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Places and Spaces in the Danish Health Services Over Time

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The CHCI Medical and Health Humanities Network will soon hold its 2020 yearly Summer Institute, "Space, Place, and Design in Medical and Health Humanities," at the University of Southern Denmark in Odense. The two-day conference will include four keynote lectures and around 40 presentations from about 60 participants. On the third day, participants are invited to visit the new psychiatric hospital in Slagelse.

The occasion for the conference being held in Odense is the construction of a new University Hospital (OUH), along with many other new Danish hospitals currently being constructed. It also marks new collaborations between the humanities and the health sciences at SDU, in which narrative medicine plays a central role.[1] In connection with this conference, I have asked Professor Mogens Hørder, former dean of the Faculty of Health Sciences and chief physician at the University Hospital, about how space and place have operated in the history of the Danish Health Services, and what function they should have in the future.[2]

Anders Juhl Rasmussen: You have been dean at the Faculty of Health Sciences at SDU for 20 years and you are still closely connected to the development of the Health Care System both nationally and locally. How would you describe the history of the Danish Health Care System if you specifically had to consider the significance of space and place, and — even more specifically — design and architecture? We have, particularly in the 20th century, made ourselves stand out with regard to Danish design, and we currently have several internationally recognized architects. The Danish Health Care System, which to a very large degree is publicly funded through the taxation of its citizens, also has a great reputation when it comes to effective and considerate treatment and patient care.

Mogens Hørder: I would say that there are three distinct movements that you could start off with when it comes to institutional building construction and health. If you go back to the middle of the 19th century, you will find the start of a very visible institutionalization of the treatment of illness. Previously, you did not have many treatment options, and the wealthy and educated section of the population was mostly treated at home by a doctor. There were also asylums and the like, which to a higher degree functioned as holding facilities rather than treating facilities. From the middle of the 19th century, three distinct movements arose.

The first one was rooted in the fact that tuberculosis was raging as the great killer and the great fear, because it also struck young people. As a consequence, sanatoriums were built in Europe, including Denmark, and very often these were chosen to be located in areas of natural beauty. People had an idea that rest and good food were important, and in Denmark we had a particular emphasis that light was important. That's because we had Dr. Niels Finsen, who was awarded the Nobel Prize in Medicine for demonstrating that treatment with light could cure the skin disease lupus. So it was assumed that treatment with light might also be healing for tuberculosis. This meant that patients were brought out into the fresh air on terraces where they were actively radiated — so-called light therapy. Thus, at Vejle Fjord there is a sanatorium that now functions as a hotel, and similarly around

the country there are some incredibly beautiful buildings from that period, which didn't just benefit the wealthy section of the population. The development in Denmark does not vary from international development, but architecturally there are some magnificent works from that time.

Illustration 1: Photo of Vejle Fjord Sanatorium (photo credits: Hotel Vejlefjord)

The second movement was a similar emergence of distinct buildings within psychiatry. The first place was Oringe by Vordingborg, then Risskov i Aarhus. Construction also took place near Middelfart, near Viborg, and the most famous one: St. Hans in Roskilde. The Danish state financed the buildings, but the initiative came from dedicated and enterprising doctors, who had an idea that mentally ill citizens should stay in buildings located in areas of natural beauty. Another interpretation has been that they simply wanted mentally ill people located away from the cities. But that claim could more likely be made for the insane asylums, which also from the end of the 19th century were built as life-long

residences for people with intellectual disabilities. The insane asylums are also far less imposing architecturally than either the mental hospitals or the sanatoriums. With the mental hospitals and the sanatoriums, we got some distinctive buildings in Denmark, which in some ways were more prominent in the landscape than the ordinary hospitals in cities. These buildings in beautiful areas of nature were possibly a sort of foreshadowing of what we today call "healing architecture." This applies particularly to the location and the exterior of the buildings, whereas the interior spaces remained very characteristic of institutions.

The third movement, which became significant at the end of the 19th century, was the establishment of hospitals in cities all over the country. When the development of surgery with the possibility of anesthesia took off, people began to build hospitals in earnest. At that time, Denmark decided on a decentralized development structure for hospital construction. This meant, in other words, that it was left up to either the cities or the counties to ensure construction. The board of directors comprised responsible citizens: important merchants, farmers, and public officials. They were responsible for budgeting and financing. Construction was often left to the local master builders, and the board hired a responsible doctor, the chief surgeon, as the director of the hospital.

