**Enabling care: Maggie’s Centres and the affordance of hope**

**Abstract**

This paper explores the role of architecture in the affordance of hope for people with cancer. Specifically, it revisits ‘enabling places’ debates to understand the influence of spatial design in the experience of cancer care. Combining interviews and focus group data from two separate studies of visitors, volunteers, and staff members of Maggie’s Centres, an organisation providing cancer support in the UK and internationally, the paper investigates the emotional power of their buildings. In particular, we explore how Maggie’s Centre buildings provided material, social, and affective resources for their users. We argue that Maggie’s Centres help its visitors to orient themselves to their changing lives and uncertain futures in thoughtful ways and, thus, their buildings offer examples of the ‘*taking place’* of hope.

**Keywords**

Maggie's Centres; Healthcare architecture; Enabling places; Cancer care; Hope.

1. **Introduction**

This research explores the place of architectural design in the experience of cancer care amongst visitors, volunteers, and staff members of Maggie’s Centres, a charity providing support to those affected by cancer. With sites across the UK and internationally, Maggie’s Centres are staffed by cancer support specialists, clinical psychologists, and benefits advisors who provide information, counselling and advice to visitors on a freely available basis, without need of referral by hospital specialists or primary care professionals. Maggie’s Centres are located within the grounds of large hospitals with regional oncology centres, serving to complement mainstream cancer care within these hospitals, whilst remaining financially and organisationally independent of state-financed care providers, such as the NHS in the UK. Frequently used as places to wait by visitors in between hospital appointments over the course of a day, Maggie’s Centres act as alternative spaces, or ‘counter-geographies’ (XXXX 2021: 238), to those spaces routinely used for cancer treatment. That is, Maggie’s Centres are planned as small buildings that are homely in atmosphere and scale compared to their neighbouring hospitals, with the architectural design of Maggie’s buildings conceived by the charity as integral to the services it offers (XXXX 2016). Designed by internationally leading architectural practices, each individual Maggie’s Centre is a bespoke building that *looks* different to other Maggie’s Centres, but more crucially *feels* different to its neighbouring hospital: as the architectural brief given to all of its architects states, ‘Maggie’s scale is deliberately a domestic one, the antithesis of the hospital’s’ (Maggie’s Centres 2015: 6). Elsewhere in the preamble of the architectural brief, architects are instructed that their ‘Maggie’s must shine out like a beacon of hope’ (Maggie’s Centres 2015: 3). This emphasis on hope is repeated several times within the few short pages of the architectural brief, with Maggie’s Centres defined as buildings ‘whose object is to help ordinary people who have cancer find the hope, determination and resources they need to cope with one of the toughest challenges any of us is likely to have to face’ (Maggie’s Centres 2015: 2).

In this paper, we will analyse the role of Maggie’s Centres and its buildings in the affordance of hope for people with cancer and their carers. Maggie’s Centres are, we argue, examples of what Cameron Duff has termed ‘enabling places’ in the experience of health and recovery (2011; 2012). Specifically, we borrow from Duff a conceptual and empirical understanding of places as, concurrently, assemblages of material, affective, and social resources that combine in order to support those that use them. In Duff’s theory, the material resources of a place (its physical features and the material assistance these afford), its affective qualities (its atmospheres), and social practices it fosters (the networks it supports) coalesce to enable and extend the sense of agency of those using that place. Building on an initial review of current debates on the experience of hope with respect to the experience of illness (and especially cancer), we proceed to review how the idea of enabling places has developed in health geography debates in the next section of our paper. Our paper combines interviews and focus group data from two separate studies of visitors, volunteers, and staff members of Maggie’s Centres in the UK and Hong Kong, and so we provide an overview of the methods underpinning our research, before proceeding to a presentation of our findings. In the empirical heart of the paper, we first discuss how our research participants spoke about the material qualities of their Centres in terms of physical affordances that mediate the social encounters within the spaces, in culturally sensitive ways. We also explore how the affective qualities of Maggie’s environments are experienced in Maggie’s Centres, and how these lead to talk of hope by both visitors and staff. We briefly reflect on the experience of Maggie’s Centres across cultural contexts, the geographical specificity within which visitors discussed their Centres, and we outline how these buildings appear to help their users as they orient themselves towards uncertain futures in hopeful ways.

