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Vannetti G., Teseleanu G., Renzulli L.
Società Italiana di Tecnica Ospedaliera – Presidente: Prof. L.Renzulli

LIVING, COMMUNICATING, TREATING
The therapeutic space: history and modern principles of humanizations

ABSTRACT: A presentation of the history and evolution of the humanization of the therapeutic space considering the dignity of life and of the individual, in conformity with the progress of international and world health principles. Therefore, the modern trends in the humanization and innovation of the therapeutic space are analysed and set forth through the illustration of a humanized hospital structure. Recalling the basic principles which, at the level of ethics and moral behaviour, guide the organization and development of national health systems, within the confines of the cost/efficiency principle, beside the commitment and employment of resources for the improvement of health linked to the quality of treatment, emphasis is also given to the allocation of sums for the improvement of the quality of life, linked to conditions of living, communication and reception in the places of treatment, in the context of the greatest possible perception of the sick person as being at the center of the ways of assistance.

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HISTORY AND EVOLUTION OF THE THERAPEUTIC SPACE

History, myths, legends, traditions, deity worship, religions intertwine along the routes which mark the evolution of the plurality of values which give identity to the socio-cultural systems which offer openings of consideration and attention to the protection of human life.

The Pelasgic and Greek civilisations, the Romans, the eastern and western empires, the Caliphates of the East and West as far as the remote, in those times, lands of India and China, mark throughout the centuries the interpretations of the needs linked to the various typologies and pathologies of human suffering, as they revealed themselves according to the times, the welfare knowledge and the contexts of life.

Therefore, from the testimony of episodes and facts of individual assistance, as in the Homeric poems which tell of such cases as Achilles helping Tefelus, of Diomedes and other heroes, we pass to the etiologic myth of Cura, with Iginus, the first century historian and mythographer, who illustrates the condition of human frailty and advances the idea of taking care of the needy. -The myth of Cura: “ One day, while she was crossing a river, Cura saw some clay mud. Inspired, she gathered up some of it and began to shape a human form. While she was contemplating what she had done, Jove appeared. Cura asked him to instil the spirit and Jove did so with good grace. However, when Cura wanted to give a name to the shape she had moulded, Jove forbade her and insisted it was to be given his own name. While Cura and Jove were arguing, Earth appeared and also she insisted her name should be given to the form which had been shaped with her own matter.

They asked Saturn to be the judge and he wisely pronounced thus: ‘ You Jove, since you have given the spirit, will take his soul after death, and you Earth, who have given your body, will have his body back after death, but since Cura has moulded the creature, he will stay beside her for as long as he lives,. As there is a dispute regarding his name, I shall name him Man, for he was made of humus.’” (Iginus).

- The temples dedicated to Isis and Serapis in Upper and Lower Egypt which evoke the pilgrims waiting to receive divine grace.

-The asclepiads and the iatrics of the Greek world, the ‘medicatrine and the valetudinarians of the Romans, the ‘xenodochi’, the ‘ptococomi’, the ‘nosocomi’(hospitals for the sick), the geriatric hospitals, the orphanages, the homes for waifs and strays, the leper hospitals or colonies, the lazarettoes, the poor houses, which offer forms, ways and possibilities of group assistance, the hospittaller and religious orders which leave traces of their buildings and their rules of aid to the sick.

- The importance of Indian hospitals, which appear in the Singhalese commentary Mahavamsa, in particular that which was founded by King Pundukabhayo of Ceylon in about 437B.C. up to the one built by King Dutthagamini, who died in about 137 B.C.

- The culture of assisting the sick poor in the Islamic world, which is revealed with the Caliph Al Walid, founder of the Hospital of Cairo in 708 A.D., with the great hospital in Bagdad, built during the caliphate of Haruma-Raschid, with the hospital founded by the Caliph al-Muktadir, made famous to the known world by the renowned physician Razes, with the hospital of al-Mansur erected in Cairo in the XIII century, among the 34 hospitals attributed to the Caliphates of the East. In the West are to be found the historic hospitals of Moreschi in Cordova, Seville, and Toledo, that of Seville having been made renowned by the physician Avenzoar.

- Buildings, rules, the culture of assistance all bear witness to the passage from social and religious forms of medicine to the spread of a medical culture which progresses in its autonomous and specialised ways , also owing to the setting up of Schools which reach their maximum expression at Cnidus, with Hippocrates at Cos, with Galen, Pliny, Discorid, to recall just some of the witnesses to this evolution.

The development and the spread of these cultures which combine aspects of social welfare with health concerns, with particular emphasis on helping the poor, pilgrims, the sick, outcasts such as lepers or those from the lazarettoes, lead to the building of structures capable of responding in a humane way to the desired need, satisfying the requirements of the sick and suffering, in every way possible, even until death.

Over the centuries and as architectural solutions matured, , among the buildings erected for this special purpose, structures destined to be hospitals are pre-eminent, with a significant progression from buildings of an imposing and sacred nature (a direct testimony to power and to the power of the commissioning authority, of the king , of the religious or lay body), to those of a more advanced type and, for those times, with a consideration for the assistential requirements of the sick,both in relation to their pathologies and to aspects of their reception, combining care of the body with safe-keeping of the soul.

Pleasant, green spaces, fountains, gymnasiums and baths were common characteristics of religious medical foundations, infirmaries, refectories, governing spaces in Roman military hospitals, as can be seen among the remains of the military camp of Novaesium near the present-day Dusseldorf(about 100 B.C.).

The distribution of spaces according to their functions are to be found in Islamic hospitals which have separate spaces for men and women, with distinct spaces for kitchens, refectories and pharmacies.

In the age of the hospittaller and religious orders, from the early and late Middle Ages until the Renaissance, architecture favours the monumental hospital of various types, with reference to the architectural styles of churches, cathedrals, monasteries and princely buildings.

In general, the hospitals of the Renaissance in Europe are wonderful examples of an architecture

which interprets beauty and art, decorated with sculpture and other works attributed to the best artists of those times and to their workshops.

The aesthetic question of the artistic details of the buildings is not skilfully linked to adequate and equally important aspects of health and welfare issues in general, subordinated or even sacrificed to the ideals of this vision of artistic beauty.

