**Affecting care: Maggie’s Centres and the orchestration of architectural atmospheres**

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**Abstract**

This article presents research on the architecture of Maggie’s Centres, a series of buildings for those with cancer, their families and friends. In particular, we explore the way in which their architectural atmospheres are spoken of by architects who have designed individual Maggie’s Centres, in interviews with staff members and volunteers in the buildings and in focus groups with visitors to their sites. We bring together qualitative research from two separate projects, and present findings from interviews, across the UK and internationally, with 66 visitors, 22 staff members and 7 architects of Maggie’s Centres. How our research participants discussed the atmospheres of their Maggie’s Centres is broken down into an analysis of, respectively, how building materials are used in these buildings; how colour and light are experienced in the buildings, and how the shape of the buildings in themselves affect the ways in which people use the spaces. These separate aspects of the buildings combine to become what can be described as the generators of architectural atmospheres. We discuss how architects, staff members, volunteers and visitors translated their intuition of intangible atmospheres into a recognition of architectural qualities, and linked these to questions of care. Maggie’s Centres, we argue, are emotionally charged buildings that shape the ways in which care is staged, practiced and experienced in everyday ways, through the orchestration of architectural atmospheres. We use the example of Maggie’s Centres as a comparison with how social scientists have characterised the design of mainstream hospital settings, in order to draw out the implications for questions of healing and recovery from illness, and how buildings may hold the potential to affect care.

**Keywords**

United Kingdom; Maggie’s Centres; Healthcare architecture; Architectural atmospheres; Affect; Care; Cancer; Material culture

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**Introduction**

This article reports research on Maggie’s Centres, a series of non-residential buildings freely open to those with cancer, their families and friends, in which the architecture of the centres is actively enrolled in the provision of advice, support and care offered by the charity. Located in the grounds of major hospitals with regional oncology hubs, Maggie’s Centres have developed from the first building opened in Edinburgh in 1996 to twenty sites at the time of writing, found primarily across the UK, but also in Hong Kong and Japan. The charity is independent of state healthcare systems, and the services Maggie’s Centres provides are complementary to those offered in the adjacent hospitals. Staff at Maggie’s Centres, who come from healthcare professional backgrounds, offer services such as counselling, welfare support and advice on nutrition and physical health on a non-referral basis, and their work is supported by volunteers at each site (Butterfield and Martin, 2016). Originally founded in response to the dispiriting and disempowering spaces in which the garden designer and historian Maggie Keswick received her diagnosis and cancer treatment (Keswick, 1995), the Centres have received a great deal of media interest on account of their design, with some of the most celebrated global architectural practices working on the planning of the individual buildings (Jencks, 2017). Each centre is a bespoke design, with architects working from the same general architectural principles to plan buildings at a more domestic scale than is typically found in clinical settings, and with the aspiration to create spaces with atmospheres that counteract the anxieties often associated with cancer treatment.

Throughout our article, we explore the way in which architectural atmospheres are spoken of in discussions with architects who have designed individual Maggie’s Centres, in interviews with staff members and volunteers in the centres, and in focus groups with visitors to their sites. By combining the perspectives of those who design the buildings, those who work in the buildings and those who use the buildings to access their services, we answer calls for research on architecture to bridge the gaps between the perspectives of those who design buildings and those who inhabit them in routine ways (Jacobs and Merriman, 2011: 218). Through using qualitative methods, our aim has been to connect the dots between the aspirations for buildings at planning stages and the experience of buildings in their everyday uses (Degen et al., 2008). Throughout our analysis, our focus remains on the feel *of* the buildings, and understanding this as subtly entangled with the ways that people feel *about* the buildings, and their understanding of the feelings that they have whilst *in* the buildings (Rose et al., 2010). In agreement with understandings of care as profoundly *situated* social practices (Schillmeier, 2017), we explore these buildings that have been self-consciously commissioned with the conviction that design can facilitate better practices of care (Jencks 2017). Thinking spatially, as we have previously argued, prompts us to consider ‘how artefacts and environments inter‐relate to encourage specific embodied actions and evoke particular atmospherics of care’ (Buse et al., 2018: 247). The *feel* of spaces in which care is delivered, we suggest, is important to fostering different practices, cultures and logics of care (Mol, 2008).

In what follows, we briefly review contemporary debates, across the disciplines of architectural theory, cultural geography and philosophy, on atmosphere in general, architectural atmospheres in particular, and how these intersect with theories of affect. Our paper draws together data from two research projects, as outlined in the methodology section. In the main body of the article, we extend our analysis of how research participants discussed the atmospheres of their Maggie’s Centres with focussed discussions of, respectively, how *materials* are utilised in these buildings; how *colour* *and* *light* are deployed and experienced in the buildings, and how the *shapes* of the buildings affect the ways in which people use them. Breaking down the separate aspects of Maggie’s Centres into their materialities, colours, lighting and shapes should not imply that these features act separately to produce the feel of buildings in predictable ways; rather, thinking about these as ‘generators of atmosphere’ helps us to sketch a complex picture of the ways in which architectural affects are generated through a *layering* of multiple objects, practices and interactions (Böhme, 2013a: 27). We conclude our discussion with a reflection on the ways in which architects, staff members, volunteers and visitors alike translated the intuition of intangible atmospheres into a recognition of architectural qualities, and linked these to questions of care. Maggie’s Centres, we argue, are emotionally charged buildings that shape the ways in which care is staged, practiced and experienced; these buildings are affecting care, as it happens in everyday ways.

