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Sensing Space and Making Place: The hospital and therapeutic landscapes in two cancer narratives

Abstract:

This article explores the role of senses in the construction and experience of place, focusing on patients' experiences of hospital care. It compares two cancer narratives for their insights into the heterogeneous ways that hospital environments are made into therapeutic landscapes, arguing that they are a product of dynamic processes rather than something that is simply built. The article draws on a relational model of space and place, alongside literary analysis, to explore the making of un/healthy environments in embodied, affective and sensory terms. It indicates that sensory experiences in hospitals are made (un)therapeutic in relation to illness and recovery, as well as a range of social and human/non-human relations. These conclusions warn against drawing broad conclusions about 'good' or 'bad' hospital sensescapes, or against treating the hospital as a homogeneous space. They also offer new opportunities for medical geography and the medical humanities, by showing how illness and recovery are part of the relational making of space and place.

It impossible to separate the senses from space and place. As anthropologist Steven Feld notes, 'as place is sensed, senses are placed; as places make senses, senses make place'.¹ In the light of the strength of this connection, the relative paucity of studies situating the senses in healthcare spaces and places seems surprising. Scholars of medical geography and anthropology have long spatialized sensory studies (or added the senses into spatial studies), while the medical humanities engage extensively with the senses in relation to medical diagnosis and illness experiences. However, these two fields rarely overlap.² Juliaan Pallasmaa's *The Architecture of the Senses* comments only on hospitals in relation to their 'sense of estrangement and detachment ... evoked by the technologically most advanced settings'.³ David Howes and Constance Classen's *Ways of Sensing* makes similar comments, in their brief section on hospitals. They observe that 'the hospital is a decidedly unaesthetic place'.⁴ Such comments often rest on broad assumptions about hospital design, and do not take into account the heterogeneous and relational nature of hospitals as sensory and aesthetic environments.

The article takes two pathographies, published accounts or 'narratives' of illness, as a route into better understanding how 'places make senses [and] senses make place'. It focuses on the processes by which embodied, multi-sensory environments (described here as 'sensescapes') are made – or not made – into healthy places or so-called 'therapeutic landscapes' that promote holistic health. Scholars of the medical humanities have paid relatively extensive attention to cancer narratives, due to their rich use of metaphor and their prevalence. However, they have tended to overlook representations of the hospital in favour of studying representations of the illness and patients' identities.⁵ Hospital narratives provide an ideal context to understand the making of place as, within them, patients tend to move through both different hospital environments and stages of an illness or recovery. These narratives show how the experience and meaning of hospital sensescapes – and, by extension, the construction of place – is aligned with the course of an illness. Healthy places within hospitals are not simply built. They are made in relation to a patient's embodied and affective feelings about illness and recovery; the same sensory environment can be a different place over the course of an illness.

Illness narratives enable a close study of the embodied and relational processes by which places are made as healthy places or therapeutic landscapes. To some extent this article abides by a geographical framing of space/place in order to facilitate such analysis: hospitals are distinct types of built spaces, with specific sensory features, and they become *places* when patients give meaning to these environments.⁶ However, it also shows how illness narratives pose problems for this neat space/place division. The hospital becomes a therapeutic landscape – promoting health in a broad, holistic sense – as the result of what geographers call the ‘relational’ aspects of space. A relational model of space emphasises the co-existence of different relations at any given time, each of which contribute to the making of place in a specific way: there is no objective ‘space’ that exists outside of these relations. As Martin Jones notes, summarising the ‘relational turn’ in geography, in this framework ‘[s]pace does not exist as an entity in and of itself ... objects are space, space is objects, and moreover objects can be understood only in relation to other objects – with all this being a perpetual becoming of heterogeneous networks and events’.⁷ In this framework, there is less distinction between an objective space and the making of a meaningful place, as all space is contested, constructed and contingent. Much work on relationality has focused on social relations, with implications for understanding power and politics. However, the concept also includes relationships to non-human actors, to affect or emotion, and to selfhood.⁸ This article shows that a person’s relationship to their illness and recovery is also part of the relational making of space and place. A therapeutic landscape is one that promotes recovery and wellness, and in illness narratives is also a *product* of recovery or the perceived path to wellness.

These themes are explored here through two accounts of cancer, one written and one graphic pathography, working through different hospital sensescapes.⁹ The first account is John Diamond’s *C: Because Cowards get Cancer Too* – an account of oral cancer from 1998, which builds on John Diamond’s newspaper column. The second is a more recent work from 2014: *Probably Nothing: A Diary of Not-Your-Average Nine Months* by Matilda Tristram; this work is a graphic diary that combines text with imagery.¹⁰ Despite being published over a decade apart, there are few significant differences in the London hospitals that they both encounter: they undergo similar tests, and spend time in similar waiting rooms and wards. Like Diamond, Tristram has cancer (bowel cancer in this case). Despite the seriousness of their illnesses, both take a comedic tone at times, using humour to highlight points of dissonance between their emotional states and hospital design. These books provide invaluable insights into the sensory aspects of hospital spaces/places and their changing meanings for patients, due to the repeated nature of cancer patients’ visits over a relatively long period of time.¹¹ They are written at least partly in ‘real time’ and document repeated visits to hospital and changes in their ongoing condition.¹² Tristram and Diamond thus don’t share the position of some other memoirs, which – to cite Emily Waples on other cancer autopathographies – offer their ‘readership a kind of reflectivity that distances the experience of disease’.¹³ They imply to the reader a tone of immediacy. This tone is important for insights into sensory experiences, and particularly their changing meaning for patients over time. They provide insights into the meanings given to hospital spaces as patients are diagnosed, receive treatment and engage with their feelings about illness and recovery. While cancer has a particular social significance and diagnostic / treatment process, these memoirs also allow some broader conclusions to be drawn about relationships between un/healthy bodies, selfhoods and places.

Therapeutic Sensescapes: A relational perspective

This article explores the heterogeneity of therapeutic landscapes, or sensescapes, using patients' hospital narratives to critique the idea that any healthy place exists outside of its relations with the patient's embodied and affective presence. As in the literature on therapeutic landscapes, it takes a broad, holistic model of a healthy place and deliberately avoids beginning – or ending – with any attempt to identify its features or quantify its effects. In this article's references to healthy and unhealthy places there is an implicit spectrum rather than a binary; there are relatively neutral places found in illness memoirs, and not all healthy or unhealthy places exist at the extremes of this range. A place is made 'healthy' when it is a positive embodied and affective experience for the patient, but not all places have the same effects or are un/healthy to the same degree. While there is undoubtedly great value in identifying the features of healthy or therapeutic environments, or measuring the degree to which a place is healthy or unhealthy, it is not the goal of this particular analysis to do so. It focuses instead on processes and on the relational making of a 'healthy place' as a broad and diverse category.