1. Hopeful geographies, enabling places

*Hopeful Geographies*

Hope is a deceptively simple word, especially within the context of healthcare, where it is conventionally understood to be key to the building of resilience within individuals experiencing illness (Panter-Brick and Eggerman 2012), not least amongst those dealing with a diagnosis of cancer (Kim et al. 2019; Lee et al. 2019). Although often viewed as an individualised psychic phenomenon, hope stems from ‘core social beliefs in collective memories, ideologies, goals, and myths’, and so rather than ‘a self-generated emotion’, hope can be characterised instead as ‘a collective emotion created, interpreted, and sustained within social networks’ (Wang et al. 2013: 243-4). Hope works at wider economic levels too, being central to the discourses of medical research and pharmaceutical industries (Petersen and Wilkinson 2015). Hope, then, can be thought of as a social construct, varying over time, by place, and in different cultural contexts (Petersen 2015). Hope in the experience of cancer has been shown to be supported through culturally specific and embodied practices, such as food preparation and physical exercise (English et al. 2008; Liamputtong and Suwankhong 2015). Across culturally specific practices, though, there are similarities in the expression of hope, namely ‘its directionality and its inherent future orientation—that is, ‘‘a something still has to happen’’ quality’ common to how hope is experienced (Wang et al. 2013: 258). Underwriting the experience of hope is a sense of openness to the future, and the possibility that our present situation may be subject to change over time (Anderson and Fenton 2008). With respect to illness and recovery, hope relates to an active sense of agency and an individual’s ‘capacity for change’ in response to a medical prognosis (Duff 2012: 1393).

Within the context of cancer, hope has been subject to different forms of measurement, quantified and metricised in the development of scales and indices that aim to trace the emotional trauma of oncology care (Brown 2015). Catherine Kohler Riessman, reflecting on her own experience of cancer, characterised oncology care as punctuated by feelings of hopelessness, because of the ‘uncertainty of the future and its new routines’ (2015: 1061). This resonates with Ben Anderson’s definition of hope as ‘a relation of suspension that discloses the future as open whilst enabling a seemingly paradoxical capacity to dwell more intensely in points of divergence within encounters that diminish’ (Anderson 2006: 747). He continues to suggest that this paradoxical quality, poised as it is between an openness to the future and an understanding of the future as somewhat diminished, distinguishes hope from optimism. On this, there is agreement with one of the founders of Maggie’s Centres, Charles Jencks, who defines hope as ‘a social chain that needs continual renewal. It is a projection to the horizon of the future, entailing willpower, effort, intervention and skill in realizing the goal. And so it is not the same as optimism’ (Jencks 2015: 7). Rather than the ersatz positivity of optimism, Jencks characterises hope as a social process, haunted by the possibility of its loss (Jencks 2015: 24). Jencks was married to Maggie Keswick, who wrote about her own experience of a cancer diagnosis and argued that medical encounters often ‘cut the patient off without leaving a chink of hope and some area of manoeuvre’ (1995: 209). Indeed, the development of Maggie’s Centres since Keswick’s death can be seen as a response to the enervating atmospheres of the hospital environments in which her oncology care was delivered (Keswick 1995). Previous research has shown that the atmospheres of hospital buildings can be experienced as unsettling and upsetting (Edvardsson et al. 2003). Too often, the hospital has been described as a space in which the patient’s experience is subservient to the institutional processes and medical technologies that clinical buildings are designed to facilitate (Blaxter 2009). Whilst careful to recognise the caring practices that happen in mainstream healthcare settings, Maggie’s Centres buildings represent an explicit attempt to provide an alternative to hospital environments and to inculcate more hopeful places for encounters to take place between medical professionals and those affected by cancer (Jencks 2015: 24-31).

*Enabling Places*

In an important contribution to health geography debates, Andrews, Chen and Myers argue that researchers must probe ‘the specificity’ of the environments in which health and illness is experienced (2014: 213). One of the most promising heuristics for understanding the specificity of healthcare environments comes from the work of Cameron Duff, and his ‘enabling places’ framework for understanding the role of the environment in processes of recovery and health (2011; 2012). Duff argues that ‘the development or acquisition of agency is the principal characteristic of all enabling places’ (2011: 150) and that a ‘place may be described as enabling to the extent that it furnishes resources like hope, joy or excitement that extend an actor’s agentic capacities, even if only momentarily’ (2011: 154). Duff argues that we need to think about places as holding the capacity to afford social, affective, and material resources to those who inhabit them. By social resources, Duff suggests that environmental factors are important in shaping encounters between people, and in the building of their social relations. Place is key to opening up social networks, and so social resources ‘inhere both in the knot of associations that comprise network relations and in the specific local places that support these networks’ (2011: 153). By affective resources, Duff identifies the atmospheric qualities of place that facilitate social encounters, events, and the forging of relations between people. His attention to affective resources captures something of the energy of place, and what that gives rise to in terms of its users’ capacities to act in the present and to orientate themselves to the future. By material resources, Duff argues that access to services and information, especially within a healthcare context, is facilitated by the physical environment, which takes on an ‘enabling function’ (154) for its users. Material resources may range from examples of physical objects, such as handrails that facilitate access to an environment to many different users, to other understandings, such as the provision of material assistance in the form of financial benefits, facilitated by specific places.