**Atmosphere, architecture and the generation of affect**

Definitions of atmosphere, across disciplinary debates, have been characterised by their vagueness and indeterminacy (Griffero, 2010). Atmospheres are, Edensor and Sumartojo argue (2015: 251), ‘intermediate phenomena, belonging neither in the world out there nor in the individual person’; that is, atmospheres blur and make hazy any distinction between subjectively felt or objectively observed phenomena. Whilst some researchers make a positive case for using haziness as a sensitising concept for understanding atmosphere theoretically and methodologically (Bille, 2015a), Böhme has argued that atmospheres be ‘conceived not as free floating but on the contrary as something that proceeds from and is created by things, persons or their constellations’ **(**1993: 122). In this understanding, atmospheres are not simply extant in our environments, but are the product of the professional work of designers and the social actions of their inhabitants. The conceptual significance of atmosphere has underwritten much contemporary design theory, especially by architects and architectural writers. So, for instance, Pallasmaa has written of using atmospheres as a spur to architectural practice that is creative, humane and empathetic (2014; see also Zumthor, 2006). Architects and designers have a particular responsibility as part of their working lives to produce affective atmospheres, with the contemporary built environment noted for the degree of engineering of affect inherent in its fabric (Thrift, 2004). Indeed, it has been argued that at least ‘one function of buildings to be an attempt to stabilize affect, to generate the possibility of pre-circumscribed situations, and to engender certain forms of practice, through the design and planning of buildings, including aspects such as form and atmosphere’ (Kraftl and Adey, 2008: 228).

Böhme suggests that the factors comprising an atmosphere ‘can be objectively enumerated and handled. We shall call them the generators of atmosphere’ (2013a: 27). He continues to include spatial qualities that can be manipulated by designers such as light and sound, alongside social practices in buildings, as examples of the generators of architectural atmosphere. Elsewhere he considers architectural practice to be akin to scenography, such that ‘it can be said that atmospheres are involved wherever something is being staged, wherever design is a factor’ (Böhme, 2013b: 2). Such an understanding leads us to make a move from thinking of architecture less in terms of designed objects *per se*, and more of a practice of designing *situation*s instead, shifting our focus from an ‘ontology of the object to the ontology of the elements’ that combine within any given space (Bille et al., 2015: 32). This begs an understanding of architectural practice as facilitating social engagement and use of its spaces by agentic actors and actants, rather than dwelling on buildings in their completed state (Awan et al., 2013). Architecture is, instead, always more provisional in its affects, as are its atmospheric qualities, which as Edensor reminds us should not be ‘conceived as conditions into which people are simply plunged and to which they passively respond’ (2015: 333). This, therefore, prompts us to reflect less on what an architectural atmosphere *is*, and rather on how that atmosphere is *generated*, and what that atmosphere *enables*.

With reference to the spatial context of health, illness and recovery, it leads us to consider the physical environment not as a material backdrop discrete from the medical encounters it hosts, and more as an assemblage formed from the intersection of bodies, buildings, and the encounters between its human and non-human elements (Duff, 2016). Recognising the built environment in terms of its agency in medical encounters has implications for how we think of care in its own terms as always *situated* (Schillmeier, 2017). ‘Thinking about care practices’, Schillmeier and Domènech argue, ‘entails a reflection concerning practices of space’ (2009: 288) and, indeed, the agency of non-human elements within the encounters of care (Mol, 2008) – including the built environment. Mol et al. elegantly argue that ‘the most difficult aspect of writing about care is not finding *which* words to use, but dealing with the limits of using *words* at all’ (2010: 10). Care is, indeed, often not easily articulated verbally but rather folded within embodied moments, gestures and attributed to the atmospheric qualities of particular places. ‘By focusing on the modulations of a body’s capacities to affect and be affected in the spaces and times of its encounters’, Duff argues, research on ‘affective atmospheres avails a means of tracing some of the mechanisms by which capacities like hope, sociality, meaning and empowerment ebb and flow for bodies in recovery’ (2016: 62). Tracing atmospheres empirically means understanding spatial affects as not merely representing the moods of any given place, but also as the frame for ‘the array of activities and practices potentially enactable within that place’ (Duff, 2010: 884). Being alert to the affective atmospheres of architectural designs allows us to better understand why certain assemblages of people, objects and environment coalesce to result in places that enable care and health promotion (Duff, 2011; 2012). As Edvardsson et al. have shown (2003), attending to atmospheres within hospital settings gives us a sense of the combination of environmental factors and caring practices that can make patients feel a sense of well-being and self-identity or, conversely, alienated and dislocated within the experience of illness. In treating atmospheres empirically, using Maggie’s Centres as case studies, we align with existing research that considers the affective qualities of place and the built environment as prisms through which to understand embodied experiences of health, illness and recovery (Duff, 2016).

Kraftl writes that ‘affective states *may* be created by architects through the use of specific materials, colours and shapes’, but that their effects are ‘the unpredictable, ongoing result of how people are using, moving through, maintaining, refurbishing, adorning and interpreting architectural spaces’ (2010: 408). His words capture the interplay in any building between the aspirations of their designers, the strategies they use to generate architectural atmospheres (Böhme, 2013a), and the ways in which ‘atmospheres are co-produced by the responses of those who experience them’ (Edensor, 2015: 347). In this paper, we analyse how our participants spoke about, respectively, the *materials* used in their Maggie’s Centres; the *colours* of their Centres, and how these intersected with *light* within the buildings; and the shape and *architectural form* of their Centres. Together, these features of the buildings offer a sense of the architectural atmospheres that are generated through their combination, and the social practices that they enable. First, though, we outline our methodology below, and also introduce briefly the Maggie’s Centres aims and scope, in order to set the context for our research findings.