Despite some rigorous and significant scholarship on the senses and place-making, particularly from geographers and anthropologists, there is still a lot missing from our understandings of the embodied making of healthy and unhealthy places. Therapeutic landscapes literature is beginning to engage more with the senses and embodiment, but this area is still underdeveloped.¹⁴ Similarly underdeveloped is the scholarly literature on how therapeutic landscapes are constructed in relational terms. Geographer David Conradson is one of the few to begin work in this area, rightly noting that work on therapeutic landscapes 'has usefully highlighted the environmental, social and symbolic dimensions of such places, [but] relatively less consideration has been given to the relational dynamics through which these therapeutic effects emerge.'¹⁵ Conradson makes some important steps towards a relational model of therapeutic landscapes, but his work can still be taken further. He focuses on selfhood as a psychological concept, for example, and illness narratives provide valuable opportunities to think more about the embodied, affective and sensory aspects of selfhood and relational place-making. He also acknowledges the importance of human/non-human relations, but then considers them little due to the focus on psychology. Hospitals provide an ideal setting to consider these relations, in a range of forms. Building on Conradson's work on relational place and therapeutic landscapes, to include embodied experiences and human/non-human interactions, it is possible to avoid the ever-tempting pitfall of a nature/culture divide.

Stories – understood in the broadest of terms – provide us with routes into the relational nature of space and place. They allow us insights into meaning, and the way that places are made at individual levels as well as social and cultural ones. Many studies in health geography have involved using 'stories' in the form of patient interviews to reach the multiplicity of experience in specific spaces, through micro-studies of particular hospital rooms.¹⁶ However, few have yet attempted to use illness narratives for this purpose. The analysis starts from the premise – argued by Angela Woods – that we should not conflate all narrative forms, as there is value in paying attention to the 'functions and effects of specific types of storytelling'.¹⁷ Illness narratives have particular value for understanding relational space, over other forms of interview and memoir. They provide an opportunity to follow a person's experience through the course of their illness, offering a new form of 'relationality' through which to understand place-making. An inherent focus on both selfhood and the body also comes with such life stories. They enable us to consider the relationship between the human body, self, culture and different aspects of an environment without falsely separating nature/culture and mind/body, as is so easy for scholars to do unintentionally. This

methodological framework particularly aligns with the work of Doreen Massey who explores post-structuralist and relational models of space in depth in her work. This geographical approach fits quite naturally with literary analysis, in the light of the value of narratives for understanding multiple experiences and individual meaning-making in similar spaces. As Massey notes, 'it seems important to hold on to an appreciation of that simultaneity of stories ... we should, could, replace the single history with many. And this is where space comes in.'¹⁸ Geographical work on space allows us to new insights into some of these stories, histories and experiences, and these stories – in turn – open up new understandings of space.

Scholars of therapeutic landscapes have long acknowledged that few spaces are inherently healthy or unhealthy. In his landmark volume, *Healing Places*, Wilbert M. Gesler examines ideas about good and bad hospital design in relation to a much longer history of ideas about healthy spaces.¹⁹ Medical anthropologists have shown the impact that cultural practices and ideas can have on the construction and experience of illness, health and place.²⁰ Sensory studies and sensory histories, many of which also draw on anthropology, have similarly emphasised the importance of culture in shaping embodied experience and meaning-making.²¹ These literatures often do not distinguish the perception of a 'healing space' from the material or medical reality; they hint at – and sometimes engage directly with the idea of – a form of 'placebo effect', in which each culture's healthy spaces and places are effective for them.²² This article takes a similar constructivist stance, in which – without denying the real potential for therapeutic effects in such sites – a healthy place only exists via the people and relations within it. These relations are unstable, and emerge from shifting individual, social, cultural, economic and political factors as well as embodied human/non-human interactions. This article focus on the latter forms of relational place-making, but without claims that they are separable from social and cultural factors.

The human and representation are inevitably at the centre of discussion about illness narratives. This article focuses on how healthy places are made in relation to illness, health and an ideal past / future healthy self. However, it also seeks to go beyond a purely representational approach and to understand the human experience as part of interactions with non-human actors. It seeks not to – in the words of one advocate of non-representational theory – 'suffocate' illness narratives with social constructivism, but to be open to the embodied and affective aspects of place-making.²³ As Hannah MacPherson notes: 'the body takes shape through its interactions with other objects, bodies and landscape'.²⁴ Bodies and place alike are made through person-place interactions, and never simply exist in a stable form. In these frameworks, many of which draw upon actor-network theory, the human is also not always necessarily the centre or the 'maker' of place. In a study of illness narratives, hospitals and 'therapeutic landscapes' literature it is difficult to decentre the human in this way, but there is still value in viewing them as part of a wider landscape of relational encounters. A focus on sensory making of place provides one way to address the limits of social constructivism or purely representational approaches, by showing how meaning is embodied and embodiment is part of meaning-making. These processes are fundamentally affective, linked to implicit or pre-cognised feelings such as optimism or pessimism about recovery. As Neil Hanlon argues, advocating 'doing health geography with feeling', 'we should not overlook considerations of context, emotions and feelings when making sense of ... narrative data': illness narratives merit the same treatment, and open opportunities for such a non-representational approach to relational space.²⁵

This article's structure also seeks to reflect some of the other forms of relationality that might exist within built environments. It explores a range of human/non-human interactions and

their role in the making of (un)therapeutic environments by considering technologies, time and thresholds in turn. Time links to Massey's work on the importance of the relationship between time and space, particularly the need not to take 'snapshots' of space to control time, but rather to recognise space as an equally complex and slippery concept in itself. The other two sections explore how first technologies, then materiality and nature, and humans interact in the making of healthy and unhealthy places. These themes all develop existing work on relational space in geography, in which – to cite Jon Murdoch – 'post-structuralism's interest in *heterogeneous* relations – that is, in mixtures of the nature and social and the human and the non-human – can help human geographers to reach across the human-physical divide'.²⁶ This claim is not limited to geographers, and helps to open up new ways of thinking about illness narratives, patients' experience and hospital design. These three categories are also not purely conceptual, as they emerge in part from the places and embodied practices found in illness narratives themselves. Hospitals consist of a range of distinct places that each connect to different embodied experiences or practices, what some scholars of the home refer to as 'body zones'.²⁷ Some of the most significant of these 'body zones' in illness narratives are those associated with specific stages of an illness, as patients go through diagnosis (technologies), waiting for results or treatment (time) and periods of rest or recovery (thresholds).