This is the age of the great monumental hospitals, in the tradition originating with the Hospital of the Holy Spirit in Rome, founded in 715 by INA of Saxony, the Hotel Dieu in Lyons, built by King Childelberto in 542 A.D., the Hotel Dieu in Paris, opened in the reign of Clodoveus, the hospital of the Regular Canons in Roncisvalle, attributed to Charlemagne, the hospital in Burgos built in 1214 by King Alphonse XVIII, the monastic infirmary of the Monastery of St. Gallen erected in 820, to cite a few examples.

In these contexts, we note that in England, in the reign of Edward VI (1537-53), there appear the first manifestations of lay government in hospitals and professional care of the sick in the hospitals of St. Bartholomew's, St. Thomas's, Bridewell and Bethlehem; the same practices were applied also in France in the reign of Louis XII in the hospitals in Paris and Lyons.

In Italy, during the Renaissance, numerous hospitals were built by the most famous architects of that period. Examples are the Hospital of St. Celsus in 1184, the Hospital of St. Eligius in 1270 in Naples, the Hospital of St. Mary the New in 1288 and the Hospital of the Innocents in 1419 in Florence, begun by Brunelleschi and decorated by Andrea della Robbia, (the latter is also present in the frieze of the Hospital in Pistoia.), the Hospital of Santa Maria della Scala in Siena in 1440, the Hospital of Brescia in 1447, the Hospital of St. Mathew in Pavia in 1449, in 1456 the Hospital Maggiore in Milan, designed by Filarete. This hospital is an example of a structural solution regarding both the receptive aspect and the limited number of beds in the infirmary, for the attention to ventilation (large windows), for the presence of heating in the form of fireplaces, for the latrines for the patients' use, for the kitchens and the laundry room.

At the end of the 18th. century in England there arose a widespread awareness of the need for a reform in the conditions of construction and management of hospitals and there was a parallel development also in France following the fire in the Hotel Dieu in Paris in 1772.

The Academy of Sciences in Paris in 1786 set up a special commission of seven scientists of the time, among them Lavoisier, who elaborated and produced a report which defined the criteria of construction of hospitals, completely superceding the rules which had been applied up to that time, giving a more ample consideration to hygiene conditions and to the welfare needs of the sick, in accordance with the medical culture of the time.

Thus we have the outline of the early forms and principles of a concrete humanization of hospital structures, innovations to which the distribution of organizational spaces and the building complex must respond.

- 1) Hospitals must be located on the outskirts of the city, in isolated buildings, set parallel, with the infirmaries orientated to the east or south-east, in order to receive light and warmth, with the windows to the north to bring cool air. The convalescents must have gardens at their disposal. The maximum intake must not be above 1200/ 1500 beds.
- 2) the hospital must have separate departments for men and women and each patient his or her own bed.
- 3) Vaulted ceilings, which required extremely thick walls, are superceded as are protruding beams. Windows reach up to the ceiling to improve ventilation and the elimination of stale air. Stairways are openly and directly connected with each other and are well-ventilated from outside.
- 4) The administration buildings are located in front of those destined for diagnosis and treatment. Structures for the reception of corpses and anatomical studies are located in a row apart.
- 5) The buildings for the hospitalization of patients must not exceed three storeys, while buildings facing them must present reciprocally a distance not inferior to their height.
- 6) The sick are received in wards with the capacity of 34-36 beds, arranged in two rows. Every

ward must be provided with latrines “all’inglese”, a wash room, a kitchenette, a bathroom and a room for the nuns and the infirmary.

This complex of rules expresses clearly the great innovation that results from the humanization of the structures, which through the perception of the dignity and well-being sought for the patients must also observe the rules of hygiene known at the time and good assistance. In the wake of this evolution/ revolution appear on the European scene the Lariboisiere Hospital in Paris in 1854, St.Bartholomew’s Hospital in London , in Berlin the Virchow Hospitals in 1906, the Eppendorf Hospital in Hamburg, the hospital in Charlottenburg in 1901, in Italy the Hospital Umberto I in Monza in 1896, the Celio Military Hospital in Rome in 1891 and the Policlinic Umberto I in 1899.

Thus we enter our epoch which begins with the system of building hospitals in ward blocks, which presents in the western world that combination of evolution and innovation in the fields of architecture, buildings, installation, organization and technology which nowadays are features of hospital welfare, with careful consideration for the dignity of the person, constantly searching for more advanced ways of the quality of life in the world of ill-health.

Our century certainly presents frontiers open to the evolution of structures within the limits of all possible ways which progress in research offers and for which continuous improvements allow us to hope.

DIGNITY OF LIFE AND OF THE INDIVIDUAL: INTERNATIONAL AND WORLD HEALTH PRINCIPLES

The principle of human dignity, that of all human beings have equal dignity and the same civil and social rights, including the right to wealth, regardless of their personal characteristics and their position in society, is affirmed solemnly and universally in “The universal rights of men” adopted by the General Assembly of the United Nations 10 December 1948 which proclaims (art. 3) “All human beings have a right to life, to security, to personal freedom,” recalling the contexts of the Declaration of Independence of the United States in 1776 (“the Creator has conceived them with certain unalienable rights, and among these is life”), and the French Declaration of the Rights of Men in 1789 (“Men are born free and remain free and have equal rights”).

These principles of the dignity of the individual and of human life regarding equal rights have been taken up and repeated in other fundamental documents such as: the Declaration of the Rights of the Child, approved 20 November 1959 by the General Assembly of the United Nations and revised in 1989, as well as the Charter of Fundamental Rights of the European Union (Nice, 7 December 2000).

At the level of health services and health the consideration of the right to health as a human right, to be promoted and protected, is practiced at a technical and applicable level by the World Health Organization, whose constitution was adopted at the International Conference for Health held in New York in July 1946 and became law on 7 April 1948.

The international literature produced and the practical interventions document a constant condition of attention and progress for a wider consideration of the dignity of human life and for its protection from birth to death.