**Methodology**

The current paper brings together data from two projects: the first Foundation for the Sociology of Health and Illness funded project was a study of how visitors, staff and volunteers in Maggie’s Centres reflected upon their use of the charity’s spaces, and the second Economic and Social Research Council funded project involved, as part of a wider study, the interview of architects who had either designed, or were in the process of designing, a Maggie’s Centre. In the first project, carried out between 2012 and 2015 in each of the four countries in which Maggie’s Centres were based at that time, DM facilitated 12 focus groups with 66 Centre users in total (45 female, 21 male), including one volunteer group. Participants were recruited from sign-up sheets distributed in the Centres in advance, and the make-up of the focus groups in terms of gender is broadly representative of the users of these Centres more generally – at the time the research was carried out, almost all individual Centres were receiving more female than male visitors. In terms of ethnicity, the vast majority of focus group members identified as White or White British, which was again representative of the users of the Centres where the focus groups took place. In addition, DM interviewed 22 salaried staff members, as well as one volunteer interview (19 female, 3 male). The interviews were semi-structured, and the researcher drew a purposive sampling strategy to access a range of perspectives from all main categories of staff members, as well as volunteers, again resulting in a broadly representative sample. DM conducted research in seven centres altogether, chosen to reflect different geographical areas (from large cities to medium-sized towns, often serving rural regional populations); different architectural styles (some Centres were converted from older buildings, whereas others were bespoke new builds), and also different on-site histories (some Centres were new buildings that had been preceded by interim settings, whereas other Centres were opened without any previous services at that site). The interviews and focus groups used similar topic guides, with questions focussing on how they used their Maggie’s Centre, how their building compared with other health care buildings they knew, and how they might imagine feeling in other Centres (this was discussed with reference to pictures of other buildings commissioned by the charity, selected to illustrate the different aesthetics and styles arising from the same architectural brief). Findings pointed to the capacity of the spatial design to foster qualitatively different staff practices and peer support activities than found in other places of care and support during cancer treatment (Martin, 2016).

Interviews with Maggie’s Centres architects come from the second ESRC project on the day-to-day practices of architects designing for health and social care (Buse et al., 2017; Nettleton et al., 2018a; Nettleton et al., 2018b). As part of that wider data-set, all authors were involved in the interview of 7 architects who have been involved in the design of a Maggie’s Centre, in a combination of individual interviews and joint interviews with architects, some of whom had worked on more than one Centre. Altogether, the architects we spoke with had experience of working on 5 different Maggie’s Centres projects, and their experience ranged from having worked on buildings over a decade ago to still being involved in a Centre during its construction stage. In bringing together these interviews for the first time here, our research relates to previous research with a similar number of architects who have worked on Maggie’s Centres (Van der Linden et al., 2016). We present all data anonymously, with pseudonyms used and case study sites numbered. Both projects received ethical approval from the University of York ethics committee.

All authors have engaged in close reading of all transcripts from both projects, as well as documentary analysis of architectural briefs and other documents that guide the design and construction of individual buildings (Prior, 2003). We used thematic analysis, assisted by Nvivo qualitative software, in order to analyse all data-sets, and the emergent themes have been discussed by all three authors. We coded across all data-sets for mention of atmospheres in, and the emotional qualities of, Maggie’s Centres by all participant groups, and focused in on the discussion of the materialities, colour, light and the shape or form of individual buildings. We go on in the next section to explore the ways in which architects, staff members, volunteers and visitors spoke about the atmospheres of the centres, their emotional and embodied responses to the buildings, and the specific ‘generators of atmosphere’ (Böhme, 2013a) of materiality, shape, colour and light. In our analysis of interviews with architects, staff members, volunteers and visitors of Maggie’s Centres, we take these generators of architectural atmosphere in turn and follow them through the data *not* to separate out their individual impact on the design and experience of the Centres. Rather, we do so in order to empirically flesh out the layered and complex ways in which affective qualities and practices of care intersect in these buildings.

**Findings**

*The architectural atmospheres of Maggie’s Centres*

The original architectural brief for all Maggie’s Centres, a set of design principles and room requirements to be interpreted in their own bespoke and site-specific designs, was based on the experience of the first building in Edinburgh, which demonstrated ‘how much a building can achieve by creating the right atmosphere’ (Jencks and Heathcote, 2010: 219). Rather than specifying too much in the way of exacting room measurements and spatial dimensions, the original brief is a short document with a more narrative approach than is typically the case. By narrative approach, we mean that it offers a set of prompts for the architect, addressed directly in the second person, to consider how their building will evoke emotional responses in its users (Van der Linden et al., 2016). In the original brief, published within just four pages, there are 19 references to ‘feeling’ or how a Maggie’s Centre should make its inhabitants ‘feel’ whilst in the building, with the eventual aim that the architecture ought to make visitors feel ‘more buoyant, more optimistic, that life was more ‘interesting’’ after visiting (Jencks and Heathcote, 2010: 222). Architects of new centres told us that they would travel to carry out observational studies of the feel and routines of existing centres over the course of one week early in the design process, in order to inform the plans for their own building (see also Van der Linden et al., 2016). This in-situ period of observation by architects in anticipation of their detailed work on a new centre echoes part of the week-long induction process for all new Maggie’s staff members, as explained by Rebecca, a cancer support specialist: ‘[We] all get put to somewhere differently, and your brief is, you’re here for the week, we just want you to sit and absorb the atmosphere, we want you to watch what’s going on’ (Site 6). The atmospheric qualities of Maggie’s Centres were noted often by our participants, across each of the research projects, as essential to differentiating their spaces from other sources of support open to those with cancer. For Laura (Psychologist, site 4), speaking in an interim setting whilst a permanent Centre was being built, achieving the right atmosphere in the new building was of primary importance: ‘[I hope it] inspires that same sense of being held and uplifted, purely by just being in there… that the building and the staff can create that atmosphere’.