Duff’s framework prompts us to be alert to the socio-materiality of environments that engender processes of recovery (Evans et al. 2015). And yet Duff also evokes an understanding of how recovery is not causally determined by environmental features – places are enabling as ‘a function of the novel practices and social interactions afforded therein, [rather] than the immersion or communion in and with place’ (2012: 1394). As Kearns and colleagues have argued, ‘health-related resources are generated in place through the exercise of complex forms of agency – including people ‘acting into’ and ‘receiving from’ place – and are not static or inherent qualities’ (Kearns et al 2014: 108). They result from emotionally complex relations between people and place, embodied encounters that are, indeed, understood in provisional ways and ‘subject to later interpretation’ (Conradson 2005: 338). Enabling places, Duff argues, ‘may have little or no innately therapeutic value at all’ (2012: 1394), and so should not necessarily be equated with the types of retreats and healing spaces described as therapeutic landscapes (Gesler 1992; Bell et al. 2018; Kearns and Milligan 2020). Indeed, research has found that environments more typically associated with risk and harm can be experienced as enabling places, and can be active in encouraging resilient responses to disadvantage and marginalisation (Ivsins et al. 2019). By bringing together a layered understanding of place as, concurrently, a location or physical space, a repository of social practices and actions, and a crucible of affective relations, enabling places can be viewed as sites where individuals can express and extend their sense of agency (Bates et al. 2019: 8). As Kearns and Milligan remind us, ‘participants actively construct enabling places’ (2020: 3).

The enabling places framework rests on an understanding that places are not simply encountered in the landscape, but rather ‘*made or created in activity and practice*’ in relation to individuals’ use of space (Duff 2011: 151). This leads to a dynamic understanding of place, with implications for understanding how hope is experienced and associated with particular places, and how affects are imbricated within the individual experience of place. And yet, whilst hope is ‘easily identified and its quantitative presence or absence highlighted’, Anderson argues, ‘the taking-place of hope, its mode of operation, remains an aporia’ in contemporary geographical debates (2006: 733). This paper seeks to address this gap, by studying how buildings specifically commissioned to be ‘beacons of hope’ (Maggie’s Centres 2015) afford hope to people living with cancer. Specially, our aim is to explore how the material environments, social encounters, and affective qualities of Maggie’s Centres combine to build hopeful places for their users.

1. **Methods**

This paper brings together data from two projects that both investigated how visitors, staff, and volunteers in Maggie's Centres spoke about their use of the charity's spaces. The first study was carried out by XXXX in 2012, and probed into the affective environmental quality of a Maggie’s centre in Central Scotland (Project 1, Site 1). XXXX carried out semi-structured interviews with 4 Centre users (2 male, 2 female), 2 staff (both female) and 1 volunteer (male). The second study was carried out by XXXX between 2012-2015, ranging across seven centres that were chosen to reflect different geographical areas (from global cities to regional towns, with predominantly rural populations); different architectural styles (from conversions of existing buildings to new builds), and different on-site histories (some Centres replaced existing interim settings, whilst other Centres were the first setting Maggie’s opened on that site). Across the centres, XX interviewed 22 staff members, as well as one volunteer interview (20 female, 3 male), and facilitated 12 focus groups with 66 Centre users in total (45 female, 21 male), including one group composed entirely of volunteers from two centres. Focus group participants were recruited through leaving sign-up sheets in each Centre where the research was carried out. Female members of focus groups outnumbered male members by roughly 2:1, broadly reflecting that Centres received more female than male visitors at the time of XX’s research. In terms of ethnicity, the large majority of focus group members in the UK groups identified as White or White British, which was again representative of visitor demographics of the Centres. Of those who offered further details on their economic backgrounds, a majority was retired from work, having previously worked in a range of occupations, including nursing, teaching, administration, counselling and in private sector companies. A purposive sampling strategy was used to recruit staff members with a variety of different roles and responsibilities for interview across the Centres; so, XX interviewed different categories of staff, including Centre Heads, Cancer Support Specialists, Psychologists, Benefits Advisors, and Therapists. Informed consent was obtained from all interviewees and focus group members in advance of their participation. Research interviews and focus groups were carried out in Maggie’s Centres buildings, but the research was independent of the charity.