In these contexts, these are some of the fundamental acts:

- 1) The European Union Charter of the Rights of the Sick.
- 2) The Charter of the Rights of Children and Adolescents in Hospital
- 3) The Charter of the Sick and Dying, whose contents are not only directed to the humanization of this reality, but also with respect of lay and religious convictions and interpretations.
- 4) The Document of the Regional European Office in Copenhagen of the World Health Organization; health for all for 2000.

- 5) The Declaration of Alma Ata in 1978 regarding primary treatment.
- 6) The Ottawa Charter (1986) for the promotion of health
- 7) The Lubiana Charter (1996) on Health Reform.
- 8) The program of the World Health Organization on “Ageing and Health” within the frame of the General Assembly of the United Nations for the Year of the Elderly.

From this universal and international complex of principles descends that ethical policy of shared values which demand a complete response for the humanization of buildings which receive the ill and the suffering, with consideration of their gender, age, the type of illness, disability and handicaps, with the perception of a “therapeutic space” for their use, which permits a person temporarily or for long periods of infirmity to be “a guest” and at ease within the welfare system of his or her own country, overcoming completely the condition of being “an object of treatment”.

And since the most complex and fitting response to this need for health is, in all health systems, entrusted to hospitals we must emphasize “the perfect analogy of thought which supports hospital matters in the same way as political-social issues.”

It is not the hospital which adjusts, in its various expressions, to those demanded by the various historic moments experienced by society and its diverse social requirements, but it was and is a real identity which controlled and controls in the same way the one and the other reality. (Pazzini A. 1958)

MODERN TRENDS OF HUMANIZATION AND INNOVATION OF THERAPEUTICAL SPACES

FOUNDING CONCEPTS

1 – Ethics and Communication

Progresses in genetic medicine and research have produced deep transformations regarding the approach to health, disease, cure and death. A constant flux of often overflowing innovation drives the medical scientific area towards an epoch-making leap into new globalizing societies. This confrontation needs a new humanistic approach to redefine the relation with an extended world. It also should set new reference marks to our actions which should necessarily have an ethic character and should suggest a common demand for dialogue, relations and search of the inner truth of living

-a common experience to everyone- without forgetting about every different cultural value.

The word ethic (from ethos “way of being”) demands our participation and thus the definition of social communication methods; at the same time it undermines a living habit which is limited to the mere passive respect of the rules (which can also be ethically unacceptable).

The humanization of cure spaces is a complex ethic concept: it relates to health ethics and bioethics (the concept of health involves parameters depending on environmental, social and ethic values), it involves communication ethics (the meeting with someone who asks for my help, the relation between health system actors and the single person), environmental ethics (sustainability topics) and finally it is re-suggested by an ethic of feeling in the means of a research of values built up on shared feelings which should be used as a base for our practical opinions.

Latter involves aspects of affectivity as integrative experience of body and mind and the ability to experiment life acts in a way which is more and more articulate, dialogical, and considering the knowledge of human nature and the nature of things in their inseparable relation. Affectivity gives voice to perception, communication and forming of values and it also suggests an attitude which is not the ‘passing over’ one – controlling the things from a distance – but the attitude of wrapping – envelopment (Sartre about Merleau Ponty) - relating to whom finds himself inside things and acts as being part of it.

From this point of view the ethic of feeling is a rationality which is guided by the values of feelings (the impersonal character of these values are shared and newly construed) taken as cognitive instruments, as well as ties between life and emotions, disposition of reason and behaviour choices.

2 – Complexity and the Living concept

Taking in consideration the humanization of healing spaces, first of all we have to focus on the complexity of this problem so as to compare and integrate, as far as we can, multidiscipline competences and methodologies trying to find an approach to health promotion.

Considering the organization of space, the relation between health staff and patient, and the organizing and administrative aspect, which all are elements that contribute to the construction of an “hospital atmosphere” we have to include them in a view that underlines the complexity of the human being as well as that of medicine and the complex form which every actor of the process must acquire.

An unitary vision is obtained by the ability to compose a synthesis, as temporary as it may be, and therefore by the ability to get hold of only one planning logic: the complexity can be managed only through the integration of different types of knowledge comparing a large amount of methods and points of view; these should be integrated and integrating concerning the different demands and they should include forms of specialization (although necessary) in this logic.

The realization of a humanized healing spaces involves considerations about our existence, about the social nature of the problem and about the relational rules of the different groups involved. Also biomedicine and science are products of social life and cultural imagination and they have to be repositioned in a critical perspective so that they can take up values on which they have to be founded such as locality, sociality and identity.

A fundamental element for humanization is the connection to the territory – too many times rationalization on large scale has failed – because the founding point to the theme of living is the reconstruction of an identity of the individual – a continuously transforming research.

We have to refer to this dimension during the different scales on which our work is carried out, trying to incentive possible forms of participation and linking them back to local cultures: living in a place means to belong to an horizon even though being aware of how unstable this horizon may be; it means to realize an experience of integration that gets rationality, feelings, memory and creativity in relation among them as a response to the homogenization of gestures, to the loss of the symbolic space, to the attenuation of the psychological dimension and to the tendency to formal abstraction of elements and functions.

To live in a place means to identify oneself in a space of existence, a place of experience and of relation with the world; it means to feel oneself present in a place which is not indifferent.

The healing space has expressed this denial of values (as for a space which calls us out of ourselves) notwithstanding the fact that the need to identify symbols which give sense to an experience of life, remains a constant element in individuals even in front of the progress of globalization processes and even if it demands for the affective identification with the places as a first condition to the development in the sense of belonging to a community.

3 – Concept of Body and Health

If we consider health as a perfect state which in a man comprises also logical, affective and relational functions and which involves also interpersonal systems and social structures, the individual turns into one only entity, undivided between body and mind, as it is not possible to separate strictly therapeutical aspects from the emotional and psychological response of the patient to the cure. This idea of reality, thus, considers the entire (the individual) as a more complex whole taken in all of its parts. The unitary formulation extends also to the socio-cultural vision to consider

the informations relating to the state of health and it implies also the ability to communicate clearly as well as humanely with the patient and his relatives and the ability to recognize sanitary problems of the community.