Many of our participants held hospitals as their benchmark for healthcare environments, and thought of Maggie’s Centres as warm and empowering by comparison:

This is more an emotional space for me to come to, where I feel more in control of me rather than being a patient that’s having things done to, which is what the hospital and the entrance say to me. (Sharon, Visitor, Site 5)

The importance of the Centres being seen as safe spaces in which emotional responses were encouraged was often highlighted, as noted here by Vicki (cancer support specialist, site 3): ‘it’s a safe environment in that [people] can also feel that if they do need to get emotional they can do, and that’s a safe environment to do that in, that they’re not going to be told to not cry’. Indeed, the characterisation of Maggie’s Centres as emotionally charged places was shared by visitors and architects alike. Thinking about the variety of visitors using his centre, at very different stages of treatment and recovery, David reflected that ‘Maggie’s has got a very diverse area it’s got to cover, and the building’s got to cover that as well. (Visitor, Site 4). Adele, an architect (Practice 1), noted something similar:

I always described Maggie’s as having lots of different voices, and so there are days I’ll go over and you feel OK to chat to people because it’s just lots of conversations of relaxed things. Other days you’ll go over and it’s a quiet building, because there’s lots of separate very personal conversations going on, and then other days you’ll go over… it’s really loud and it’s full of laughter and they’re all teasing. So, it has lots of different voices and I think that for me is the really lovely thing about it, that it just translates. In the same day, it can be four different things and it takes it, the building can take it and hold it and it’s good.

Adele’s words conjure up a sense of the building in terms of its agency and, indeed, this idea was echoed by visitors across sites. One building visitor, a spouse of someone being treated for cancer in the adjacent hospital, called his Maggie’s Centre ‘the silent carer’ (Site 2). By this, he was describing the sense of comfort he received from spending time in the building (which he preferred to use alone, rather than participating in group discussions); this sense of comfort was attributed to the building itself and its surrounding landscape, rather than the activities it hosted. In this phrase, he articulates an understanding of care that encompasses non-human elements as much as human interventions, and their inter-relations (Mol, 2008). Schillmeier has argued that care is ‘not generally divided between carers and those cared for, but distributed between the different actors involved’ (2017: 56), which includes non-human agents and environments - in this case, the Maggie’s Centre building. Such an idea of distributed agency can be found in Bissell’s definition of comfort as a ‘highly complex sensibility’ (2008: 1697); that is, comfort is experienced in embodied ways and composed from the affective layering and entanglement of material things, physical environments and the wider cultural scripts of comfort that we individually recognise and negotiate. As we have argued elsewhere (Martin, forthcoming), in Maggie’s Centres, such semiotic understandings of comfort are drawn on by designers and visitors in facilitating different practices of care.

James described his Centre in terms of warmth: when asked whether that warmth was down to the work of staff in the building, he replied:

the atmosphere is that the place creates in its own way. You know, you can walk in here, there might be one member of staff, but you still get that, or I do, I still get the same warm feeling when I come in, so that’s got to be down to the building. (Visitor, Site 4)

James’s observation resonates with the aspiration, in the original brief, that the buildings should ‘feel safe and welcoming’ (Jencks and Healthcote, 2010: 219). In the same text, the brief requests that ‘the buildings [should] be interesting enough that they are a good reason to come in rather than just ‘I’m not coping’’ (Jencks and Heathcote, 2010: 219). In other sites, visitors spoke of their buildings in terms of animation and palpable energy:

when I came in the first time here I came with my sister in June, there was no one around because [the staff] were upstairs, and straightaway I felt, I felt that, you know, power, that oh gosh, I really want to be here, and it doesn’t matter what they provide… it was really powerful. (Joni, Site 2)

In the same focus group, Donna concurred, stating that:

there’s a very strong, powerful sense to [this building], it’s not just peaceful, there’s real strength. One day coming to tai chi I was late, and the class had started when I got there, and I opened the door and it was palpable … that’s partly a group exercising together, but a lot of it is the building… it just felt so powerful, it was almost like going into a church, different to a church, but that sort of level of spirituality. (Donna, Site 2)

Donna and Joni describe their building in terms of its affective charge, and their words evoke Dewey’s classic understanding of aesthetic experience, and the ways in we are *struck* by art or particular landscapes, as a combination of reasoned contemplation and intuitive understanding (1958; see also Nettleton, 2015). Donna’s suggestion that her Centre shared some of the atmospherics of church architecture clearly positions it against the affects we associate with hospital settings (Edvardsson et al., 2003). Nicky, a cancer support specialist, spoke of the typical hospital ward atmosphere in terms of its multi-sensory affects – and their implications for care encounters.