The researchers carried out their research projects separately; this paper brings their findings together for the first time. XX is an environmental psychologist who researches the interplay between people and their environment and the impact of those interactions on mental wellbeing. XX is a sociologist, with a background in researching the social aspects of architectural design, especially within the context of health and social care. Both researchers knew of each other’s work via professional networks, but only after their projects were completed. We were interested in synthesizing two different – but interrelated – disciplinary perspectives on research carried out with similar aims. XX’s research was carried out with the aim of understanding how Maggie’s Centres support wellbeing and what constitutes ‘hopeful architecture’ in the context of cancer care. Using Maggie’s Centres as case studies, XX’s research was primarily interested in exploring whether architecture and the built environment can have a beneficial effect on their individual users and, if so, how this is articulated by the users themselves. Supplementary questions related to the therapeutic qualities of certain building types, questions of whether architectural scale shaped the therapeutic benefits of individual buildings, and whether everyday or more distinctive building design has a bearing on the services people access through them. Although the projects were carried out separately, with discrete research aims, what stood out for both researchers were the powerful ways in which their participants spoke about Maggie’s Centres, and how these buildings impacted on their experience of cancer. The ways in which respondents across both projects spoke about Maggie’s Centres’ enabling or empowering qualities were striking, and made us interested in exploring questions of individual agency, and how this was related to the experience of the building itself. We mapped these interests with respect to Duff’s ‘enabling places’ framework (2011; 2012) and Anderson’s arguments about the ‘taking place’ of hope (2006; 2014).

Data were analysed using the steps of thematic analysis, in order to identify equivalent themes within the data across projects (Braun and Clarke 2006: 87). Both researchers familiarised themselves with data across the projects, after these had been anonymised, in line with the ethical approval obtained for the studies. Ethics approval for the first study was granted by XXXX University Research Ethics Committee, and was granted for the second study by the XXXX Ethics Committee. Analytically, the data were coded using a mixture of deductive strategies (i.e., for mention of Duff’s core categories of material, social and affective resources) as well as inductively, to complete the analysis. Overall, our approach exemplifies the description of theoretical thematic analysis as ‘driven by the researcher’s theoretical or analytic interest in the area’ (Braun and Clarke 2006: 84). In what follows, interview and focus group data will be presented with participant identifiers that indicate which project the data derive from (P1 or P2), which site (S1-S7), and whether the individual speaking is a staff member, visitor, or volunteer. Pseudonyms will be used throughout.

1. **Findings**

In this section we will discuss some of the ways in which participants across both projects spoke about Maggie’s Centres buildings in terms of their material properties, the social networks and encounters they facilitate, and their affective qualities. We then move on to a discussion of how hope and hopefulness figured within our interviews with staff and visitors alike, as well as offering a reflection on the cultural factors that help to shape the experience of care within the Centres.

*Material resources*

Material resources refer to the importance of physical environments and material objects in our experience of wellbeing, and the capacity of such places and things to ‘take on an enabling function to the extent that they facilitate the realisation of specific enabling or health promoting activities’ (Duff 2011: 154). The things that surround us, and the places in which we are situated, are vital in understanding the cultural contours of care (Puig de la Bellacasa 2017). As noted above, Maggie’s Centres today still directly descend from the response of Maggie Keswick over two decades ago during her experience of a cancer diagnosis, and the enervating effects of the clinical hospital waiting room and consultant’s office (1995). Time after time, across centres, visitors compared their first visit to a Maggie’s Centre to their experience of hospital spaces, as in the following quote:

The thing that really struck me when I came in here was this is not just functional, this is not just about treatments, diagnosis, all that stuff, this is about other stuff.  Clearly there’s attention being given to how it looks, to the art and all the rest of it.  That is so refreshing when you’ve just come out of a hospital, because there it’s all function and efficiency. (Peter, P2, S4, Visitor)

Peter describes his Centre in homely terms, where the objects (artworks and ‘other stuff’) connote a domestic and comfortable, rather than clinical, environment, and thus act as material resources. Of course, ideas of domesticity are not universal, and one person’s notion of comfort varies from those of another (XXXX 2021). Nonetheless, this association with domestic spatial norms is a deliberate strategy for architects of Maggie’s Centres (Van der Linden et al. 2016), and was replete throughout the interview data in both projects. Across different centres, staff often confirmed the therapeutic benefits carrying out their work in rooms surrounded by domestic objects. As Jeremy, a clinical psychologist, describes:

I spend a fair, half my day in the lounge with the fire… I find that particularly homely, the fire helps, they’ve got a sofa in there, and I find if I have a family in there in particular, it’s just, I’m sure the room helps to put people at their ease and to feel more comfortable and able to talk. (P2, S3, Staff)

Jeremy details the material objects, or resources, that connote comfort (the sofa, the fire) within the context of a counselling session. And yet, this evocation of home is an artifice, in line with Charles Jencks’s aspiration that a Maggie’s Centre should be ‘like a house which is not a home’ (2015: 28). This ambiguity of the environment is, according to Mandy, constructive to the work of staff, where she suggests that, in comparison to the value of home visits as a counsellor to discuss cancer care,

this building can actually work better than a person’s own home. I think the reason is because people come in here and it feels homely so they relax to the same point they would in their own home**,** but they’re not surrounded by so much of their own life... So they don’t have the kids in the next room, or the dog, or they’re not surrounded by all the things that may constrain them in their communication day-to-day. (P1, S1, Staff)

Mandy here captures the value of familiar environments to the work of counselling. She also notes the subtle ways in which the material culture of the built environment can render feelings of comfort that are simultaneously objectively expressed (in that comfort can arise from the familiarity of certain objects and surroundings), aesthetically orchestrated (in that the appearance of domesticity, planned by designers, can evoke feelings of comfort in the counselling conversation), and affectively sensed (in that the qualities of the environment encourage an embodied sense of ease and relaxation in the social encounter) (Bissell 2008; XXXX 2021).