While medicine still tends to underestimate the human factor, trying to avoid its interference with technical scientific procedures, researches testify that brain regulated systems do respond to environmental, physical or social stimulations with a clear influence on all the communication systems internal to the body (hormonal, immunitary and nervous). The actual health concept insists on a strong link (continuum) which continuous starting even from before birth up to death with its genetic, behavioural and environmental interconnections.

On this trace the World Health Organisation recommends the education of the patient as the entire amount of practices that place the individual, who has been informed and formed sufficiently, inside the decisional process of the therapeutical course, defining the “educational act as a therapeutical act on its own as it tends to transform the object-patient into a subject and to let him participate to the determination of quality standards through the concept of life quality.”

The holistic vision seems to be the only way to reconnect the variety of forms and knowledge levels in therapeutical traditions and to point out the areas of convergency and of syncretism. In some hospitals where resources and systems are at disposal, can be combined and work as one and only system, there is the tendency to the achievement of cosmopolitan medicine or better of the plurality of medical resources. These systems don't act only on etiological levels and on the cure of the state of the disease; they enter into a global dimension in which even prevention and maintenance of health play a fundamental role.

“There is no better hospital than a happy body”

Over the years medicine has disregarded the subjective aspects of diseases to follow only the objectivity of the information. That means that it has achieved only a cause/effect point of view placing the body in an isolated state as a combination of parts that can be cured separately. Medicine can “explain but not understand”, can “refer to a cause but not to a sense”. We need to get over this dualism being aware that the key concept around which revolves humanization is the body considered as existence avoiding any kind of form of reducing the body to a simple organism that has to be sanated.

APPLICABILITY ASPECTS OF HUMANIZATION

Complexity lays at the basis of the discussion about the elements that exert their influence on an hospital climate from the spatial organization point of view as well as for the managing organization and the relation between medical staff and patient.

Each planning vision must be positive, tending not only to eliminate problems or to elaborate solutions against stress but also to create places of living, patient centred places which can favour also a constructive experience and not only suitable to improve welfare conditions.

Under the same logic will be considered the spatial question and its concrete possibilities which usually is being understated and which has not yet received a well-defined position in debates on humanization.

1 – Health-medical aspects

Technical progresses and the extension of medical intervention on new spheres of society under the strict medical point of view, have produced increasing expectations and requests from the consumers but they have been carried out through a significant technical specialization which has more and more excluded the medical staff in the sense of giving up on an integrated approach to disease and restricting their relational dues towards the patient.

Specialization, necessary to complexity even if not functional to it, follows logics that end up depriving health actors of their role and turns them to be more and more depending on market logics.

Under this point of view humanization is depending from:

- “theoretic aspects and social, cultural and institutional difficulties that undergo the healing process and that point out an evident gap between existing clinical structures and real needs of the population;
- organizational, deontological and social difficulties (central function of the patient during the process of diagnosis and cure);
- training of health staff due to the new demands of citizens and of social transformations” (Delle Fave, Marsicano)

It is necessary thus, that concrete actions will be directed towards health promotion, towards the realization of participation as well as of health staff training, towards the monitoring of the patients satisfaction to move against the elimination of the emotional character inside the healing process and finally towards the attention on the new aspects of medical anthropology and sociology.

2- Psychological aspects

a) Relational

Human relations are an essential dimension of the entire existence of each individual: it builds up his identity by evolving and revealing his capacities and resources.

This dimension reveals professional intervention and it is therefore essential to the healing process. Health promotion passes through the construction of healthy “mental places” in welcoming “physical places” and through the support of an active participation of the patient.

To speak about relational and affective competence, excluding technical contents, is like starting up a relation with the patient in an adequate way finalized to activate his resources so that he does not suffer under his disease.

Dedicating attention to the relational process serves to form a patient that builds up a good relation towards the healing process, towards the health structure and who is able to re-elaborate his identity with what he got through.

b) Health

These aspects do relate more specifically to disease prevention and treatment, to analysis and improvement of Health Care systems and the development of its politics, as well as to the promotion and the maintenance of health during an healing process.

c) Spatial

Space can have an educating and developing function to the individual as well as an emotional role, reconnecting the relation between emotions, body and architecture. Emotions on one hand are considered as active and organising elements of experience and, on the other, as the response to existential needs through the meeting with space and its different forms; the experience and the comprehension of the world manifest through the body.

“So my perception, is not a sum of data.... I capture one only structure of things, one only way of existing that speaks to all my senses at the same time....Space and perception in general indicate, in the heart of an individual, the fact of his birth, the endless contribution to his corporeity, a communication with the world which is older than thought”. (Merleau Ponty)

The consideration regards the relation between body and the perception in spatial experience; the conscious and the unconscious aspects of our relation to space; the combination between body, imagination and environment in a hospital context (“to perceive means to believe in a world...” – Merleau Ponty).

Psychologist J.J.Gibson frames senses in five sensorial systems: visual, auditive, gustative-olfactorial, basic orientation, tactile, but if we take the Steiner-philosophy we don't use less than twelve senses (touch, sense of life, sense of our movement, balance, smell, taste, sense of warmth, hearing, sense of language, sense of thought, sense of ego) and we could at least add also the sense

of space.

The architectural space does not exhaust in four dimension...in architecture it's the man who in some way...creates the fourth dimension...by moving inside the building...and offers to the space its complete reality. The main character of architecture relays in its acting with a tridimensional dictionary which includes men" (B. Zevi).

The impression is that this dimension of truth (there is no architecture without men) has been going obliged together with the awareness that architecture reinforces the experience of existence, the sense of the being-in-the-world and that this is mainly a reinforced experience of oneself. (J. Pallasmaa).

3-Sociological aspects

Humanization is considered by Social Sciences as the response to the demands and the wishes of all the actors involved in the healing process. Great attention, not only directed to patients but also to medical doctors, health staff, visitors and so on...leads towards the search of operative solutions which can improve services, the liveability of the spaces, as well as the search to personalize the therapeutical processes acting on the organizational, social and spatial level of the structure.