[Hospitals] smell a certain way, they look a certain way, the phone’s constantly ringing, there’s buzzers going off, always… so the situation you were in with other people [at hospital] was that they started to feel that they were an irritation if they were asking you something, because they can hear the buzzer go, they can hear the phone ringing, there’s somebody shouting your name down a corridor, all that kind of stuff, everything is all, in those environments is all about moving you away from the situation you’re in. (Site 1).

Taking the hospital environment as starting point as a spur to designing atmospherically different types of space was a tactic noted by the architects who spoke with us. Paul suggested that ‘the worst thing you could do is have vinyl on the floors and those blue chairs, and the temperature being 24 degrees, and the smells…’ (Architect, Practice 2). What Paul and Nicky point to in their reflections might be considered as the ‘generators of atmosphere’ named by Böhme (2013a: 27) – and, indeed, as evoked in Maggie Keswick’s own account of the sights, sounds and materialities of the hospital setting in which she received her cancer diagnosis, and from which the idea for Maggie’s Centres developed (Keswick, 1995). In the next section, we isolate some of these generators of architectural atmosphere in order to dig deeper into the everyday affects that are assembled and marshalled within Maggie’s Centres to inculcate different practices of care.

*Materials*

Böhme has identified the importance of materiality in relation to the generation and experience of affective atmospheres, especially with respect to architecture; for him, we ‘sense a material insofar as the atmosphere it radiates enters into our disposition’ (2017: 60). In our previous work (Buse et al., 2018), we have argued that social scientists should develop a keener awareness of the significance of the material cultures of care settings and practices. In this research, the importance of materiality in the design of Maggie’s Centres was spoken of by architects, just as it was by staff, visitors and volunteers who live with the buildings in everyday ways. Paul spoke of the most special characteristic of the Centre that he was working on at the time of the interview in terms of its materiality:

we’ve invested a lot of time in the character and feel and the quality of the space, and the timber trusses you can see on here is the architecture of the building. Without those timber trusses, I think the building would be completely different and I think it would be a lesser building for it. (Architect, Practice 2)

He continued to discuss this design decision that explicitly linked the building’s materiality with the atmospheric affects that follow from using that material – ‘we wanted warmth and the quality the timber brings to the building’. Bille et al. have argued that our experience of atmospheres is intimately related to our sensory and embodied encounters with the ‘texture of things’ (2015), constituted through a complex interweaving of the tangible and intangible elements of space. Certainly, the choice of wood across Maggie’s Centres was commonly commented on in focus groups with visitors and interviews with those who staff the buildings. For example, Annie discussed her favourite place in her Centre as being a wood-lined room, precisely because of the materiality and the intensity of her emotional and embodied response:

I love wood, I think it’s very tactile, I can’t go near it without touching it. I just love it, and if I was coming in as a centre user and I needed time to myself, I would hide myself in there, because I feel it’s womb-like and comforting. I just, I can’t say enough about it, I just love it. (Volunteer, Site 1)

In another Centre, which was very different to Annie’s building in terms of its spatial layout, Fionnula spoke about the importance of materials in creating an intriguing space for men to visit (her Centre was typical in having more female than male visitors): ‘the men always notice the wood, and they quite often notice the high spec of the building as well, far more so than women’ (Centre Head, Site 3).

The use of different materialities across Centres point to the sense of architectural quality, the feelings we have in response to this quality, and the importance of materialities in architects’ work as they stage atmospheres in their designs (Böhme, 2013a). For Adele (Architect, Practice 1), her Maggie’s Centre was ‘about craftsmanship and so everything arrived as a raw material’, acknowledging the additional effort construction workers put in to finish their work to the highest possible standard. This additional effort by construction workers was in recognition of the type of build it was, their creativity and their professionalism in working with such high quality materials. This type of account was repeated across Centres, with Elaine recounting that ‘when you look at all the creativeness in terms of the woodwork and the curves, Dave, one of the project managers, said this is really a special building, it’s been built with love’ (Centre Head, Site 2). From the user perspective, the choice of materialities, their tactile qualities and their assemblage in concert with other aspects of the building were imperative in the creation of a welcoming atmosphere, as Sharon noted:

I love the layout, and as you come through the door you get that splash of colour from here, the oranges and the texture of the materials even, they’re very tactile. That hit me as soon as I came in, that and the warmth of the greeting. (Visitor, Site 5)

After a further discussion in her focus group about just how much of their Centre is composed of concrete, not typically thought of as a warm material, Sharon continues to say that:

if you described it to me and gave me a percentage of how much of this building was concrete I’d be thinking really, it wouldn’t work. You come in and experience - I love the doors, the sliding, they’re quiet, they’re graceful. All of those little touches that make a difference about being here… This building is very clever, very clever. It brought me in, I felt very safe, which was important, the colour made me feel welcome, the greeting was amazing. (Visitor, Site 5)

Sharon here spells out the complex layering of materialities, objects, social interactions and colours that tincture the spaces of her Centre and affect her emotionally. It is to the topic of colour and light as generators of architectural atmosphere, in combination with other design factors, that we now turn.