Staff often commented on how the physical layout and functional design of their Centres helped them to accelerate meaningful dialogue with visitors, as described by Cath:

having the little spaces where you can slide the doors closed and hide away with people, get things done in privacy [is helpful].  I think it puts people at ease that they know when you close that door they’ve got your undivided attention, and that they’ve got that privacy. (P2, S5, Staff)

Cath’s example of simple objects and their effects on social encounters within particular places (how sliding doors enable privacy within conversations) brings to mind Bruno Latour’s study of how a door-closer confounds conventional categories of the social and the technical, and of the human and the non-human (see Johnson 1988). In this case, social encounters between two individuals are tacitly mediated by the nonhuman artefacts that surround us – the closed door into a counselling space inscribes the social roles of both the staff member and the Centre visitor. Cath’s example is echoed in Charlotte’s account of how the simple act of closing a door distinguishes counselling conversations from public talk:

So I might know someone in one way around the table here, but… if you then have a booked session with them, that would be quite different… I would be different and they would be different, and the people intuitively understand that, that here we’ve got an appointment, the door’s shut, this is different, and the building just does that by itself.  (P2, S6, Staff)

In both these examples of how closing a door can facilitate a different kind of conversation, we glimpse the play of material resources within social encounters. It is to the experience of social resources within Maggie’s Centres that we turn to next.

*Social resources*

Understanding the potential of places to broker intimate encounters leads us to think about the social resources facilitated through enabling places. Duff argues that environments can become ‘supportive of the generation and distribution of social resources – like communicative and expressive competencies’ that shape social relations (2011: 153). In the previous section, we saw how private conversations were facilitated by mundane material resources; in public areas of Maggie’s Centres, we observed how the absence of certain materialities in their buildings signal the difference in services provided elsewhere, especially in hospital settings. So, Tom suggested that:

Were you to walk into a Maggie’s, you would not tell who’s the one with the cancer, who’s the one who’s perhaps caring for the person or the members of staff or the volunteers; they are all dressed in a similar way. (P1, S1, Visitor)

Similarly, in another Centre, Jeremy remarked that:

In waiting rooms people tend not to talk to each other very much, sat around in sort of quite low chairs with lots of magazines, and everyone’s just staring at the time. We don’t have a clock here, so we do encourage people just to sit around the table, and people do mingle here. (P2, S3, Staff)

Separately, Jeremy pointed out the absence of clocks, low chairs and magazines, and Tom the absence of uniforms in their Maggie’s Centres; together, they point to the absence of the material markers of the hospital described by Keswick in her account of cancer care within mainstream settings (1995). These evocations of domesticity and disruptions of institutional norms are part of a strategy of creating comfortable spaces (Van der Linden et al. 2016; XXXX 2021), alert to the cultural contexts within which care takes place. As Jeremy describes, the corollary of disrupting such material cultures is the tendency for people to mingle, to sociable ends (Cattell et al. 2008). This opens up an understanding of Maggie’s Centres as affording social resources through its use of everyday objects and familiar settings in its buildings, in order to conjure culturally resonant practices of care.

In every focus group and interview XXXX would ask people to describe their favourite place in their building (Korpela et al. 2008), and the kitchen table was frequently discussed in response. Maggie’s Centres avoid reception areas and waiting rooms and, instead, visitors typically arrive into a well-lit space with a kitchen table. Sarah, a cancer support specialist, commented on the value of the kitchen table for visitors:

The conversations that go on around that table, you know… they cover everything, from death and dying, to, well, everything goes on… with strangers, people they’ve never met before (P2, S2, Staff).

From a different building, Walter spoke about his Centre:

There is a social dimension to it, very much so. There’s also the fact there’s an opportunity to identify with someone of the same age with a similar disease indications and exchange views and attitudes and indeed information about… how you have coped. (P1, S1, Visitor)

What we glimpse in Walter’s and Sarah’s accounts are indications of Maggie’s Centres as social resources, with the kitchen table in particular drawing on cultural scripts of home, which enables communal encounters between individuals who are otherwise strangers to each other (XXXX 2016).