The so called "Environmental Sociology" also studies relational aspects between the actors of the healing process as well as relations between the latter and the physical environments in which these relations happen; in other words it studies the aspects of the humanization of the physical-spatial dimension of hospitals and how these may have an influence on facilitating the social relations of all the actors, on reception and the wellness of the individuals.

This research, acting both on the private level of the person as on the public one of the organisation, works on elements producing comforts and on those reducing environmental stress, on the ethnic-cultural differences of all users and on the way of integrating these characteristics inside the fruition of healing places.

4-Architectonical aspects

Architectonical research plays a complex role in the construction of a hospital, essential and not only functional: environment influences our behaviours and adapts our actions, our thoughts and our emotions; space is perceived in relation to the dimension of our body, to its sensitive sharpness, to its movements and its intentions and it can give support and nourishment to every days experience creating an emotional balance. More over a physical system is not separable from the social one with which it gets mixed and integrated to the definition of a final message.

Architectonical aspect which have to be considered in defining a place of humanization are:

a) the 'genius loci'

C. Norbert-Schulz has underlined the psychological implications of architecture and the demand on behalf of men of works which should represent existential situations, spaces provided of a distinctive character as a significant duty of architecture for the living of men. In this sense, living means to recognise oneself in an existential space, to feel ourselves present in a non-indifferent place, where our body is not denied.

The humanization project wants to create a place where it is possible to keep up our identity, a sensitive place able to preserve the link between thoughts and emotions and a complex object of perceptions.

At the same time there is the demand to analyze and redefine the nature of relations such as inside-outside and further on between global and intimate, that is the hospital as possible expression of cultural and local roots of a civilization;

b) architecture in the health promotional process.

Architecture is an element of an educational process of the patient when it contributes to put the sufficiently informed and formed individual in the centre of the therapeutic process through realizing a place around him which is sensitive to his body-existence values..

Conceiving a hospital space on this idea of the body leads us to:

- reject it as a suburban place, isolated and “other”- space (but in relation with the city);
 - define it as a place of emotional redemption and intimate growth;
 - imagine it as a dismantled place, that is open, flexible and ready for hybrid functional combinations (that is the possibility to add other socializing functions to it);
- see it as a place of rational possibilities;

c) architecture as a project of relations

“When you start to meditate a little, it is always surprising to find out the difference between thinking things and thinking at the relation between things” (G. Bateson)

Architecture builds up significant systems (i.e. responses to specific functions) but most of all it puts systems of meanings in relation among them. Its quality is formed by its character of being a “relational art” that acts between the identity of a society and the environment in which it develops.

The main goal of the humanizing project will be that of taking in consideration the characteristics of a space and their relation with our experiences in the complexity of relations:

- between different kinds of intervention scales: urban (analysis of the area, relation to pre-existing elements...), architectural (typology, linguistic structure, building-technical structure...) and of interior design (materials, lights and use sequences...);
- between the actors of the process (medical doctors, managers, patients and designers) trying to combine rationality, wishes and feelings;
- between the different difficulties (sanitary, technical, aesthetic) and the synergy among the different parts of the project to recreate spatial relations supporting social ones.

d) peculiarly design aspects

The project has to communicate an affectivity which is able to reflect on the patient and that has to be clearly perceived as a combination of attentions considering space and interior design. Each solution has to be founded on a well defined space poetic that addresses to the human spirit and to the control of the patient over its surrounding environment.

Architectural knowledge is synthetic; so is perception (I perceive it as a single structure which addresses to all my senses) therefore I have to give proper importance to the first impression (the image) that a place can give to an individual and to the values that it is able to transmit.

The rational aspects of the project should respond to the satisfaction of general needs of wellness and of the fruition of indoor and outdoor ambiances; they should also respond to how the building gets integrated with its surroundings, to how it welcomes us, to how it communicates the passages (sequences) characterizing its functions.

The weight of the spatial question, compared with relational psychology and with environmental sociology, proposes the following:

1) criteria for interior design:

- a) the realisation of an environment which transmits positive, receptive and hospital emotions;
- b) the definition of an open, accessible and comprehensible architectural organism;
- c) the attention to details, the use of colours in relation to forms, their meaning and potentiality;
- d) the study of the sequence, the movement and the playgrounds of the use of the spaces;
- e) the preference of the usage of natural light; the study of artificial light and its effects;

- f) the realization of perceptively interesting spaces never impending but able to develop elements of familiarity on an equal and calibrated human scale and able to suggest views and possibilities;
- g) the furnishing of services able to turn the patient into an active actor and to give a meaning to the time spent for the healing process;
- h) the attention towards materials and furnitures which tend to realise a whole giving expression to specific personal needs and which possibly should tone down the medical aspect;
- i) the attention to privacy, and to the personal and territorial aspects of a patient;
- j) the defining of a comfort level which gets articulated in a sound favourable environment, in visual solicitations, in the control of light, in ergonomics, in the inner climate and finally in safety;
- k) the support of an art which is useful (organically conceived in behalf of the architectural project to obtain the solution of specific functional problems having an emotional conscious impact or just taken as a positive distraction) for fixed elements but also for temporary activity-elements. In hospitals, art should develop as an organic element without overdoing, by confronting with themes such as identification groups and one's own identity as far as turning itself into a humanizing practice;
- l) the usage of elements belonging to the culture/identity/origin of a place (this can be realized in different ways: in the new hospital of Singapore, opened in the year 2000, domestic and local handicraft elements have been included in hospital spaces);

2) criteria for exterior design:

a) nature as a therapeutic element:

emotions are in strict relation to nature themes, the experience of beauty and a mean of physical and mental health. The most interesting experiences do use nature as a central key in the healing process: from infant psychology over to the Alzheimer Syndrome, from chronic diseases to oncology clinics and to "special" patients;

b) urban design as an urban link of the hospital to the city;

c) the realization of an external multifunctional space, open to other activities at different hours;

d) environmental art as a form of social ecology:

a tool for teaching caring, a way of caring out that socio-cultural diversity that is necessary to awaken society's active consciousness, for characterizing places and controlling the risks of a spatial disorder (illness is sometime considered as "disorder"). The idea of environmental art passes from the confrontation with life over to other meanings as that of a bridge between the culture of the hospital and that of the city; a connection which is build up on exploring the places and their individual characters suggesting new existential links.

e) Sustainability aspects

The hospital has to be part of the ecologic city and has to found itself on a changing of the rules. Ecologic city: these two words sound almost antithetic and it is not by chance that when we talk about ecology we do mainly refer to extra-urban spaces. Despite this, urban ecology is instead a central theme if only we consider that the city is not an entity separated from the surrounding environment; that natural processes are relevant for planning processes and for the form; that diversity is a necessary principle for social and environmental health; that the city forms an ecosystem founded on the relation between natural and artificial environment (it produces transformations on physical, biological and visual ambient, on climate, sound and on the air that we breath...).