Technology: Diagnosis

In hospital environments, human-technology interactions are a key form of relational place-making. Technology is part of the material environment, it is a space or place in its own right, and it simultaneously shapes and responds to embodied experiences. The relationship between humans and technology has, however, long been a fraught one in relation to health. Historians and social commentators have cited technology as a reason for changes to the sensory aspects of diagnosis, apparently diminishing the importance of senses such as touch in favour of the visual.²⁸ Extensive contemporary literature in the late twentieth century also raised concerns about the implications of 'dehumanised' high technology environments for patients, staff and visitors, often with specific reference to issues such as sensory overload.²⁹ Reading illness narratives from a relational perspective, however, indicates that human-technology relationships operate to make place in a range of ways and that high-technology environments are not always detrimental to holistic health.

Diagnostic technologies are common features of sensescapes in illness narratives. As part of a wider sensescape, diagnostic technology is in the control of the hospital and – sometimes in the absence of a machine operator in the room – serves as a dehumanised replacement for the doctor, over which the patient has no control. However, high-technology environments cannot only be read in these terms. While a healthcare practitioner might have control over a diagnostic machine, often creating an untherapeutic environment when viewed in terms of social relations, these other forms of relationality are more complex. Human-technology interactions also make place in a range of unpredictable ways, not all of which are negative or given meaning in terms of power or dehumanisation. As well as operating within wider sensescapes, and social relations, diagnostic technologies operate as sensescapes in their own right in illness narratives. It is in this context that we find a form of relationality that is individual, rather than predominantly social.

The diagnostic scan is a repeated trope for Tristram. It represents a specific space and place, and its meaning is distinct from the room in which the machine is located. In the two images shown below in Figure 1, from two different MRI scans in the narrative, Tristram indicates no awareness of a healthcare practitioner operating the machine, or the space within which

the machine is situated. These images focus on the relationship between human and machine alone, and the embodied, sensory making of place that occurs during the diagnostic process. From Tristram's perspective, in the second of the images, the machine is place and place is the machine: the image excludes the room surrounding Tristram, and her body is part of the human-technology sensescape. Despite having the same material qualities, the MRI machine is a distinct place depending on Tristram's embodied relationship to it, including her changing position inside/outside the machine and whether she listens to music or opens her eyes. The room increasingly disappears, as Tristram enters the MRI and it becomes place – rather than an object in place. This speaks to the significance of human/non-human interactions in the making of place and supports relational theory that do not separate objects from space and place.

[Figure 1. Images of the MRI in *Probably Nothing*]

The first image in Figure 1 is of an early MRI scan, when Tristram was not yet diagnosed, while images two and three are from a single panel much later in the course of her illness. Although Tristram actually has cancer in the first image, and is in remission in the latter, her emotions are the reverse: she does not anticipate a cancer diagnosis at first, and is highly anxious about the results of the later scan after previous bad experiences.

There are some notable differences between these early and late experiences of the MRI, in line with these fluctuating emotions. Tristram's body is depicted in a less comfortable position during later scans and the sensescape is less pleasant. In the second image her graphic form invites the reader into a point-of-view position in an MRI machine and enables a position of greater sensorial empathy than written narratives ('the tube looks like this'). The embodied experience of being trapped or feeling claustrophobic feeds directly into her affective response to the music and makes an unhealthy sensescape: the idea of 'scratching' music and being trapped in a coffin are evocative of live burial. The MRI machine is thus a different place for Tristram later in her illness, and is embodied – spatially and sensorially – in relation to the fear of death. Before diagnosis (in the first image), rather than intrusive noise, the machine's sounds had triggered individual associations with a life outside the hospital and non-institutional meanings for Tristram. The text below the image gives meaning to 'beep!' and 'zzzzk!': 'The machine sounds like breakcore. I think about DJ Scotch Egg and raves at the Electroworks'. Although in the final image in Figure 1 Tristram refers to a preference for 'chillout' music over the 'awful 90s triphop', her earlier more positive reference to 'rave' music indicates that there is also no innately good or bad music for patients. The value of such sensory experiences implicitly lies in their personal meaning, and in the value of control or choice over sensescapes. The making of a soundscape is inseparable from an individual's idea of the distinction between sound and noise. As Peter Coates argues: 'Noise is to sound what stench is to smell (and what weed is to plant)-something dissonant, unwanted, out of place, and invasive'.³⁰ This distinction is made through a network of relations including person-culture, person-life history, person-machine, and person-illness. It is perhaps no coincidence that similar metaphors, of invasion and something 'out of place', are often used for cancer itself.

The relational nature of diagnostic technology as places, rather than just in places, is also evident in Diamond's memoir. Diamond's engagement with technology is generally at the cognised level, with places being made healthy or unhealthy in relation to cultural references and life history. Diamond also uses simile to depict the CT machine's sensescape to the reader, drawing in this case from popular culture:

It was one of the machines that appeared from time to time on *Tomorrow's World*, the BBC wonders-of-science programme which I'd once presented for a while. The great thing about the CT scan is that it looks just like prime-time viewers think the medicine of the future ought to look: white, clean, non-invasive. Press a button and five minutes later you have an instant picture of just what's wrong with the patient. Just like in *Star Trek*.³¹

Diamond is less negative than Tristram in the meanings that he gives to such sensescapes, representing them in relation to quite positive images of space-age technology. At this point in the narrative, the future also carries possibilities for Diamond: it represents progress and opportunity. Later in the book he also notes that the laboratory, because his father worked in one, had a more positive sensory meaning for him than for most people: 'formaldehyde' 'white coats' and 'whirring' for him were not 'the unknown and the terrifying: for me they still have a comforting homeliness'.³² Technology thus holds multiple temporalities for Diamond, all of which are associated with health: a happy childhood, and a future full of possibility. Just as experiences in hospital shaped patients' interpretations of sensory experiences, experiences outside the hospital shaped the meaning given to senses within it. A high-technology environment is made into a therapeutic landscape in relation to Diamond's personal life history and associations. Again, though, they also operate in relation to his feelings about illness and recovery and Diamond is not consistent in his response to high-technology environments. Later, when in bed and struggling to sleep, 'stir crazy' and worried about nine days in hospital, the machine 'whirring' that had previously comforted him becomes bothersome: he would listen to 'the whirr of my feeding pump, and ... seethe.'³³ Sounds of technology are not distinguished as innately good or bad in the patient's experience, but are relational to life experience, illness and recovery.

