LATITUDES
EURAU26

Situated reflections on architectural research

UMA 10-13 June 2026

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ISBN: 978-91-6850-075-1

Umeå University

June 2026

ISBN: 978-91-6850-075-1

Cover image: Maria Luna Nobile

Acknowledgements:
This publication is a result of the research project LATITUDES / LATITUDER funded by Riksbankens Jubileumsfond.

Other fundings have made possible the organization of the symposium and the production of contents related. Thanks to: UTRI Umeå Transformation Research Initiative, Umeå University and Umeå Municipality (conference grant), Italian Institute of Culture in Stockholm, Arctic Arts Summit, UmArts research centre, Reykjavik Municipality, Swedish-Icelandic Collaboration Fund.

Umeå School of Architecture and the EURAU International committee have supported with their time the production of this publication and the organization of the symposium.
Alicante University and the UOU Scientific Journal have contributed fundamentally to the process of double-blind peer-review and selection of the submitted contribution.

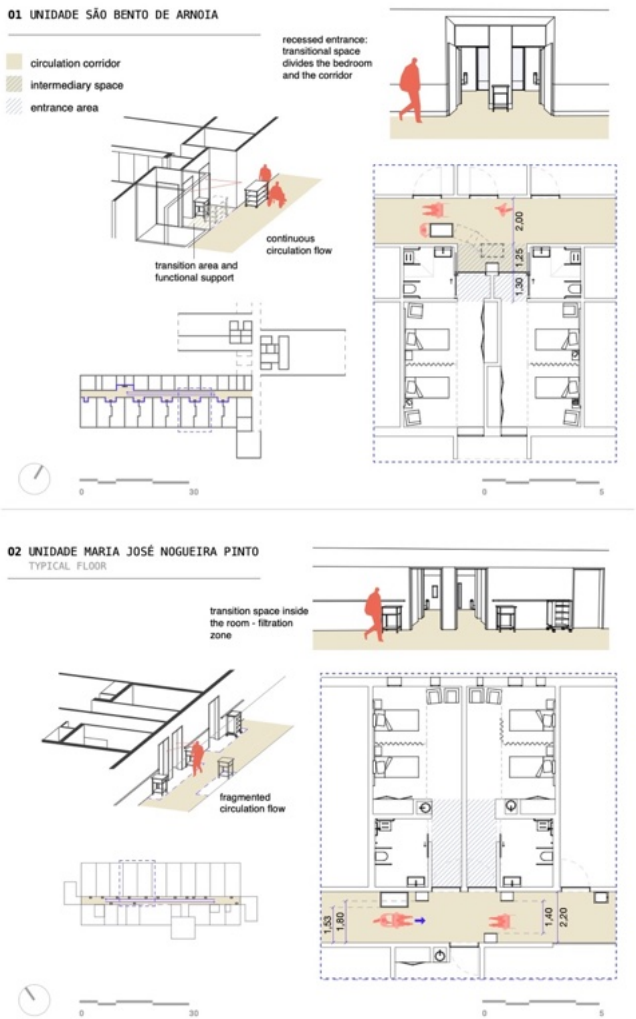

Fig. 1. Analysis of solutions for transition between the patient room and circulation space. Teresa Maciel 2025.

Architecture and Care. Therapeutic Experience and Contextual Practices in Palliative and Continuous Care Units

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This paper proposes a critical analysis of architectural practices that enable the building to function as a therapeutic instrument, promoting comfort, well-being, and an active, humanised recovery, drawing on a recent investigation on this theme[47]. Within a context of demographic ageing, increased chronic diseases, and aggravated social isolation, the study focuses on Palliative Care Units[48] (PCU) and Continuous Care Units[49] (CCU) as responses that go beyond a strictly clinical dimension, integrating spatial solutions oriented towards the physical, emotional, and social needs of the patient.

The research proposes a reflection on the *concept of care* as a theoretical and design framework for architecture, exploring how it can operate as a mediator between technical requirements, clinical practices, and human needs. Therefore, it raises the following question: in what ways can architecture conceive

[47] This article was developed following the research that led to the master's dissertation of Teresa Maciel conducted within the research project *HoTT: Housing Think Tank: Knowledge Integration on Multi-Family Residential Buildings* (CENP, FAUP, Portugal).

[48] Care dedicated to stabilising disease in patients who are in an end-of-life process or have an incurable chronic condition.

[49] Care involving treatment and support for patients with physical and/or psychological dependency, with a strong social component.

healthcare spaces that reconcile technical dimensions and therapeutic principles, promoting comfort, well-being, and the active participation of the patient in the care process?

To analyse the architectural responses of PCU and CCU, a comparative methodology was defined, based on four case studies in different geographical, urban, and institutional contexts, complemented by in situ visits. This approach clarified how cultural and regulatory frameworks are reflected in the built space.

Given the diversity of solutions, the analysis was narrowed through key design principles: i) *interior–exterior relationship*, ii) *the positive use of circulation areas*, and iii) *the transformation and appropriation of space* by the patient. This selection resulted from specialist literature, on-site observations, and the research aims.

