the moment and allows one a place of reflection, of humour. It gives one perspective on a shared journey ahead, made with others in the same boat. Some doctors have spoken up very positively about these aspects of the centres. One described how surprised he was to find a talkative mood in a group session at Maggie’s, among a cluster of dour Scots who usually suffer in shyness.

Seeing middle-aged Scottish men sitting around talking about their health and supporting each other made me think: ‘There’s an atmosphere here that works. There really is something different going on here.’<sup>25</sup>

Another doctor emphasized that Maggie’s ‘has changed a lot of people’s views about how much architecture can influence the way people feel’. A third, at yet another hospital, said that Maggie’s ‘helps [patients] move on to a new phase . . . it’s non-physical: you could almost say spiritual. Probably the best way to describe it is that it’s about heart.’ A fourth opined that ‘having a positive attitude and support of family and friends can make a huge difference to how people feel – and there is some evidence that mind-over-matter can improve the way treatment is tolerated.’ At a fifth hospital, in Inverness, a doctor again emphasized the new ‘proactive approach to talking through things’ and connected it with the unusual architecture:

Maggie’s Highland is a very clever design, like a boat. It’s a completely different sort of space, none of the walls are straight, all the doors are curved. It’s a really arty building. It’s non-standard, non-authoritarian, a nurse and doctor-free zone. It brings calm to people at a really terrible time of their lives.

How could the doctor have got it so wrong, seen things that are not there? None of the doors is curved (only one sliding partition is curved), and we know the building was designed like an upside-down mound, not a boat. But the mistake illuminates a point. Such is the effect of highly metaphorical buildings that they alter moods, change how people see things,



*Maggie's Centre Inverness by Page and Park: the illusion of curved doors.*

even doctors. Patients are normally treated in a hygienic atmosphere that is impersonal – the white cube. So then, when they walk into a colourful place of great personality, they perk up and respond emotionally, seeing reality in a different way. Again there is testimony to this. One of the models for Maggie’s Centres was the Wellness Community in Santa Monica, and when its senior vice-president visited our buildings he was struck by the affirmative message and immediately led to a metaphor:

What you all have created, in terms of architecture, is a community statement to patients and carers that Your Life Matters. Walking from the hospital into Maggie’s is a concretization of hope – just as the daffodil reminds us of spring.

‘Concretization of hope?’ Maybe those doors are curved.