The state also had a role, in the form of high-level planning and authorization via the Danish Health Authority. In his memoirs, Johannes Frandsen, who was chief medical director from 1927 to 1961, explains the development in this period from the establishment of the first surgery-based hospitals in Denmark and up to the Central Hospitals.[3] The Central Hospitals are characterized by having surgery, medicine, anesthesia, and x-ray technology. The whole country was covered, and that was very important for public health. Many of these hospitals reflect in their design more general developments in architecture, including the "Good Building Practice" movement, which produced some of the best constructions made of bricks. Since they were often built with the best craftsman's quality and building materials, many of these buildings were preserved and are reused for many purposes,

including housing, privately owned businesses, and public institutions. The most forward-looking hospital of this period was the Aarhus County Hospital, a beautiful hospital designed by architect Høeg Hansen. With its large bright rooms, halls and open spaces, stunning views, and location in an open park, this hospital is an icon among architects.

A significant element in the development of the Health Care System is the role the general practitioners attained over time. In Denmark, general practitioners are in principle independent businesses. However, they enter into an agreement with an organization that represents the citizens. Initially, called "Sygekasser" [Health Insurance Associations], they were insurance-based membership associations whose function is now cared for by "Sygesikringen" [the Danish National Health Services], which is anchored in the Regions and is financed through the general taxation of all citizens. The shift from individual GPs toward the public Health Care System we have today in many ways runs parallel to a similar developments in other areas of our society. It corresponds to the development of civil society, in particular the associational life. What is special about this part of Danish history, according to recent research, is the particular influence of the poet, minister, and opinion leader N.F.S. Grundtvig.[4] It was precisely Grundtvig's thought on free schooling for everyone that allowed the majority population group at that time, the peasants, to achieve a higher educational level. Have you ever wondered why Denmark is possibly the only place in the world where the peasantry are liberals? Everywhere else in the world, the peasants are conservative. In many places, the peasantry and the aristocracy existed as a unit. This is true of Russia, Germany, and England. Today the many Danish hospitals, which ensure a high quality of health services for all, are unquestionably closely linked to Grundtvig's tradition of public education. These hospitals were created by citizens with a local political responsibility and local financing.

AJR: If this is the first era of the Danish hospital services, then what has happened to architecture moving up to the present?

MH: From 1960 and forward, specialization took off like an explosion, and you started to get specialists for everything. The Central Hospitals came under pressure and consequently they expanded and then there were too many of them. This, in turn, led to the closing of hospitals and the construction of specialist hospitals in the large cities. At the same time, the importance of interior decoration was evident, and one of the best examples from this period is likely to be Herlev Hospital in Copenhagen, which was decorated by the artist Poul Gernes. The Municipal Hospital of Aarhus was built by C.F. Møller, and architecturally, it was of very high quality. However, it did not have any innovation in terms of either its spacial experience or decoration. The same applies to the "concrete hospitals," Odense University Hospital and Rigshospitalet in Copenhagen.

However, in 2005, a new municipal reform was approved, whereby the many counties were eliminated and replaced by five regions that were supposed to handle the establishment of five super hospitals that could handle this super specialization. The first specialization had consisted of around 20 specialties, and now a further sub-specialization has arisen, which required medical competence. It is no longer sufficient to be an orthopedic surgeon; some are specialists in shoulders, others in knees, etc. Now, we can only have a few of these specialists in the country, and this is then at these new super hospitals. One is being built in Aalborg, one in Aarhus, one in Odense, and two in Greater Copenhagen, Herlev and Rigshospitalet respectively. Previously, there were even four hospitals in Aarhus. The planning phase of these hospitals includes many trends with an innovative way of thinking about space.

AJR: How does this same development look in the area of psychiatry?