Diamond also refers to sensory experiences defined in part by absence, such as the inability to move in confined spaces. Such experiences indicate how some sensory aspects of hospital spaces/places might 'fall down the gap' if we just use the five traditional senses: immobility and claustrophobia are physical sensations associated with specific sites, for example, but would not be considered as 'touch'. Such experiences also highlight the importance of intersensoriality, in that patients' perception of other senses is affected by this entrapment. As one sensory capacity declines, such as touch or movement, others heighten. For Diamond, time slows as the sensory gaze turns inwards. The restrictions of the diagnostic machine make him focus on his body and on hitherto little mentioned senses such as taste: 'for five minutes read half an hour, lying stock-still ... a syringe full of gunk ... heats up the bloodstream and leaves a nasty taste in the mouth'.³⁴ Staying still, and having no capacity for visual distraction or stimulation, leaves Diamond unable to focus on anything but the negative sensory experiences that represent medicine and the threat of his illness spreading. These kinds of embodied sensations are also evoked in Tristram's images discussed above, in Figure 1, through the angles used in drawings that create a sense of the scanner closing in on her, and through representations of her physical discomfort. It may be significant that images in which a scanner surround her, and which evoke a sense of discomfort and claustrophobia, are also those in which she is more aware of the sounds of the machine. Claustrophobia and the restriction of her visual sphere makes Tristram focus on other sensory experiences in other technological diagnostic sensescapes as well.

For both writers, diagnostic technology represents an important sensory space and place, in part because it moves their perception away from the visual and forces them into stillness. In this context, other senses become increasingly important but not in any consistent way. Senses that represent high technology are negative for Tristram, but not for Diamond.

Tristram focuses on sound in the absence of the visual, while Diamond's perception turns inwards to embodied sensations. For both, though, these senses are uniquely associated with the experience of diagnostic technology: these sensescapes make the CT and MRI machines distinct places within the hospital. They are not inherently therapeutic or untherapeutic sensescapes, however, in contrast to many of the assumptions found in literature about dehumanisation and high technology environments. The making of a human-technology sensescape as a therapeutic environment is a relational process, depending on factors such as whether a diagnostic outcome is expected to be positive, and individual associations with those machines – both through repetition during cancer treatments, and in individual life histories. The machine is also not a passive or stable object onto which feelings or meanings are projected, but part of a dynamic human-technology relationship.

Time: Waiting

Time is a more abstract concept than technology, but an equally important form of human/non-human relationality. It may be no surprise that waiting is a repeated feature of illness narratives. Waiting is one of the hospital experiences that every patient shares, and the waiting room has recently been a focal point of designing non-institutional, therapeutic landscapes.³⁵ Some scholars have examined the making of therapeutic landscapes in hospital waiting rooms, in part because of this focus on waiting room aesthetics. One article from 2009, for example, attempted to bridge the 'physical, social and symbolic' aspects of therapeutic landscapes by 'reading' waiting room art through Foucault and Lacan. While bridging the 'physical, social and symbolic' is in line with this article's goals, a focus on power relations leads to a very specific understanding of medical spaces: in this framework waiting rooms are 'clinical spaces where patients' bodies await physicians' gazes'.³⁶ While there may be some basis to this understanding of how the waiting room operates as a therapeutic landscape, there are also limits to such a theoretical model. Research questions that focus on the making of healthy and unhealthy places, rather than the making of spatial power relations, facilitate different understandings of waiting spaces. Illness narratives indicate that the waiting room is made a therapeutic landscape in relation to an individual's feelings about illness and recovery; the person makes the place, as much as the place affects the person.

The graphic form of Tristram's work lends itself to a particular engagement with time and waiting. As Hillary Chute notes, with regard to comics but also applicable here, the narrative form 'register[s] temporality spatially'.³⁷ Figure 2 shows two episodes of waiting in *Probably Nothing*, highlighting the space-time hybridity of the graphic form. The use of three similar consecutive panels emphasises the sense of time and of waiting and watching others as it passes. This passage of time can be conceptualised as a sensory experience in itself in such narratives, in the ways that it interacts with – and shapes – other hospital sensescapes. Like many cancer patients – Tristram has to attend chemotherapy repeatedly. The emphasis on the passage of time in her panels relates both to this act of waiting for a specific treatment, with a sense of anxiety that slows the passage of time, and to the broader repetitive act of chemotherapy and its temporality; similar panels occur throughout the book. The gaps between panels also articulate the act of waiting. As Johanna Drucker argues, in relation to the 'white space' that organises image strips, 'the navigational elements organize our reading experience in advance of our actual encounter with either verbal text or visual pictorial content'.³⁸ Each 'gap' marks a temporal shift as well as a change in the nature of the waiting room as a place. Each scene represents the same material environment and perspective, but a different sensescape as Tristram moves around the room and interacts with the people and objects within it. *Probably Nothing's* form allows relatively stable graphics alongside

soundscapes, showing how places are made and remade in sensory terms and challenging any notion of a clear space/place division. This layering of senses evokes a feeling of multi-sensory overload, articulating Tristram's embodied and affective experience of waiting. It provides an example of a so-called 'affective atmosphere', echoing ethnographic and geographical work that identifies a specific feeling of "“anxious waiting” ... generated by the emotional demeanours and voices of the people ... in the hospital waiting rooms, the practices of the hospital staff and the sounds, odours, tactility and appearance of the waiting room and the hospital environment generally in which they are located'.³⁹

[Figure 2. Images of waiting rooms in *Probably Nothing*]

In line with the literature on 'affective atmospheres', the hospital waiting room is dynamic and Tristram's feelings develop in conjunction with those of the people in it. Tristram's response to one conversation shows how, despite having previously visited this waiting room, it is a distinct place to her on each occasion: "it's always like this" (it isn't). This comment is directed towards other people in the waiting room, implying that it is the intrusive sound of their presence that makes it an unpleasant environment. There are, in addition, other layers to this comment. Tristram's movement around the room indicates an attempt to find, or make, a better sensescape by locating her body away from other people. Ultimately this proves impossible: the waiting room is made 'like this', an untherapeutic sensescape, as much in relation to her own feelings as it is through social relations. Tristram is waiting for her early treatments in the first panel within Figure 2. She is alone, concerned about her health and focused on the illness that surrounds her. The chemotherapy waiting room is represented as institutional, in visual terms. It is light in colour, drawing on a long history of cultural association between whiteness and sterility, both literal and symbolic. The people around her do not 'humanise' this environment, but are perceived and made noisy in relation to Tristram's illness.