The public areas of Maggie’s Centres are also flexible enough to afford other, quieter, forms of being with others. Sharon described a busy event by a nutritionist hosted around the kitchen table:

you’ve got the kitchen table, but there is that lovely seating space to the side, where what happened when this was going on, that two or three people that came in, made a cup of tea and kind of sat, they would talk quietly, but they could also see what was going on, so there was that additional bit of space that they were able to utilise... So they were part of it but not really engaged in the demonstration (P2, S5, Visitor)

Sharon describes here the capacity for quiet sociability, even in the most public spaces, that was frequently reported across different centres. Helen, a volunteer at another Centre, captures the social resources inculcated through her Centre’s welcoming atmosphere:

I think just going to help yourself to your cup of tea, you feel at home a bit, people come and, also, they don’t necessarily want to talk. Well, they say they don’t, they will eventually, but they’ll go and find some space to sit and they just, it’s just that feeling of being safe and you don’t have to talk if you don’t want to. (P2, S1, Volunteer)

In a sense, Helen is describing the sense of Maggie’s as a safe space, replete throughout interviews with visitors across sites (XXXX 2016). It is to an understanding of Maggie’s as affectively charged spaces (XXXX et al 2019) that we turn to next.

*Affective resources*

Duff frames his understanding of affective resources by building on an understanding of affects as constituting the body’s ‘unique capacity to affect (and be affected) by the world of bodies and things that it encounters’ (2011: 153). Clare represented a common view of the affecting qualities of her Centre when she remembered that

From the minute I came here, I felt at ease… when you’re at the hospital waiting for your test results coming through of my MRI scans and things, you feel at the end of your tether, you feel very nervous but the minute you walk through these doors… there’s something about this place. (P1, S1, Visitor)

Her phrase (‘there’s something about this place’) was a common refrain amongst users of very different styles of building. Many visitors recounted memories of entering their buildings and being hit by an overwhelming and affecting feeling. Joni said that

I’ve got two sisters, one lives in France and one lives in Australia, they came for the week and I took them here. So they’ve got nothing to do with cancer, and both of them, when they came in, they felt, they both felt gosh, I don’t know, it’s powerful, it’s peaceful. (P2, S2, Visitor)

Joni describes her centre in terms of its affective resources. She offers a description of the sensation of interior spaces when encountered from the outside, but staff and visitors alike often spoke of the affecting qualities of Maggie’s outside environments, when glimpsed from the inside (Figures 1 and 2).



Figure 1: Inside, looking outside, Maggie’s Glasgow



Figure 2: Inside, looking outside, Maggie’s Oxford

Fionnula, a cancer specialist, used views outside to the garden to relax visitors:

if you’re with a very distressed person I think this room is very good for that… because you’ve got a little bit of background noise, which is quite helpful, and I think you just can look out and you can see the squirrels in the tree... (P2, S3, Staff)

Indeed, the tree Fionnula refers to was remarked upon by Graham who suggested that

[The] great big tree is an amazing thing when you walk through the front there, and you think oh my god, that is a huge tree, it sort of reminds me of strength if you like. (P2, S3, Visitor)

In an echo of Joni above, the affecting qualities of the environment are referred to in terms of strength, as well as peacefulness. Indeed, this combination of peacefulness and strength was reported many times across different Centres, designed by different architects and with very different aesthetic qualities; yet their environmental affects were spoken of in strikingly similar ways.

Understanding buildings and environments in terms of their affective resources involves an understanding of how atmospheres are related to our embodied inhabitation of space (Bille et al. 2015). Charlotte, a clinical psychologist, observed that when

people come here, and the first thing they do, you see them kind of relaxing when they walk in the door and feeling that oh, this is nice… They feel that they can sit and they can ignore us completely if they want to, just sit and have a coffee, and they just immediately relax from the environment. (P2, S6, Staff)

At another Centre, Jodi noted the benefit to her work of visitors being calmed by the environment, where she suggested that, in reaching her room

People do tend to have that phew moment, where they just sort of sit down, things relax, and often they tend to sort of calm down and calm *into* the session. (P2, S2, Staff)

Jodi here notes here how the affective qualities of the building prompt embodied responses in visitors, and a sense of relaxation that is drawn from the environment. Jodi’s account indicates how the affective resources of certain places impact on how people act in encounters within that environment. It is to the related question of how affective resources of certain places are linked to how their users anticipate their futures that our paper turns next.

*The affordance of hope*

As noted above, engagement with nature is key to how individuals access the affective resources of their Centres. Mandy spoke about the importance of the garden in her centre at length:

I think one of the most amazing aspects of the centre is the way the garden interacts with the building. We were talking about the fact that so many of the doors or walls of the building can be open or moved. That means that people coming into the centre can interact with the garden, either in an overt way because we would encourage them to do that, or in a very subtle, subconscious way where they maybe be simply sitting at the table with the door open and they can hear the sounds of the wind and the trees. I think that’s really, really helpful because the people we are supporting are going through a time in their life where everything will change; their appearance will change, they’re energy levels will change, their emotions will change and a lot of them fear and worry that that will never change back. So encouraging them to engage with nature’s life cycle… helps them understand that while their own life, and their own appearance even, is changing, it’s part of a cycle and it’s part of a process... I think it’s incredibly helpful (P1, S1, Staff)

Duff has argued that, within the context of health and recovery, hope is ‘linked to the capacity for change’ (2012: 1393); in the quote above, Mandy identifies the danger of people with cancer feeling emotionally immobilised by change. She identifies the temporal ruptures that characterise many people’s experience of cancer, and how illness can be accompanied by the inability to see a clear sense of their future (Riessman 2015). In a focus group discussion, Kenny and Andy speak about this issue, how it can be compounded by careless medical encounters.