Healing spaces do not serve only as places for assistance and therapy but also as places were to take care about prevention; and the first prevention is certainly the protection of the environment.

The right for health is therefore part of the more general question of life quality: healthy materials for men (biocompatible), eco-sustainability (attention for the environment), bioclimatics and

energy-saving and the use of renewable energies; applicability of bioarchitectural concepts to the project of healing places and humanization is certainly one of them.

To these concepts have to be added:

- attention to the re-usability of existing buildings through its restructuring, before arriving to its demolition or to the building up of new complexes that determine a strong environmental impact;
- building concepts that should correspond to local climatic characters, that should allow a grade of flexibility (for example dry reversible structures) and that may work also for materials that can be recycled and for the reducing of waste yard materials.
- a landscape projects aware of vegetal essences for an efficient environmental quality and the reduction of pollution on a micro-climatic scale.

These aspects are not yet sufficiently considered and they need a particular effort also to define rules that accept possibilities founded on new criteria.

f) aspects of participation and monitoring

This is a theme which promotes awareness, comfort and satisfaction of the users.

As reported on the Alma Ata Chart, people have the right and the duty to participate individually and collectively at the planning and the realisation of the health assistance they need. This means that individual and community independence and the participation to the planning, the organization, the functionality and the control of primary health assistance need to be promoted as much as possible using all the local, national and other available resources; for this purpose the capacity of participation of the communities have to be promoted through an adequate education.

Planning attention can not be realized without a participation method that can be structured in different scale and ways for each single case.

It is a question of both a process of gathering information regarding planning problems and discussing and evaluating specific proposals. This can happen through various techniques at the same time: interviews, meetings, focus groups for a higher quality and more detailed survey upon the opinions, evaluation methods about the satisfaction of the users, both human as well as environmental; and turning to the patients, the medical staff, visitors, managing staff and all those who use the building.

Participation serves to clarify goals, to improve solutions, to spur positive reactions in the user, to create a sense of community. But necessary conditions to this are the will and the sensibility to act in the direction of the central function of the patient and it has to be based on a periodic action of control about what has been done starting from the first conceptual act of the problem up to the final evaluation of the users satisfaction.

g) quality aspects

The architectural conception is the cultural matrix of any act of operating on the territory which has to grant that a work can be realized and also that principles are coherent; a role, this, which, on one side, is conceptual and, on the other, is research and guarantee of quality.

It is quiet complex to define the concept of quality in architecture: we can for instance talk about planning criteria, formal qualities (allocation in space, dimension and proportions, materials and surfaces, colours, and so on...) or of congruence of a solution (rationality, introduction into a context, right use) as well as of the capacity of a structure to be communicative and informative (expressions that a form gives to the outside and whether these are comprehensive), and of climatic modulation, of constructive methodologies, of architectural conception, and so on...

At the end of all we have to consider also the management of the physical structure and we have to bring those who live in it to account, as well as the transformations that inevitably are carried out on it over the time. In this sense it is necessary that the user himself is aware of how an architecture is realized and how it has to work; he has to understand and accept its values and its limits acting

correctly and coherently in relation to these presuppositions.

Finally, the quality of architecture has to be considered for its communicational role between community and environment that is in direction of an education to the principle, the values and the forms of the territory to which it belongs.

EXAMPLES OF HUMANIZED HOSPITALS

Humanization is an intercultural problem which involves the individual and the social sphere.

In spite of all the wide considerations that have been made up till now about humanization, we still today can verify a notable distance between theory and the state of practical realizations; therefore there is a demand for larger exchange solutions of critical analysis referring to outstanding experiences as well as to monitoring studies, which may reveal an articulate and acquainted working method through the results they have obtained.

Humanization can be carried out in many ways but in first place it has to start as a response to the culture and the problems of every single place trying to introduce themes and actions that turn it sensitive to specific problems. This may comprehend innovations in healing techniques (see the introduction of complementary medicine such as acupuncture, fitotherapy, homeopathy, Chinese traditional medicine into Italian hospitals), new methods of organization and management, or things carried out in which architecture has been not only used to change the space but deliberately to build up a new culture of healing for it is able to carry out a role in the construction of an individual experience, on an emotional and a perceptive level, and at the same time a role in the proposal of new therapy place conceptions.

As an example for studies in this direction I want to present the New Pavilion for Hemodialysis of the Hospital of Pistoia – planned by the architectural office Vannetti in 1999 and carried out between 2001 and 2005. The project has been published by the American Association “Center for Health Design” among the 161 best projects of the world which in 2005 were dedicated to hospitals as “functional, aesthetically amiable, promoting efficiency in treatment and health services... able to create an atmosphere that improves comfort and well-being of patients, health staff and visitors.”

THE NEW HEMODIALYSIS PAVILION OF THE PISTOIA HOSPITAL

1 – VOLUMETRICAL AND ARCHITECTURAL LOGIC

The Hemodialysis Pavilion derives from the desire to suggest a new hospital model linked to an organic vision of architecture and centred on the idea of architecture as an instrument of education of the patient to be responsible of his own health.

A unit of living developed horizontally, within which there is a participation on different levels: physical, as the perception and the interaction with a geometric form and the sensorial stimulation which the interior ambient suggests; psychological as the ambient tends to propose a more profound meaning of interior research.

The two volumes, one tubular and the other one on oval plan, are connected among them in a relation which is symbolic, spatial and functional.