There are subtle changes in tone, in *Probably Nothing*, in line with the waiting room's shifting association with illness and recovery. The second image in Figure 2 is taken from the outpatient waiting room, late in Tristram's treatment and after the birth of her healthy baby; it is visually represented as a warm pink with non-institutional, artistic fittings. This image in some ways is the opposite to the first panel in Figure 2, in creating a sense of peace rather than a dynamic and noisy environment. She has company, but no other bodies are present, which is a marked shift from the first panel in which she is alone but surrounded. It is not made clear whether the second space was really a quieter waiting room, or whether this is another symbolic shift: the quiet, comforting presence of a family member and a positive turn of events makes the rest of the world disappear. Taken out of context, it might not be possible to recognise these images as a hospital at all. The artworks appear to be of healthy bodies participating in sports events: as people look at these images, they exist in relation to an ideal, healthy self. This bright setting seems somewhat incongruous, as Tristram is waiting anxiously for test results. In some ways her image draws attention to the tensions that can exist between emotional states and aesthetics. In others, though, this less institutional imagery marks the turning point during which she receives an 'all clear' result, and the fact that – Tristram notes – 'I wasn't letting myself be as worried as I actually was'; the room exists in relation to this complex set of emotions. Tristram is also in a highly unusual dual position, in which her health is relational to that of her baby. When the baby is born healthy, Tristram's anxieties about her own illness appear to become less significant in shaping her embodied experience of the hospital. The shift in tone may represent the genuine differences in spatial and sensory design of waiting rooms for different purposes. It is also, though, a symbolic

shift that represents changes in Tristram's feelings about her illness. The waiting room is gradually made into a therapeutic landscape, as Tristram's perception of the space focuses more on its warmth and its non-institutional features. These features align with a therapeutic landscapes literature that emphasises the importance of emotive design that is 'warm' and 'homely', but also indicates that these features are made as much as they are built.⁴⁰

The making of waiting rooms as places also closely aligns with the course of Diamond's illness. At one point during the diagnosis process, Diamond wrote what he describes in *C...* as 'a manipulative sort of column' that played up and into fears about a cancer diagnosis. Diamond notes that he believed himself to be clear of cancer, but wrote a column that he thought would be more interesting and would reflect – in grim humour – the feelings of somebody who was anxious about their diagnosis. Although not a genuine insight into his feelings, the landscape that he describes is drawn from real experiences and is written up through the imagined eyes of a more anxious person:

I'm sitting in a day room in St George's Hospital in Tooting ... it's given me a chance to study the hospital's collection of discreet *mementoes mori*. It's not just the leaflets from the local council posted around the place telling you, so tastefully, how to register a death, or the instructions on how to get hold of an emergency priest or a rabbi when the moment comes. It's everywhere. The reception area is piled with old glossy magazines, each one especially selected to remind you of what the worst-case scenario is about hospitals – and, while you're here, the only-case scenario about life generally. 'When You've Got To Go...' a piece on weekend breaks in *Country Life* is headlined, and 'Dead Reckoning' an article on graveyard photography in *Amateur Photographer*.⁴¹

These comments about information leaflets and magazines highlight another form of human-object relationality in the waiting room. Patients project feelings (albeit in this case imagined ones) onto even ostensibly benign objects, such as *Country Life* magazines, which in turn operate to reinforce those feelings. Although designed to be humorous and to present an exaggerated form of this sensescape, Diamond makes some important insights here into the ways that material objects are not simply passive in the making of place. Later, once undergoing treatment, *Country Life* appears in his memoir again as a symbol of the boredom and repetition of the process.

From 4.06 to 4.10 I'd flip through the property pages of one of the copies of *Country Life* left lying about the waiting room and live the brief metropolitan daydream of the pound-for-pound conversion of a medium-sized city home into a mansion standing in 25 acres of somewhere cold and inaccessible.⁴²

Here, the magazine does not feed into a sensescape associated with death, but instead facilitates the existence of an imagined, wealthy and healthy self. With repetition and boredom also comes the potential for recovery, although it still seems distant and 'inaccessible'. It might be an over-reach to claim that *Country Life* forms part of a therapeutic landscape in this extract, but it is at least no longer a symbol of illness; aligning with Diamond's own emotions, it is relatively mundane. As scholars of material culture have shown, even ostensibly banal objects have long operated as producers, conduits, symbols, and stores of emotional states; objects in hospitals are no exception.⁴³

The emotional dimensions of waiting rooms for Diamond are further indicated by another example. In the following extract, social relations rather than human-material relations or ill-healthy self relations are central. When relatively recently diagnosed, but with a quite positive prognosis, Diamond notes a surprisingly 'cheerful' atmosphere to the Royal Marsden hospital:

As I queued in the outpatient's department for my first appointment with Henk I saw that the woman in front of me had three appointment cards taped together like a jet-setting business traveller with her bundle of visa'd passports. As I waited I worked out from the number of appointment spaces on my own card that she must have been here getting on for 100 times. She was approaching middle age, well turned out, half bobbed, clothes Marks and Spencer trendy. But after 100 visits to deal with her recalcitrant condition she looked no less apparently cheerful than any other queuing Briton. No less cheerful, indeed, than the dozens of outpatients waiting their turn in the reception area, every one of whom had cancer or was a relative or friend of someone with cancer. The waiting room should have had the atmosphere of a modern death row without the blue harps and the tin cups ... The Marsden is the most cheerful hospital I've ever been in.⁴⁴

In his relatively positive mental state, Diamond creates a sense of control in his engagement with the visual landscape. He focuses his line of sight on patients who he finds interesting and who appear 'no less apparently cheerful than any other queuing Briton'; he briefly acknowledges the visibility of illness around him, but this is not the focus of his writing. Although Diamond indicates his belief that such 'cheerfulness' is 'down to the hospital itself', implicitly *he* is also making the space a 'cheerful' one through his selective gaze and emotional state.⁴⁵ As in the *Country Life* example above, this extract ('after 100 visits...') also indicates the ways in which repetition can operate to mitigate some of the high emotions associated with the hospital compared with – for example – waiting for test results. Later, when Diamond goes to a private hospital for another biopsy, his tone changes somewhat and the hospital's aesthetic is considered to be 'depressing' for its 'pretend-grand' design.⁴⁶ This language of the 'depressing' visual aesthetic of the hospital echoes comments made early in his diagnosis, of the 'depressingly familiar' sight when attending St George's hospital for a biopsy.⁴⁷ The emotion-based description of arriving at hospital echoes his own fluctuating anxieties, in terms of mapping onto circumstances in which he is waiting for a biopsy or for test results.