However, the application of these principles is conditioned by regulatory frameworks, models of health system organisation, and specific institutional cultures. In the Portuguese context, the integration of care within hospital structures or within the National Network for Continuous Care (Monteiro, Santos, Costa, 2013; ERS, 2015) tends to privilege operational efficiency, whereas some European hospice models seek to distance themselves from classical hospital language, prioritising the therapeutic and humanised dimension of space. The complexity of human well-being demands a reassessment of traditional spatial models centred on functional efficiency and regulatory compliance (Arnaut, 2020). In this respect, PCU and CCU highlight the need for architectural approaches that place the patient's experience at the centre of the project, considering the diversity of ages, clinical conditions, and emotional states.

Architecture should acknowledge the plurality of bodies and lived experiences, integrating care transversally into design practice (Schweitzer, Gilpin, Frampton, 2004). This perspective aligns with approaches such as Evidence-Based Design and Psychosocially Supportive Design, which recognise the direct impact of the built environment on well-being, stress reduction, and a more active attitude on the part of the patient (Ulrich and others, 2008).

In Portugal, two examples were analysed: the São Bento de Arnoia Unit in Celorico de Basto, in a rural area and integrated into a former Benedictine monastery, with a horizontal layout organised along a transversal axis connecting inpatient wings and common areas; and the Maria José Nogueira Pinto Unit on the outskirts of Cascais, organised vertically, separating types of care by floor and adopting a linear circulation system that branches according to function.

In the international context, both examples are in densely urbanised areas. Pavilion 79, in Vienna, is part of the Wilhelminenspital hospital complex and combines linear and radial circulation around a central courtyard, balancing socialisation and privacy. The Urban Hospice Unit in Copenhagen is arranged radially in small sections linked by the common area, encouraging visual and social interaction between floors.

The comparative analysis of the case studies, across the three dimensions, revealed significant differences in the architectural approaches. In the international examples, there is a stronger emphasis on the sensory and emotional dimensions of care, expressed through a strong interior–exterior relationship, the enhancement of circulation spaces, the creation of intermediate areas, and more flexible strategies. These strategies reinforce autonomy, facilitate the management of privacy, and stimulate spontaneous social interactions, strengthening the patient's perceived control over daily life.

In contrast, the Portuguese context relies more on spatial models of an institutional and functional nature, characterised by more rigid solutions and an organisation that limits adaptation to different degrees of mobility and clinical conditions. This mismatch between contemporary care paradigms and the spaces that accommodate them is often conditioned by regulatory frameworks and design approaches centred on operational efficiency.

Overall, the comparison demonstrates that the conscious integration of key principles does not compromise technical aspects but highlights the potential of the built environment to enhance the therapeutic experience. The differences observed

suggest that, while the international examples tend to adopt more holistic approaches centred on the patient's experience, the Portuguese cases reveal significant potential for development through the critical incorporation of more humanised, flexible, and inclusive design strategies.

The research shows that architecture can assume an active role in the therapeutic process, as long as it's conceived beyond a strictly technical and functional response. The comparative analysis indicates that the conscious integration of principles contributes significantly to comfort, well-being, and autonomy, without compromising the regulatory and operational requirements of healthcare facilities.

In this sense, PCU and CCU reveal the potential of a care-centred architecture, capable of mediating between technical requirements, clinical practices, and complex human experiences. More than an exercise in regulatory compliance, the design of these spaces requires a critical and sensitive approach, oriented towards the dignity of the patient and the humanisation of the therapeutic environment. Architecture thus emerges not as an isolated solution, but as a fundamental instrument in constructing care experiences that are more qualified, inclusive, and humanised.

Acknowledgments

This work was supported by Nuno Portas Centre for Studies, funded by national funds through the Fundação para a Ciência e a Tecnologia (FCT) under the project/grant UID/00145 - CENP.

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The organization of this international symposium and this publication was made possible through the enormous commitment and contribution of UMA members of staff, academics and administration and of our students, without them LATITUDES would have not been possible.
The EURAU International committee members with determination and energy has supported also the organization fo this EURAU26 symposium, with them I have the pleasure to share this experience since 2010. Thanks to the Scientific committee of EURAU26 and the UOU – University of University Network, including the Editorial board of the UOU Scientific Journal, who ensured the quality standards through a thorough process of peer review, selection and publication of the results of the EURAU26 symposium.

Umeå School of Architecture at Umeå University and UmArts research centre have ensured that the EURAU symposium would have been possible.

A huge thank to Roberta Amirante, for her trust and guidance throughout the years, and with her to Maria Madalena Pinto da Silva, Gülsün Sağlamer, Joaquín Ibañez Montoya, for being present, for encouraging and reassuring me in every single step of this journey.

EURAU, the European Research in Architecture and Urbanism Symposium would have not been possible without the commitment of its initiator Farid Ameziane, to whom we are all grateful. And it is in memory of Farid that we continue this journey.

This publication is dedicated to the ones dreaming every day in a better world.