*Colour and light*

Sharon’s observation above that associates colourful spaces with a sense of welcome and warmth was echoed many times in focus groups in different sites, as noted in the following comment:

[I like this Centre] because the decoration is very colourful. Also, it has a sense of family, it is very welcoming, it seems that the building invites you to come to the centre. (Anya, Site 7)

Staff members across sites described how using colour assisted their work, in practical ways. Jennifer recounted how she used differently coloured rooms in her Centre in therapeutic ways:

I try to take [visitors] to different rooms, so this time the orange room, the next time the green room, the blue room … Because different colours of the room represent different themes, I want them to see the different themes, different perspectives of this building itself, and then lead them to see different perspectives they take on in their lives, so it’s like an analogy of some sort (Psychologist, Site 7)

Colours affect us not only in their intensity, but also interaction with other colours (Albers, 2006). The ways in which certain Centres staged strong contrasting combinations of colour was remarked upon often, especially in staff interviews. So, when asked to speak about other centres she had visited for training purposes, Rebecca commented on the West London Centre:

I guess its quirky, they’ve got lots of quirky colours, chairs and that’s what struck me when I went in. Although it was bright orange and you’re walking in and you think well… it was all the corners with this purple chair with a green cushion or a pink chair beside it… I really loved that. (Cancer Support Specialist, Site 6)

Certainly, the use of colour was something that impacted on visitors’ experience of their buildings, with Andy articulating its impact on the atmosphere of the relatively new Centre he visited:

I think the lack of colour made me feel a wee bit uncomfortable, because then it was really stark, wasn’t it? They’ve only recently just started to get the pictures on the walls and things like that. It was very clinical then, it’s warmer now, but it still needs a bit more work to it. (Site 1)

From the same site, Tom compared his Centre to the feeling he had as a visitor to Saint-Chapelle in Paris (Visitor, Site 1), because of the way in which colour infused the building – which was, in turn fundamentally related to the impact of light within the space, and the entanglement of these generators of architectural atmosphere.

For Edensor, lighting is key in ‘guiding what we are able to see, inflecting visible colours and informing our sense of the shape of space’ (2015: 331). When reflecting upon what makes an ideal Maggie’s Centre, John noted that ‘you need light’ and went further to emphasise the need for ‘light, over colours’ (Visitor, Site 5). John was an architect by profession and, indeed, designing with, and for, light is one of the core elements of architectural work (Edensor, 2017) and the staging of the atmospheric qualities of space (Bille, 2015b). Jane emphasised this point in an animated discussion where she suggested that ‘the things we’re talking about [in architectural design for care] are so basic. We know this stuff, every human being knows this. You know that you feel better in a room with a window, you just know that!’ (Architect, Practice 4). Jane here articulates the kind of aesthetic understanding proposed by Dewey (1958), in her reach for an intuitive formulation of good design as supplementary to the reasoned and research-led principles of architectural practice. Whilst we might be cautious about claims to the universal experience of daylight (as Edensor reminds us, ‘cultural responses to the styles and attributes of illumination vary’ (2015: 336)), the question of lighting was a prevalent theme in our interviews with architects. Christopher spoke about the importance of bringing as much light into the spaces he designed, and made a distinction between these skills and the use of colour within a building, which he viewed as a secondary concern:

We’ve tended to try and avoid [design regulations in health care] because they tended to talk about wallpaper and colours and things like that. There’s nothing wrong with that, and you can get into that, but I think what we do as architects is far more fundamental than that, which is actually about the plan of the building. (Architect, Practice 3)

It is to the question of architectural form, as generator of architectural atmospheres, that we turn to in the next section.

*Architectural form*

Maggie’s Centres are notable for the multiplicity of shapes they take individually, in spite of each architectural team working with the same brief, or set of design principles. As an illustration of this, Jencks indexes the variety of building shapes in the first 16 Centres, ranging from pinwheel forms, spirals, doughnuts, blobs and rectilinear plans (2015: 28). Such arresting building shapes emphasise that Maggie’s Centres are extraordinary structures in themselves, especially by comparison to their larger hospital complexes (Van der Linden et al., 2016). As Paul notes, such striking architectural forms can have an impact in encouraging visitors to take that first step over the threshold:

even things like the image of the building when you’re arriving, if you look at the Maggie’s Centre in Nottingham, it’s quite a striking building, sitting in the trees. I think each of these centres may have a nickname, but it’s again breaking down those barriers and helping those people that are nervous about entering the centre or seeking help for whatever reason, just to help them, make it easier for them to make that step. (Architect, Practice 2)

Bjerregaard has noted the importance of how we enter a building, in terms of shaping our experience of the space and the staging of its atmospheric qualities (2015). Carole’s recollection of the first time she entered her Centre stresses the potential for striking architectural forms to attract new visitors: she reflected on how its ‘unusual’ and ‘unformed’ shape ‘caught my curiosity’ and intrigued her enough to visit (Volunteer, Site 2). The unusualness in the case of Carole’s building comes from its curved shape and spiral form. Despite its non-traditional shape and visual eccentricity on first appearance (compared to the surrounding hospital estate), Frida, a cancer support specialist at Carole’s Centre, stated that this disarming effect was potentially valuable for new visitors:

I think even if it’s just sometimes a second or two, you see quite a lot of people forgetting their cancer, even if it’s just for a few minutes... You shouldn’t judge a book by its cover, you know - elderly people, and they get the space, they get the way the arms [of the building] are coming round. They feel safe, and they just get it all. (Site 2)