Waiting is not simply a matter of change over time, but of each moment in time being heterogeneous. As Massey argues, space does not order time: it must be understood as an equally complex concept. Waiting also occurs at a number of levels in illness narratives, during which patients often inhabit a form of limbo between illness and health. At a micro-level, in the hospital, illness narratives are dominated by the theme of waiting: waiting for tests, waiting for results, waiting to recover. Time itself is a sensory experience in these contexts, or is inextricably bound with the meaning given to and experiences of sensory environments. At a macro-level, space-time is made in relation to the temporality of illness. Illness operates as a form of 'narrative disruption', which pauses or interrupt the expected flow of time or imagined development of self.⁴⁸ Recovery represents an important return to temporal flow, albeit often on a different path to that previous imagined with a healthy body. Therapeutic landscapes are made – or unmade – in relation to these different forms of temporality.

Thresholds: Recovery

After waiting rooms, patients often spend time in wards or in lengthy chemotherapy treatment sessions. These places are also made in space-time terms, and additionally provide insights into the relationship between the hospital and the outside world. When the potential for recovery seems closer, many patients find themselves in direct sensory contact with the outdoors. As sensory experiences associated with the 'outside' find their way 'inside', at a time when patients are often feeling more positive about their prognosis, these thresholds

often operate as symbols of recovery and become central to the making of a therapeutic landscape. The blurring of hospital/home is not always a straightforward one though, and an imagined healthy self can seem too distant for some patients, turning thresholds into barriers.

Windows offer a particularly interesting case studies of thresholds between the hospital and the outside world, which they operate both to close off and allow in. Windows and light have always had important broad cultural symbolism of relevance to illness and health, particularly when – to cite Duncan Patterson’s history of the window in art and architecture – ‘one side is cast as hopeful and filled with possibility relative to the other’.⁴⁹ In the late twentieth century, the thresholds of hospital spaces also took on more practical significance in evidence-based design as views from windows were found to improve recovery rates.⁵⁰ In sensory terms, windows allow the patient to look out but also dilute the medical sensescape through the entrance of sounds, smells, air and other senses associated with the non-institutional world. Such porous boundaries have great significance – good and bad – in illness narratives.

The window is a central theme in Tristram’s work. It operates in symbolic terms as well as practical ones: natural light represents recovery, while the dark indicates fear about her health. In the first image shown in Figure 3, the absence of a window represents fear and the absence of hope and implies ‘bad news’. The absence of a window represents the power of the medical profession over the affective environment, echoing a wider culture in which dark space is used to mark – and in some contexts to create – particularly ‘affective experiences’.⁵¹ Following this logic, it is perhaps unsurprising that Tristram finds great value in windows when she is provided with them. In the second and third images depicted in Figure 3, the sensescape of the outside – and particularly of nature – represents recovery and helps to create a therapeutic landscape. In these images Tristram is 26 weeks pregnant. Although potentially in early labour, the prognosis looks good: she is being reassured by ‘excited’ nurses and notes that ‘this hospital has a good reputation for looking after premature babies’. She is pictured as smiling and comfortable with her hands resting comfortably on her bump, embodying the space in relation to an unusual form of dual selfhood: her own illness and her healthy baby. As in the waiting room, she gains comfort from the growing health of her baby, and the place is made healthy in relation to her outlook on the child’s prospects. The window is open, and her path to the outside world seems closer than ever. Her words reinforce the graphic symbolism of the outside and nature, as sensory symbols of hope at this time. As with some of the discussions above, about human-technology and human-material relations, human-nature interactions are both part of making the sensescape and one cannot be simply subordinated to the other. The window is open, and smells and sounds of the outside travel in to Tristram, but she also opts to give them her attention and to ignore – or minimise – those features of her sensescape that she associates with illness and with the hospital. She even makes some sounds of the hospital that she cannot control, such as babies, into part of the natural sensescape that she enjoys. As with some of the waiting room images discussed above, it would not be possible to identify some of these spaces as hospitals if taken out of context.

[Figure 3. A selection of images representing windows from across *Probably Nothing*]

The importance of the window for Tristram as a symbol of recovery, and as central to a therapeutic sensescape, is implicit throughout her images. It is the most vibrantly coloured feature of her illustrations, despite being in the background. It is made explicit that, for Tristram, the visual is a more important sensory experience than physical comfort, although in practice the two are not really separable: the importance of the window grows *because* it

offers an escape from physical discomfort and fear. The window exists as a feature of a therapeutic landscape in relation to an imagined, healthy self who lives ‘out there’. Tristram’s perception of the window, and the explicit relationship with pain management depicted in Figure 3, is not unique; extensive research has drawn similar conclusions. Put simply, Malenbaum et al. argue, ‘[p]atients treated in rooms with brighter natural lighting experience less pain and take fewer pain medications’.⁵² The window also appears to serve a more metaphorical purpose in Tristram’s imagery, although there is no clear separation between representation and embodiment in the making of therapeutic landscapes. In Tristram’s images the window provides a way to avoid looking at the illness and technology around her. She is regularly depicted as looking out and away from the hospital, mainly towards trees but also towards city scapes; both of these indicate life. The outside is the focus – literally and symbolically – of her recovery process. The indoor light – and the importance placed upon the window as an escape – fluctuate in line with the course of her illness.

The blurring of the outside world and the hospital sensescape is not always conceptualised as a positive. Diamond, when anxious and unable to sleep, makes a specific point of referring to the intrusive sounds coming through his window: ‘the small night-time noises of the ward outside, of the Fulham Road and the dawn-waking pigeons’.⁵³ In the context of wider sensory overload, anxiety and frustration, sounds – including the pigeons that Tristram notes as a ‘lovely sound’ – become ‘noises’. ‘Noise’ not only implies intrusion into the room, but also intrusion into his body. It represents another level at which interiority/exteriority is blurred; As Yasmin Gunaratnam notes in her work on ‘noise’ and end-of-life care, ‘sound is a complicated sensual, psychic and metaphoric medium for delineating bodily surfaces, within a field of forces, through which we come to feel and solidify relationships between inside and outside’.⁵⁴ Although scholars of sensory studies have long rejected the idea of listening as a passive activity, it is significant that Diamond cannot close his ears: he is of and in the soundscape, not an outside observer who is able to divert his senses. Rather than offering hope and a return to a body in his control, these sounds – like the cancer itself – enter Diamond’s room and body without permission. The differences between Diamond and Tristram may also reflect their own senses of place and personal geographies. Both are based in London during their treatment, but Tristram grew up in Sussex. Her focus on the natural world and conception of the ‘wood pigeon’ as ‘lovely’ reflects her more rural sense of home, while Diamond conflates the ‘dawn-waking pigeons’ with the waking up of a city and its traffic. Other sections of *Probably Nothing* involve Tristram returning to walk on the Sussex coast, and nature is an important part of her sense of rootedness and home.