MH: Within psychiatry, the development was different. In Denmark there has always been a political struggle over whether psychiatry should be governed by the same agencies as those governing the somatic part of the Health Care System. There was a period in the 1970s with the rise of anti-psychiatry in Italy, which lead to social psychiatry, which asserted that

mental illness was equally caused by social circumstances. This struggle is still ongoing. Recent years' re-prioritizing of psychiatry has resulted in a new wave of construction in psychiatry, where the architecture and illness are conceived as combined, as you can see in Slagelse and Svendborg. The psychiatric patients also move back into society faster, so the need for the institutions is, at least on paper, lower than it was previously. The psychiatric institution should be a place where you can come and go, and consequently, they are more society-oriented than the general hospitals.

AJR: What are the greatest architectural challenges for present-day hospitals?

MH: We know that patients will not stay there very long, and we also know that many patients will be treated on an outpatient basis and not be admitted at all. You have to have good conditions while you wait, and the access conditions to and from the hospital should be good. For this reason a light rail is being constructed in Odense and Aarhus. It isn't just about architecture; it's also about logistics.

Additionally, the construction has to be very flexible because progress is happening so fast. The building should be able to be converted to handle other functions, because the needs that we see now may be completely different in ten years. I was the dean at the Faculty of Health Sciences when it was decided that we would build the new Odense University Hospital (OUH) on a site very close to the existing university. Among other things, this opens up to the possibility of a closer cooperation between medical science and the liberal arts. The current OUH, from 1967, was constructed with concrete walls that you simply cannot convert from hospital wards of four beds into wards with single beds. You simply cannot move the walls. When this hospital was constructed, it was thought it would last a hundred years. With regard to the new OUH, it is important that the citizens, which we call patients, will experience even better conditions. A balance must exist between medical efficiency and the people coming and staying at the hospital throughout the day. The new OUH must be a place where you feel good — like in an airport terminal that's not too

over-crowded. When you look at illustrations of the new OUH, you also see the hall. In the old days, you only saw the ward.

At the same time, we face a challenge that we still have not solved: when the patients no longer stay for extended periods at the hospitals but spend most of their time at home. We call it the "easily accessible Health Care System," i.e. close to the home of the citizens. This means that the municipalities and not the hospitals have to handle preventative measures and rehabilitation after a chronic illness. Perhaps the treatment of heart disease or the like is only one afternoon, and then you are back home again needing rehabilitation. Diabetes treatment has also been moved from the hospital to the general practitioner. Even within the area of cancer, patients are now offered day treatment at the hospital or even at home. The question is: how should the institutions look when the treatment itself is a brief, intensive procedure rather than a longer-lasting stay?

So, you see, more and more of the treatment of illness is going in the direction of moving back into the home, and in many ways that is reminiscent of the way the whole thing began about 200 years ago. The number of hospital beds in Denmark peaked in the 1960s, and since then the number of beds and institutions have been steadily declining, while the number of out-patient treatments and home treatments have increased tremendously. Thus, illness should now and in the future be integrated into daily life. By way of example, I should mention that in the 1990s occupational therapists were removed from the hospitals, and now they are in high demand in the municipalities. You are now a citizen with a disorder rather than a patient at a hospital, and so you primarily need help and support in your daily life. People no longer consider themselves as a diagnosis, but rather as a citizen with a disability. It is my belief that where in the immediate past there was a need for physical institutions, in the future there will be a greater need for good "digital spaces." It is an open question as to how the "digital space" for health should be designed. Most of the existing solutions are not very user-friendly.

AJR: Following this historical sketch, I would like to return to the original point of departure and ask: what is your understanding of the concepts of space and place as they relate to health?

MH: I would probably consider space as an experience of the dimensions of the space and its coloration — you could have winding staircases, plants, and people moving around in the space. I can look at a picture of a space, but you only experience a space when you are in it. Also, I don't think a space is completely described until you recognize it in its daily function. Many architects and civil engineers create a physical space, but an actual space is populated by people who are doing something.

And place, well, there are places you can experience as recognizable, where you feel at home, and you constantly move through spaces as a patient. There is the place where you see a super specialist, the place where I have to meet my own GP. My own home is also a place where I can talk to my doctor though my computer, or maybe where a district nurse will pay a visit. I think it is important all the time to think from the perspective of the patient: what kind of place identifications do patients want to experience? Place is like a map of the sea or land, where you have to consider what kind of journey the patient has to go through. You begin and end up at home. There is not enough scientific research of how patients perceive space and place and find a connection between them.