Within the original brief, architects are offered a good deal of artistic license in designing their buildings, by being told that Maggie’s Centres ‘should not patronize pat you on the head, patronize you by being too cosy’ and, indeed, designs that are ‘surprising and thought-provoking’ are encouraged (Jencks and Heathcote, 2010: 219). Commissioning architecture that challenges vernacular building shapes and familiar forms is not without risk. Visitors in other Centres, when shown images of irregularly shaped Centres elsewhere, could respond negatively, with comments such as ‘I would say that’s an architect’s flight of fancy. We didn’t appreciate that [building] at all’ (Peter, Site 6). Focus group discussions, especially those in Centres with unusual building shapes, often captured the tensions between challenging building designs and their surrounding environments, but also the elements that could mitigate the challenge of the new architecture. When debating images of other Centres elsewhere, focus group participants often reflected upon their embodied experience of being in an unusually shaped building, and how the immediate and physical experience of the Centre was tempered by the affective qualities of the wider environment. Nicola commented that, in her Centre, she first noticed:

the glass, the angles, the concrete, the exposed materials, but it’s all softened, not by textiles but by nature, because you’ve got that lovely garden… growing on one end. I walked past and went oh, that’s beautiful, you know, so you’ve got this very angular, stark building, which will not show signs of decay, and all around you you’ve got the trees and the rotting colours, the garden changing. I don’t know about you, but every time I come up I look in the garden, I go that still looks amazing, it just gets better and better. (Visitor, Site 1)

Nicola continued to recount that each time she visits the Centre, she does ‘the full circuit’ around the building, so as to ‘see all of it from the different angles, because it’s always changing, because of the outside perspective’. Her experience points to the value of bringing the outside environment into the inside of the building, of course, but also succinctly places the individual inhabitant of the building front and centre, in terms of understanding its architectural affects.

One architect, when discussing different intellectual approaches within contemporary architecture, distinguishes between those who see design as a ‘sculptural thing’, those who view architecture as ‘a more technological thing’ and those, like himself, who think ‘it’s a social art… it’s primarily about people’ (Christopher, Practice 3). Such a view is echoed in Adele’s argument that ‘architecture is secondary to use. It should be of a good quality, it should stand its own merit, but the predominantly we build buildings for people to use them’. She continues to note that ‘if our buildings work for the user and work for the environment that they’re meant to be for, that’s much more successful, and if they disappear and fade out of the everyday then that’s great’. (Practice 1). The idea of an architecture that disappears from view, because of restrained design that serves the emotional needs of its users is captured evocatively by Tom, speaking about his Centre as

a building that’s trying not to be here, it’s that spare, it’s like its concrete parts are like tiny little legs that are just given enough shelter… even the walls themselves, we write ourselves on these walls, the barer the better, and I love this building, absolutely love this building. (Visitor, Site 1)

A running theme throughout the data was the idea that Maggie’s Centres were of an elevated standard of quality, by comparison with the typical spaces of contemporary care. As researchers have argued, in spite of increasingly sophisticated protocols, quantitative measures and ostensibly objective techniques within the design and construction industry for measuring building standards, architectural quality is better thought of qualitative, subjective and affective ways (Dutoit et al., 2010). Charlotte spoke of the tensions of architectural quality and accessibility for users, where she reflected that

you could have a building that is fantastic and really impressive, but actually not a nice place to be in. I think [a Maggie’s Centre] still needs to… have that closeness and you need to feel held in it. It’s not just about doing something really impressive and inspiring, you know. A cathedral can be impressive and inspiring but you might not feel you want to sit there and have an intimate chat with somebody there. (Psychologist, Site 6)

Tom also spoke of the qualities of his Centre, and how the atmospherics and social practices they hosted avoided any feelings of deference amongst visitors:

when you walk in here you won’t tell a volunteer from a carer from a staff member or someone who’s terminally ill. It’s like that’s another degree of levelling, they’re here for us, and that’s, I think it’s ingenious. (Visitor, Site 1)

Holly expressed a similar view, where she noted that there ‘is something about the value that the building and the furniture, everything gives to people, that does say this is special and you’re special, I think’ (Volunteer, Site 4).

These interlocking themes of architectural quality and respect for building users were explicitly articulated by architects when responding to the question of designing for care. Adele notes some of the generators of architectural atmosphere discussed above in outlining her sense of the affective qualities and potentialities of caring environments, shot through as they are with attention to the material culture of the settings.

It’s about the little things. It is like daylight, it’s floor to ceiling heights, it’s finishes. I think a care environment should have as much love and attention as any other building that you might have, but because it’s in a sensitive nature, for me anyway, it should have that quality that you would give yourself. So, it’s about respect as well, and I think that’s one significant thing that we tried to take to Maggie’s, that each of the rooms, as a series of rooms, should have a quality to them. (Architect, Practice 1)

For Jane, the question of how to design for care relates fundamentally to her own identity as an architect, and what Jos Boys has termed the practice of ‘care-full design’ (2016):

I do think it’s kind of fundamental to ‘what’s the point of architecture’?... You can build buildings without architects and in fact most of the buildings we build in our society are built without any involvement from architects. All the [Maggie’s] buildings we are talking about are the tiny percentage. So, it’s part of your job really, isn’t it, as an architect, to provide that care… You can provide a very basic answer to this problem or you could do something that actually takes a bit more care about it and thinks about how people are going to use it, thinks about how people will feel in that space, and try to give something more than just the bare minimum. (Architect, Practice 4)