Diamond’s feelings about thresholds also extend to the hospital sensescape reaching – or symbolically contaminating – the outside world of recovery. In another passage, he describes a balcony that provides direct access to the outside:

In Weston Ward in the newest of the hospital blocks I had private room F ... Sliding doors opened on to a balcony which ran along the whole of one side of the ward, along which promenaded pyjama’d men and women slowly pushing drip stands, talking to family and visitors, seemingly unaware – this being the head and neck ward – of their missing ears or cheeks or eyes or noses. Some had cream-coloured plastic tubes jutting forward from their throats: the tracheostomy I’d been promised.⁵⁵

For Diamond the outside world does not yet offer hope, and the balcony is a barrier rather than a bridge. He does not look past the balcony to picture a route back home or to the city beyond, but rather focuses on the visions of illness that block the view. These social relations also exist in relation to Diamond’s illness, and a potentially more unwell self. The people represent a dynamic sensescape, a ‘promenade’ of revolving ill people who constantly remind

Diamond of his own prospects. In relation to fears about never making it to the outside world, or about the implications of his illness for his body, this balcony symbolises obstruction and the bleeding of hospital into home.

This relationship between hospital and home is a common theme of illness memoirs and of therapeutic design literature. The goal of making hospitals more ‘homely’ has often been associated with the idea of making them more ‘humane’, comfortable and cheerful. Although scholars of housing studies have begun to challenge popular models of homes as places of retreat, showing the complex ways that they operate in social and embodied terms, the home remains a powerful cultural reference point and symbol for many people.⁵⁶ The feeling of home entering the hospital is indeed welcome for some. As noted above, Diamond and Tristram’s healthy spaces are both often made in relation to ideas of ‘homely’ sensescapes, although what this means differs for them. While Tristram’s feelings are articulated through natural sounds and smells, it is television that provides Diamond with a sense of normality and an embodied feeling of homeliness: ‘Nigella and I lay on my hospital bed and watched afternoon TV and forgot, for a moment, why we were there. Halfway through *Quincy* an air-hostess nurse came in to take my blood pressure’.⁵⁷ There is no single design or feature of ‘homeliness’ in these narratives, which is as much a feeling as it is a material or architectural environment. Therapeutic environments are often made in relation to this feeling of homeliness, which – in turn – symbolises leaving illness behind, and an imagined healthy self. The home, as in Diamond’s comment, is to ‘forget’ the illness.

The blurring of boundaries between hospital and home is not mono-directional. Towards the end of *Probably Nothing*, Tristram depicts a significant shift in her sensory perception. Instead of interpreting hospital sensescapes with reference to her outside life, Figure 4 shows her interpreting sensory experiences at home through reference to the hospital. Previously pleasant smells take on new, negative connotations:

[Figure 4. Smell and the hospital in *Probably Nothing*]

This observation indicates how the same sensory experiences can take on very different meanings and significance, over time and in response to experience of healthcare environments. Repeated visits to hospital, a particular feature of chronic illness and cancer narratives, change the meanings of these sensory experiences. Cultural and individual reference points fade, as particular senses become increasingly associated with illness and the hospital. Tristram’s changing reaction to a sensescape, with its new medical associations, indicates that there is no simple return from the narrative disruption of illness. The patient is fundamentally changed by their experiences, and often – in accounts of cancer – in fear of returning to hospital. They embody sensory experiences, and make place, in a new way in consequence. Just as the home enters the hospital, the hospital enters the home.

Thresholds are not only material in illness accounts. Windows offer the most obvious symbol of the porous boundary between the inside of hospital and the outside, but thresholds are as much mental as they are material. Other human-technology, human-nature and human-object interactions also make place in relation to the ‘wider world’. Most commonly, this imagined ‘wider world’ is situated in the home, which is all at once a building, a region, a person and a feeling. As with many of the other hospital environments, there is no consistency in the making of therapeutic sensescapes. Windows can be thresholds to pass or obstructive barriers, while the blurring of home/hospital can make the hospital therapeutic or the home untherapeutic. The theme of thresholds again shows how places within hospitals are made

healthy or unhealthy in relation to illness and recovery. They show, further, how therapeutic landscapes always operate in relation to another imagined place and – even more powerfully – an imagined self who exists outside of the hospital. The less clear this imagined self seems, the less clear the view from the window.

Conclusions

This brief discussion of hospital narratives has identified no simple alignment: few sensescapes are represented as inherently ‘good’ or ‘bad’, ‘healthy’ or ‘unhealthy’. Within Tristram’s and Diamond’s accounts, the senses articulate broader physical and emotional feelings connected to illness and recovery: there is no separation between sensorial experience and the meanings given to those experiences, which constantly inform each other and are in flux. The one consistent point or conclusion is that place-making is embodied, affective and relational. There is no therapeutic environment that simply makes people feel better or imposes power relations upon them, nor are people acting with ‘agency’ to resist these impositions. The making of place is a more implicit process, often pre-cognised. In cancer memoirs and accounts, place is made primarily in relation to illness and recovery as both embodied and emotional states of being. A therapeutic landscape thus exists in relation to a patient’s feelings about their prognosis. Another form of relationality is that between human / non-human features of hospital sensescapes. Illness narratives support a reading of therapeutic environments that does not prioritise – or even separate – the material or the human, but considers them in relational terms as part of dynamic interactions.

The embodied making of place, and the implicit role of feelings in making therapeutic environments, is of potential significance to design practice. In terms of illness and recovery, such embodiment operates in complex ways. In the most obvious terms, illness narratives highlight links between sensations – such as pain – and the ways that authors/patients engage with hospital spaces. In more complex terms, these embodied sensations do not exist in separation from those spaces. Multi-sensory experiences – ranging from comfort to noise – enter patients’ bodies, while patients operate in turn to make and shape sensescapes. Moving away from an emphasis on visual aesthetics provides us with a better understanding of how the body exists as part of environments, rather than as an outside observer. Finally, these forms of embodiment and place-making are all inseparable from affect in patients’ narratives. How a patient feels about their prognosis and their changes of recovery, in terms of their relationship to an imagined healthy body and self, impacts how they feel in all senses of the word. Illness narratives show how these embodied, affective feelings are often pre-cognised and in hindsight do not necessarily align with the seriousness of an illness. As with a relational model of space, these conclusions indicate that there is value in viewing therapeutic landscapes as a process – or what geographers increasingly term an ‘affective atmosphere’ – rather than a purely material entity.