There is a basic angst in having a disease, especially before you get the result of a test or a scan, and many patients need the calmness a well-designed space can provide. Many Danish architecture and design solutions have a humanistic dimension. Our famous furniture designers always used the human anatomy as a basis. The chairs should first and foremost be comfortable to sit in and then they should be beautiful to look at, not the other way around. The history of the Danish chairs is the story of how function and aesthetics constantly have to balance, and actually it is this balance that needs to be transferred to the architecture and design of the hospitals. Because there *are* current examples of

the function not having been sufficiently considered along with the aesthetic solution. One example is the new psychiatric hospital in Aabenraa, where the architect has emphasized its location, with a view toward a forest, and as an institution it is easy to get to. However, all the facades are made of glass, and both patients and staff have been complaining about this because they feel like they are in an aquarium. It does not provide peace of mind. There is a misunderstanding here of the importance of view and light.

AJR: In your opinion, what should the relationship be between the home and the hospital ward? At the new OUH, for example, the wards are designed almost as a home with a single bed.

MH: As I said, the patient identifies his or her illness journey with the places he or she is at. The more comfortable it is, the better you feel. You could ask, why did we not think of that before? Now the patient ward at the current OUH has the character of a hotel room and it does not smell much like a hospital. There is really no reason not to take the step fully towards a homelike ward. It is just that the stay in hospitals nowadays is very brief. On average you are in a bed for three days, and half of that time you are being examined or treated. Thus, it is very hard to meet individual needs. One example of creating comfort is in India, where the entire family moves into the hospital. They cook the food and sleep on the floor in the ward. You cannot build that in as a premise in Denmark, but you can let yourself get inspired by seeing how solutions are worked out in other cultural traditions.

AJR: I would like to ask you very directly: What does ‘healing architecture’ mean to you?

MH: My understanding of the concept of healing architecture is that it is primarily of importance to out-patient treatments, and when you are in a rehab situation after an acute procedure followed by a long period before you are well again. Let’s look at South America, which is leading in the area called healing architecture. Take Brazil, where their hospitals have green gardens and flamingos. It is absolutely horrible to get into a white, cold room

and then have to discuss rehabilitation, as we have done in Denmark for many years. It is better to sit in one of the new Life Room houses, which the Danish Cancer Society has been building in various places around the country.

Illustration 2: Photo of one of the Life Room houses

In Denmark, for a period of time, we have probably been more concerned with medical efficiency improvement, but now we are back at the historical starting point with sanatoriums and psychiatric asylums, where you again put more emphasis on the importance of space and place for the health of humans. In Denmark, as opposed to the United States, we are closer to the public Health Care System achieving the ideal of social equality in health. We also have — again as opposed to other countries — competitions to get the best constructions for hospitals. That is why we have seen so much public construction of high quality. By way of example, it was C.F. Møller who won the competition to design the new OUH

Illustration 3: Photo of New OUH (credits: JV CMB/Itinera)

AJR: You are a doctor and have been working with evidence-based medicine in clinical biochemistry throughout your life. What are your thoughts on the evidence that may be used as a basis for the idea that architecture and design may have a healing effect on human health?

MH: I have not dealt with this subject systematically. You could make a comparison and say that nobody will claim that to include the users or patients in decisions of care is worthless even when there is no documentation that this is an actual fact. Sometimes people ask tricky questions: would you rather fly with a nice pilot or a competent pilot? In other words: would you rather get surgery from the most attentive doctor or the most competent doctor? Of course you would like to get both; but if you had to choose, most people obviously prefer the most competent professional in the field. Needless to say, the hygiene has to be in perfect condition at the hospitals, but it is also important to have patient satisfaction in the Health Care System. That is why I am saying, start with the patient —

she has the key to what healing architecture means to her. You could possibly argue that so-called healing architecture is accommodating to a certain segment of the population. For some people, healing architecture may exist in completely different settings than those you and I value.

AJR: You mean that maybe not every citizen would prefer a chair designed by Wegener at their hospital ward or an abstract painting by Gernes on the walls?