The oval building which encloses the dialysis rooms, is reassuring and it amiably surrounds the patient to create a place with unique characteristics.

The tubular building on two levels, holds the services needed for the dialysis room which in this way has been completely liberated to become mono-functional and exclusively build up to improve comfort for the patient.

The first floor of this building was supposed to be destined to nephrology hospitalization with a link to the health walkway of the hospital through a climatized tunnel. Later, during the construction upon request of the health institutions (Azienda USL) the destination of this area has been changed

into ambulatorial, eliminating the link.

This volumetry derives on one hand from a symbolic reason of composition due to contain, protect and create a symbiosis with the dialysis room, and on the other hand it derives from the will to create a soft separation between the new and the old culture of the hospital.

The whole of the two volumes tends to set a morphological central space inside the hospital area, an eccentric element which produces a non-accidental space where the physical dimension leads to an experience that influences actions and emotions.

The two buildings also realize a geometrical symbiotic relation: the generatrix and the arches which constitute them are all strictly connected and contain each other; the structure intentionally does not have a centre and is characterised by many different visual and perceptive centres and is therefore constituted by a mere sequence.

Under a profile of spatial poetic:

- the form of a pavilion has an winding character, oval because of an affective type, cut in the middle by a garden which juts up towards the sky and out towards the city and which lets natural light spread in all directions;
- instead the tubular form contains, protects and shields the pavilion from the rest of the hospital, that is, from a culture which is different from the one proposed.

* * *

The Dialysis Pavilion up till today holds the maximum amount of hospital beds allowed by the actual law in force (26) but in any case it is realized on a 'free plan', that is, free from structures and installations which could restrict the interior use. The ceiling wooden boards distributes electric and mechanic installations, while the floor holds radiating panels. Inside subdivisions are obtained through equipped fitting partitions or through dry technologies.

Interior and exterior finishing materials have been chosen by privileging natural products (wood, copper, marble), trying to present a pleasant aesthetic aspect, far from the hospital one, to realize maximum hygiene (possibility to clean with specific products), minimum need for maintenance and being durable and secure.

2 – HUMANIZING ASPECTS

A complex vision regards both the different levels of intervention: urban (analysis of the area, relations with pre-existing structures), architectural (typology, linguistic structure, technical-constructive structure), interior design (materials, light, sequences of use...) and the way of combining together different clues (sanitary, technical, aesthetic) and synergies of the various parts composing a project.

When we talk about a project that follows an "organic" matrix more than thinking about a style we rather have to think about a way to look at the things that in a second moment leads to produce also different forms. An organic space looks for the sensorial and perceptive qualities of an environment, for the psychological qualities but at same time also for the healthiness, the promotion of knowledge and innovation and finally the communication between inside and outside.

List of the innovations adopted in the Pavilion comprehends:

- the definition of an open, accessible and comprehensible architectural structure;
- a diversified access depending on the type of users and on their different needs of privacy
- the choice of an horizontal development of the building for a better accessibility and a more direct relation to nature;
- the control of the dimension and the scale of the different areas;
- the realization of a space which perceptively is interesting and never prevailing on the others and

able to create the feeling of familiarity;

- therapeutical evaluation of nature;
- the realization of an emotionally positive environment, welcoming and hospitable, built on psychological analysis and on the requirements of the individual subjected to cure;
- qualitative specialization of the different areas (following the different types of patients or of cures);
- the possible cooperation of an useful art that is an art which is organically conceived within the architectural project;
- particular attention to details, use of colours in relation to forms and its chromo-therapeutic functions;
- the study of paths and sequences in constant reference to the outside, of movements and sceneries
- the preference to the use of natural light; attention to artificial light levels, to its tonalities and to interior light comfort; the care to eliminate all sorts of exterior light pollution;
- the inside and outside use of natural materials;
- the use of security glasses that do not screen ultraviolet winter rays;
- particular attention to hospital stay areas: realisation of special bed structures, use of privacy systems;
- phonoabsorbent ceilings for a better sound climate and also sloping so as to lead the eyes to look to the outside...;
- the equipment with services that can turn the patient into an active person giving a sense to the time of his hospital stay (internet, radio, television for personal use).

All this for the realization of a place which should be a means of mental, physical and spiritual health.

Among all this elements of innovation at least three need to be shortly explained in detail:

The sense of nature

The project sets the relation between physical and mental spaces generated on the individual by hospitals, as a central theme.

This relation is actuated considering nature as a therapeutic instrument recognizing its capacity to carry on a complex wellness process (relief of physical symptoms, stress reducing processes, general self-improvement and that of self-expectations).

From this point of view the garden is a mental place, an intimate space around which the hospital area is developing. The place of growth and development of vital and intimate phenomena. So is the "spazio del sé" (space of oneself) that cuts the dialysis, and the opening on the therapeutical gardens on the west side; and so are also the two horti conclusi that follow along the walkway inside the tubular building, paradoxes of an included nature that tends to contain infinity.

Nature is present also inside the pavilion as a pure device in the stair case where the walls in reinforced concrete support the signs of a bamboo wood in green copper, oblique lines that follow underneath and over the heads of the passing people together with a small citrus plant.

The use of art

As hospitals are not only functional covers but also physical testimonies of a civilization, the project of the Dialysis Pavilion has been developed since its origin feeling a strong need for a presence of art inside. The history of this hospital was actually linked to the culture of the city and art was an integrated as well as an integrating part of it. This relation to the surroundings got lost over the years together with the mentality that had turned it into a social lifestyle.

Inside the Pavilion art becomes an instrument of communication between places, a cultural link between the hospital and the city but it is also an occasion to think the concept in a new way ; a hospital as a sustainable place for health, as a place to live, open to the natural environment and to

external cultures, and thus not isolated and thought as a functional ghetto.

Art was not superimposed to the project. It has been inserted as an organic proposal as far as to turn it also into a humanizing practice confronted with the themes of identity.

A useful art which has accepted the limitations imposed by the rules and the realisation of the functional topics that have been proposed; an art that has been able to get closer to life and to the relation with the public, opening to the possibility of social communication.