This article has only skimmed the surface of what is possible in this field. There is great potential for further studies engaging with relational place-making and the senses in healthcare environments. The rise of hospital memoirs from non-patients, for example, provides opportunities to engage with the ways in which ‘places make senses [and] senses make place’ for often overlooked groups such as hospital staff, patients’ relatives. We need to engage with a wider range of patients, for example those with specific sensory needs or wheelchair users, and to engage more with how specific illnesses affect the senses and embodied making of place. More work exploring changes over time, in hospital design and experiences of these spaces, would help better to contextualise the embodied and affective aspects of place-making. We also need better to understand how sensory place-making in

healthcare is shaped by demographic and cultural factors including – to cite Marichela Sepe’s work on ‘places of perception’ – ‘local, religious and political identities’.⁵⁸ Each of these offers a new way of understanding the relational nature of place, of hospital sensescapes and of the making of therapeutic environments. We must avoid leaning on broad assumptions about the hospital as an ‘unaesthetic’ space, and engage more with the heterogeneity of its sensescapes and the meanings given to them in the making of healthy places.

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Figure Legends

Figure 1. Images of the MRI scanner in *Probably Nothing*

Figure 2. Images of waiting rooms in *Probably Nothing*

Figure 3. A selection of images representing windows from across *Probably Nothing*

Figure 4. Smell and the hospital in *Probably Nothing*

1 Feld S. Waterfalls of Song: An acoustemology of place resounding in Bossavi, Papua New Guinea. In: Feld S, Basso KH. eds. *Senses of Place*. Santa Fe, NM: School of American Research Press, 1996: 91.

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3 Pallasmaa J. *The Eyes of the Skin: Architecture and the senses*. Chichester: John Wiley & Sons, 2012: 22.

4 Howes D, Classen C. *Ways of Sensing: Understanding the senses in society*. Abingdon; Oxford: Routledge, 2013: 58.

5 For example Winslow M, Seymour J, Clark D. Stories of Cancer Pain: A historical perspective. *Journal of Pain and Symptom Management* 2005; 29 (1): 22-31; Skott C. Expressive Metaphors in Cancer Narratives. *Cancer Nursing* 2002; 25 (3): 230-235; Clow B. Who’s Afraid of Susan Sontag? Or, the myths and metaphors of cancer reconsidered. *Social History of Medicine* 2001; 14 (2): 293-312.

6 On this definition of place – as meaningful space – see Cresswell T. *Place: An introduction*. Chichester: John Wiley & Sons, 2014.

7 Jones M. Phase Space: Geography, relational thinking, and beyond. *Progress in Human Geography* 2009 (33), 487-506.

8 See, for example, relational work about human / non-human interactions in actor-network theory; Bosco FJ. Actor-network theory, networks, and relational approaches in human geography. In: Aitkin S, Valentine G. *Approaches to Human Geography*. London: Sage, 2006: 136-146. On relationality and affect see Andrews GJ., Evans J, Wiles, JL. Re-spacing and re-placing gerontology: relationality and affect. *Ageing & Society* 2013; 33 (8): 1339-1373. On relational space and selfhood, see Conradson D. Landscape, Care and the Relational Self: Therapeutic encounters in rural England. *Health & Place* 2005; 11 (4): 337-348.

9 Space does not permit a full discussion here of pathography as a genre, but there is extensive scholarly work on both; as starting points see the extensive work of Anne Hunsaker Hawkins on pathography and Ian Williams on ‘Graphic Medicine’.

10 Tristram M. *Probably Nothing: A Diary of Not-Your-Average Nine Months*. London; New York: Viking, 2014. All images discussed within this piece are taken from this book, which is unpaginated. Images depicted next to each other are generally for the purposes of comparison, rather than being original panels: only the images of the waiting room and the MRI scan were consecutive in the original. Many thanks to Matilda Tristram for the kind permission to reproduce the images within this article.

11 Cancer also has other specific sensory dimensions, such as the well-known impact of chemotherapy on taste, and the narratives also discuss other embodied sensations such as pain. These physical symptoms are, however, not the focus of this article due to its interest in hospital spaces/places.

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- 12 Tristram's book is written as a diary in the present tense, with a sketched form that reinforces this tone, albeit of course later collated from a position of remission. Diamond's book is a more complex narrative form, which resists classification. It is informed by his real-time newspaper columns, but looks backwards from a position of perceived recovery; the 'afterword' informs the reader that this position is unfortunately not accurate, but that few changes were made to the text in consequence.
- 13 Waples E. Avatars, Illness, and Authority: Embodied experience in breast cancer autopathographics. *Configurations* 2014; 22 (2): 158.
- 14 Gesler conceptualised 'therapeutic landscapes' in multi-sensory terms in theory but, in practice, most of his work focuses on sight and he draws little on sensory studies. Some interesting work in this area has emerged in recent years, but there is still much room for development. See, for example, Gorman, R. Smelling Therapeutic Landscapes: Embodied encounters within spaces of care farming. *Health & Place* 2017; 47: 22-28.
- 15 Conradson D. Landscape, Care and the Relational Self.
- 16 For example, see Curtis S, Gesler W, Priebe S, Francis S. New Spaces of Inpatient Care for People with Mental Illness: A complex 'rebirth' of the clinic?. *Health & Place* 2009; 15 (1): 340-348.
- 17 Woods A. The Limits Of Narrative: Provocations for the medical humanities. *Medical Humanities* 2011; 37 (2): 74. It should be noted that Tristram explicitly objects to the use of the word 'story' within *Probably Nothing*, and to other metaphors such as 'journey', but it is used here without the implication that 'storytelling' is not 'real'. This article argues, however, that sensory experiences within such narratives are simultaneously real and symbolic.
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- 23 Andrews, G. J., Chen, S., & Myers, S. The 'Taking Place' of Health and Wellbeing: Towards non-representational theory. *Social Science & Medicine* 2014; (108): 211.
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- 26 Murdoch, J. *Post-Structuralist Geography: A guide to relational space*. London: Sage, 2005. Emphasis in original.
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- 32 Diamond, C: 215.
- 33 Diamond, C: 160.
- 34 Diamond, C: 24.
- 35 For example Crooks VA, Evans J. The Writing's on the Wall: Decoding the interior space of the hospital waiting room. In: Williams A. ed. *Therapeutic Landscapes*. Burlington: Ashgate Publishing, 2007: 165-80.
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