Kenny: for a senior oncologist, professor to tell me in an offhand fashion that I probably had about eight months from when my cancer started to metastasise.  It robs you of that feeling of having a future

Andy: takes away your hope

Kenny: it does, because eight months is nothing, it’s the blink of an eye, it’s a season and a half.  Fortunately, I’m beyond those prognoses now, and I have structure in my week, week to week, and as normal the weeks are just rolling by, and I’m not suffering, whether that’s because of my mental attitude, which has been helped along by Maggie’s in a huge way, and the feeling that there is positivity there, and talking to other people who’ve had cancer and recovered, or are managing their cancers (P2, S1, Visitors)

Here we have a precise articulation of the interlocking dynamics of hopefulness and fear that Jencks defined as being at the root of Maggie’s instructions to its architects and aspirations for its visitors (2015). In a different Centre, Nancy spoke about the importance of hope in her work:

It’s a very big challenge to help people who have chronic illness like cancer to pick up some hope or to find some hope to live on, that’s why they want to… end their suffering.  And when I joined Maggie’s, after I joined Maggie’s I find that the environment actually can do a lot… I can see people, that they may feel also very hopeless, yeah, because people see cancer like a life threatening illness, and… they worry about the future pain, the future suffering. If they feel that they are cared and they’re supported… and you feel empowered then you have the courage to face it. (P2, S7, Staff)

In her interview, Nancy spoke of hope as coming from the environment and as enabling for its users. To cite Anderson’s definition, hope is ‘a disposition… it enables bodies to go on’ (2014: 92), no matter how uncertain their futures are. In Nancy’s Centre, a discussion within a visitor focus group also turned to the experience of hope and how the Centre’s connection with blue space and green space, aligned with peer support, was the key to unlocking the affective resource of hope. Hope, Tony suggested, took the form of a room with a view:

Because we can see … the nature outside, so it’s suitable for a chat between friends in a little room where you can see the nature outside, so you have a bigger vision, hope. (P2, S7, Visitor)

Nancy and Tony both spoke from their experience of the Hong Kong Centre which, at the time of the research, was the only Maggie’s Centre not based in the UK. Counter-intuitively perhaps, our analysis of the data reveals many more similarities than differences between responses of both staff and visitors to the Hong Kong Centre and those of staff and visitors to the UK Centres. That should not imply that responses across different centres were generic – there was a sense of *geographical specificity* in how our participants spoke about their Centres as landscapes of care (Milligan and Wiles 2010), and related them to other types of building and space within their cities. So, for example, whilst some staff members and visitors to the Hong Kong building remarked upon the sense of spaciousness of the Centre compared with the typical dimensions of flats in the city, there were similar spatial comparisons in several UK centres (e.g., a contrast between the Glasgow centre and tenement flats in the nearby West End of the city). Notwithstanding the geographical specificity of interviews, given our focus on the capacity of these buildings to afford a sense of hope amongst its users, and the cultural specificity of hope in research into the experience of cancer in particular (Ashing-Giwa et al. 2003; Kim et al. 2019; Sulmasy et al. 2010), the common response to Maggie’s Centres across different national and urban contexts is, perhaps, a surprising finding.

Reporting on their research into the discourses of Feng Shui in Hong Kong, Wang and colleagues stress the differences between individualistic Western cultures and more collective Eastern cultures, and how this raises tensions in ‘how hope unfolds as a dynamic emotional experience’ (2013: 260). How might we account for the essentially equivalent ways in which hope was articulated in the Hong Kong interviews and focus groups compared with those in the UK Centres, and in spite of the geographical specificity of observations about the buildings? Centres in both Hong Kong and the UK followed a similar programme of activities in terms of supporting visitors through counselling appointments, financial advice, diet and food preparation workshops, and physical exercise sessions. Although this programme was devised and developed in the UK Centres, there has always been a strong strand of non-Western therapies, exercises and practices included within the programme, such as time allocated for Tai Chi classes, or meditation workshops. Long before the Hong Kong Centre was opened, Maggie’s Centres had been working with a support programme that combined elements derived from Eastern *and* Western approaches to health and care. Charles Jencks has written that Maggie’s Centres are examples of a ‘hybrid building type’, because of their mixed uses and varied functions (2015: 28); this architectural hybridity is, perhaps, matched by the cultural hybridity of the programme of support and activities their Centres host.