Following this line the project has been developing as a frame within which to find an organic proposal and there have been singled out seven artists ready to face the architectural topic and to share points of view and philosophy with it.

On the outside, Gianni Ruffi has realised a 30 mt long bench in the form of a half moon which dialogues with the curve of the tubular element; Robert Morris builds up an entrance arch in iron cor-ten and wistaria assembled with two curved cone-trunks that reproduce vertically the shape of the tubular building; Dani Karavan creates a wood and marble gazebo to represent a welcome space. In the inside, Hidetoshi Nagasawa realizes three zen-gardens with specific reference to the architecture in which they are contained; one of them designs through using stones, the space which is created by two concentric elements, one pentagon and one heptagon which is an ineffable space that can be traced only after a slow observation. Sol Lewitt reproduces in his wall painting, placed in the entrance hall, a sanguineous flux composed by concentric and intersecting circles. Claudio Parmeggiani designs the floor of the main walkway that carries the patients as if they were suspended on top of a Milky Way made with a marble mosaic; Daniel Buren carries out the partitions between the beds of the patients and a path of colours inside the Dialysis.

Light and colour

The first planning choice regarding colours was the one relative to light: natural light in all areas, to modulate the indoors and to obtain a connection with the outside; artificial light of effect on the outside; warm and diffused light indoors for a better comfort of the patients, with good chromatic rendering tonalities. Then it was necessary to choose the materials, that is the support of colour; finally the intention is to create a specific perceptive function through the use of colour.

Outdoors there have been used nature tonalities: natural cedar, marble from Trani with uneven warm white ground tonalities, copper with green or natural patina, frames in dull pearl grey and finally the gardens in front of the dialysis room composed with yellow or yellow-green leafed evergreen plants. In the gardens colours are always chosen to reach an environmental effect so as to insert it fluidly among the green hospital area.

Indoor the choice of colours has always been conditioned by the necessity to find accordance to the artistic projects, to respect specific sanitary conditions and to create an emotionally positive environment. The use of colour in this last case always tends to suggest a mental order following a psychologically compensative type (chromo-therapeutic and/or colour theory following concepts related also to specific geometric forms).

We are aware of the fact that even if on one hand colour is part of our social sensitiveness and on the other we can't separate it from our personal experiences, nevertheless it is possible to make further researches and propose their continuous differences.

The final sense of this work is dictated by the wish to express the necessity for a change of direction in designing healing spaces and by the hope that the choices that have been made may contribute to the definition of such places as agents of mental, physical and spiritual health.

CONSIDERATIONS AND CONCLUSIONS

The principles which at the level of ethical life and moral behaviour guide the programs and the

organizations of health systems are as follows:

- 1) The Principle of Human Dignity
- 2) The Principle of Need and Solidarity
- 3) The Principle of Cost/Efficiency

For the first two items there is an articulated analysis of the historical developments and contemporary aspects of interpretation and perception of the therapeutic space, in a current, prospective vision of the humanization of structures, within the frame of philosophy and the requirements connected to the concept of the centrality of the patient, in conformity with the directions of international health. The principle of cost/efficiency opens a discussion on the consideration of the scale of values and therefore of priorities, which must be considered in the planning/restructuring of a hospital building within the context of national health systems, according to the W.H.O. terminology.

Therefore the need to choose between different types of activity or different interventions and solutions, requires considering a reasonable and balanced rapport between costs and expected results, measurable in terms of improved health linked to the quality of treatment and/or to an improved quality of life linked to conditions of living, communication and reception in places of treatment.

In many systems, the necessity to rationalize expenses depending on funds available, tends to privilege the architectural planning and functions of the hospital as a "healing mechanism", like a factory with various specialized production lines, according to the principles and methods of progressive patient care of the W.H.O. (1967), which is defined as "a polyarticulated route in which patients are grouped on the basis of specific needs of assistants, determined by the type and level required for their health."

With this technical approach to health, not enough attention is paid to the rapport of the hospital within the urban and social context and to the general aspects of relations and communications with the aim of humanizing the reception and stay in hospital.

In the correlations among the dimensions of culture, solidarity, assistance and the fact of medicine and science becoming biosocial, Aktou's definition (1989) on the modern hospital is particularly indicative: "hospital is a group of activities aimed at defining and fixing the great orientation of the time in terms of structures and means. It is in some ways the permanent maintenance of a vision of the future with constant monitoring, with information on the external and internal environment."

Thus we have the outline and formation of "a new cultural model, where the hospital will be part of the territory and community, known particularly for the flexible possibilities of its structures". (Guzzanti E. 2006)

Having established that a hospital is part of the urban context in which it is located, relating and communicating with it, it follows that also the particular world of the sick person must live the life and possess the characteristics of the urban and social network to which it belongs.

Consequently, all aspects of humanization which give identity to daily life are to be considered and taken up to allow a continuity of sensations, emotions and behaviour corresponding to the habits of life and to human and social expectations both of the individual and the group.

Therefore it appears neither logical nor rational to have an exclusive functional technical and technological vision of the therapeutic space, which limits or, in some cases, ignores the use of spaces for reception and stay in general, in accordance with habits of daily life, with a vision and a presence also of aspects of beauty and art, as physiologically rooted in co-existing realities of assistant processes in places of treatment.

Therefore the improvement in the quality of life for the sick person, who experiences the health system, constitutes a benefit of well-being which cannot be ignored by modern treatment, and for results objectively and subjectively obtainable justifies within the general framework of the allocation and distribution of resources the assignment of funds to this end.

"In hospital one is treated and cured, one works, lives, is born and dies, but one also hopes and

dreams". (Romanol 1995)

This vision of the humanized therapeutic space opens the horizon and the prospect perhaps to illusions, to hope always, in the common feeling which looks to the world of the mind and the spirit and to the philosophy of the infinite, as M. Heidegger (1947) recalls in his "Letter on Humanism." "Man of the Atomic Age could find himself, dismayed and helpless, at the mercy of the unstoppable excessive power of technology, and that will happen without doubt, if man today does not bring into play in this decisive game, meditating thought as opposite to that which is pure calculation."

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