**Concluding Discussion**

In the findings section above, we traced how people’s general reflections on the atmospheres of Maggie’s Centres could be explored in greater depth by identifying how they spoke about materialities, colour, light, shape and building form in particular. We chose these elements of the Maggie’s environment as they work to add to the overall feel of these buildings – they are generators of architectural atmosphere (Böhme, 2017). Whilst they have, to an extent, been analysed in separate sections, we do not argue that they work separately to generate the atmospheric qualities of Maggie’s Centres. As Edensor and Sumartojo argue, ‘affects, sensations, materialities, emotions and meanings are all enrolled within the force-field of an atmosphere’; though the different elements of the force-field (or generators of architectural atmosphere) can be usefully analysed separately, ultimately ‘atmospheres are phenomena that blur the boundaries between them’ (2015: 253). Moreover, because of the purpose of these buildings, we can understand the architectural generators of architectural atmosphere outlined here as contributing factors to making ‘enabling places’ that can support better practices of care (Duff, 2011; 2012). In arguing this, we align with understandings of care that are *situated* and with due consideration for the agency of non-human elements (Mol, 2008; Schillmeier, 2017) – in these cases, buildings. The architectural atmospheres in Maggie’s Centres coalesce to *affect care* – the caring practices that are anticipated there, shaped there and found there. The type of care we have observed in Maggie’s Centres - whether in their designers’ intentions or in the everyday workings of the buildings – can be thought of as a ‘collective accomplishment, a social process of psychological, physical and emotional learning that re-relates bodies, materials and technologies, ideas, affects and feelings’ (Schillmeier, 2017: 59). This is an expanded sense of care which relates to experiences of ‘becoming well’ that, Duff argues, rely ‘on a heterogeneous cast of human and nonhuman objects, bodies and forces, rather than the perseverance of individual bodies’ (2016: 64). The sense of comfort these objects, bodies, atmospheres and their interaction are always provisional and mutable (Bissell, 2008), but attending to the generators of atmospheres gives us greater empirical purchase on why it is that some places are so ‘care-full’ (Boys, 2016).

The atmospheric properties of healthcare environments have been characterised, more typically, as less ‘care-full’, but rather infused with social relations and power dynamics (Gillespie, 2002). If hospital designs articulate culturally prevalent notions of patienthood, health and medical care (Bromley, 2012), then they also enunciate econometric norms taken from other sectors (Nettleton et al., 2018b). Internationally, researchers have critically analysed the retail saturated spaces of Western medicine in the late twentieth century (Kearns and Barnett, 1999; Sloane and Sloane, 2003). Within the UK, recent waves of hospital design have demonstrated the riven logics of hospital environments that try to, concurrently, offer sites of clinical efficiency, community accessibility and public space (Gesler et al. 2004). As a spatial echo of more general ideologies of contemporary medicine (Gardner and Cribb, 2016), hospitals become articulations of patient-centered care; so much so, that the concept of patient-centeredness operates ‘as a potent conscription device’ in their design (Bromley, 2012: 1057). What ties such disparate trends together is a sense that, in an era of increasingly commoditised and privatised healthcare, hospital environments often aim to attract visitors through de-institutionalised architectural atmospheres. And, as shown above, these are spatial models that Maggie’s Centres consciously depart from in the services they offer, the buildings that host them and the architectural atmospheres they promote.

The architects who work for Maggie’s Centres distinguish their buildings through the creation of atmospheres, bearing in mind that ‘each channeling of affect entails an ethical, cultural, or political decision’ (Kraftl and Adey, 2008: 225). Similarly, Bille et al. argue that ‘in terms of lived experience, the deliberate staging, orchestration, or manipulation of atmosphere, also becomes a way of performing what the world both *is*, and *should be*’ (2015: 34). The architectural atmospheres designed into the spaces of Maggie’s Centres affect the care that takes place within them. Visitors to, and staff members within, these Centres have spoken to us of the agency of their buildings, and how the architecture actively contributes to and *enables* the situations through which care is delivered and experienced – so much so, that in the suggestive phrase of a visitor noted above, the building can become a ‘silent carer’. Maggie’s Centres demonstrate the potential value of shifting our focus from architecture as a process that embeds and reproduces established tropes of patient-centredness (Bromley, 2012) towards a practice of architecture that works within the interstices of affect, emotion and atmosphere to afford a more ‘care-full’ environment for the everyday experience of health and illness (Boys, 2016). Drawing on our interviews as evidence, we can see that the Maggie’s Centres charity points up the emotional consequences of cancer care environments as they *are* today and, indeed, goes further to offer a vision of how cancer care *should be*, through the examples of its buildings.

For Duff, ‘the notion of affective atmospheres provides a novel means of tracing more of the social, affective, ethical and material *becomings* of recovery’ (2016: 62), and so we hope our findings on the type of atmospherics designed into, maintained within and radiated out from Maggie’s Centres adds to what we know about the significance of the built environment in the experience of health and illness, even (or especially) its less tangible aspects (Van der Linden et al., 2016). We do so because, as we have previously argued (2018), a spatial focus affords an opportunity to reflect upon how care is configured in particular settings, and the implications of these arrangements for the type of caring practices these settings facilitate. In their study of hospital environments, Edvardsson et al. argued that ‘the atmosphere of a ward can support and/or obstruct healing’ (2003: 392). They continue to challenge health professionals to consider whether those they aim to heal in their environments sense ‘symbols of welcome, nurture and calmness’, or ‘chaotic activity and depersonalization’ instead (2003: 392). The participants in our studies often pondered the question of whether the type of welcome they encountered in Maggie’s Centres could ever be replicated in hospital settings, given the difference in scale - Maggie’s Centres are domestic in scale, whereas contemporary hospitals are, by necessity given the technologies they accommodate and the size of population they serve, vast buildings. However, maybe the question of scale is secondary to that of atmosphere. Perhaps re-framing the question to consider the *feel* of medical spaces, and their potentialities for different types of caring practice, might affect care better for the future.

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