1. **Discussion**

Maggie’s Centres, we have argued in this paper, create hopeful spaces, as fragile as the future may be for many of their visitors. These buildings are designed by different architects in different cities, but they are all specifically intended to be ‘beacons of hope’ (Maggie’s Centres 2015) for those living with cancer. Our aim in this paper was to explore how the ‘taking place’ of hope is built through the material, social, and affective resources enabled through Maggie’s environments. Anderson writes that hope can be thought of as a disrupting force, albeit provisionally, to ‘the lived experiences of suffering, harm or damage. Situations that had appeared to offer no way out are opened up, even if only momentarily, even if only in minor ways, and even if possibilities are then curtailed, lost, damaged or destroyed’ (2014: 97). Kearns and colleagues describe hope as ‘a belief in “something more” that leads a person to feel more capable and more dynamic, potentially moving them to seek change’ (2014: 114). This resonates with the ways in which our research participants spoke about their encounters in Maggie’s Centres, and their reflections on their hopes and fears for the future. The experience of hope and fear occurs in a dialectical way, and this experience ‘is not merely a possession of the individual’ (Anderson 2014: 97) but a social process, in which individual experiences of hope and fear are shaped by the resources afforded through their environments.

The buildings we researched certainly acted as counter-geographies to the hospital complexes within which they sat, and our research participants spoke across sites of the enabling qualities of their buildings, and how these helped them to look forward to their futures, as uncertain as these were. Maggie’s Centres use an affectively charged architecture as a method of hope (Miyazaki 2004), with individual buildings intended to help users to orient themselves to their changing lives and uncertain futures. Maggie’s brief instructs its architects to design buildings that afford a sense of hope for their users, but does not include a protocol of features to achieve this; rather, Maggie’s Centres invites its architects to interpret the brief in their own way, and thus demonstrate a high level of trust in their capacity to achieve hopeful spaces. As Van der Linden and colleagues suggest, this approach ‘makes close collaboration between designers and client not only a characteristic, but even a key success factor in realizing a healing environment’, in which the user experience is placed at the centre of the design process, rather than over-prescribed technical details (2016: 531). This collaboration between client and architect in the pursuit of enabling places is perhaps the largest lesson of Maggie’s Centres, rather than the impressiveness of individual buildings, for anyone interested in healthcare environments that afford hope for their users.

The research reported on this paper is subject to several limitations. Whilst we did not find significant cultural differences between Hong Kong and UK contexts, in future research we would put exploration of cultural factors more directly at the heart of the research question and recruitment strategies. It must also be noted that we spoke only to staff, volunteers, and visitors that opted to speak to us after being informed about the research aims; our research did not reach those who have may have engaged with Maggie’s Centres but have not returned, and so we cannot report on the experiences of those who do not access Maggie’s for support. Finally, our research offers a case study of the environments of one organisation only, albeit with findings that span two different geographical and cultural contexts. To address this limitation in future research, we would encourage researchers to compare different organisations who seek to use their environments to enable their users and develop hopeful orientations to their future health.

1. **Conclusion**

Health geographers have called for research that explores how health organisations use affective strategies in the design of their environments, in order to shape and influence the encounters they host (Andrews, Chen and Myers 2014: 219). Our paper answers this call through an analysis of the ways in which staff, volunteers, and visitors of Maggie’s Centres used their buildings to open up new perspectives on coping with their illness, or their work supporting those with cancer. We combined data from two separate studies and used this data to engage with Duff’s ‘enabling places’ framework. That is, we argued that Maggie’s Centres be understood as, simultaneously, offering material resources, social resources, and affective resources for those who use them in everyday ways. In doing so, we do not wish to suggest that these categories are easily disaggregated; rather, they intersect and are deeply related within each other (Duff 2012). We also explored Maggie’s Centres as environments where the ‘taking place’ of hope occurred (Anderson 2006; 2014), through thoughtful architectural designs that deliberately counteract the atmospherics of hospital environments, provide access to calming internal and outside spaces for their visitors, and use these in the delivery of their programme of care and support.

One of our participants argued that receiving a cancer diagnosis was like a trauma, and that his Maggie’s Centre was ‘a trauma centre’. ‘I don’t know what’s going to happen’ Tom continued, ‘I don’t think anyone knows what’s going to happen to them, but that’s the sort of thing I want to focus on’ (P2, S1, Visitor). His building offered Tom, and many others, a hopeful place in which to think about and prepare for the future, no matter what that might entail. Affects, Anderson argues, ‘become both objects and mediums for forms of intervention that aim to produce and reshape life’ (2014: 19); we found Maggie’s Centres to be buildings in which its users can pause from the turmoil of a cancer diagnosis, reflect on their changed circumstances, and seek to fashion an understanding of the future. This is what the architecture enables, this is how the care takes shape, and this is how the hope takes place.

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