MH: What is important is recognizability, and thus, you have to have flexibility in the design of the space.

AJR: So, if you only operate with one standard of aesthetics, you might — even with the best of intentions — be amplifying some social differences relative to health?

MH: It is at least something to think about carefully. At the moment, I am very much occupied with how we can assist people with dementia. Some places, for example in Holland, they design a space the way it looked in the 1960s in order to have something recognizable for the person who was young during the sixties. If you bring it to a head, it is not certain that everyone in Region of Southern Denmark will recognize anything in C.F. Møller's aesthetic taste.

AJR: At the new psychiatric hospital in Slagelse, designed by the office of architect Christian Karlsson, they have asked the writer Ursula Andkjær Olsen to write some poetic verses for wall decorations. As far as I understand, she has delivered these verses in an incomplete state and asked for the psychiatric patients to complete them before they get painted on the walls

MH: This is a good example of placing the patient — no, the citizen — at the center. That is my current mantra, always place the citizen at the center.

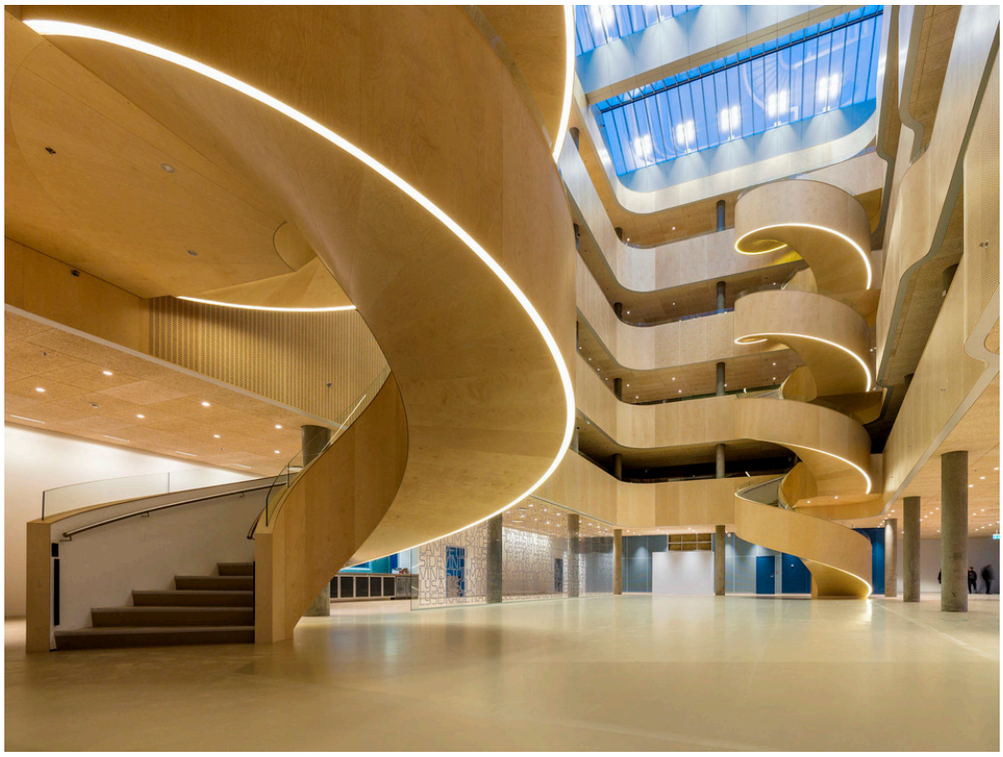

Illustration 4: Photo of Psychiatric Hospital Slagelse (credits: Karlsson architects VLA / Jens Lindhe)

Notes

1) In 2017 the University of Southern Denmark introduced a mandatory course in narrative medicine for first-year medical students and an elective course for graduate health care students; both courses are inspired by the principles and practice of narrative medicine developed by Rita Charon and her colleagues at Columbia University.

2) *In The Fate of Place: A Philosophical History* (1997) the American philosopher Edward Casey has argued in favor of maintaining a distinction between place as something geographically defined and space as something subjectively defined, even though place is always experienced by someone and space is always created by some materials. The relationship between place and space in the area of mental health is addressed, among others, by Sarah Curtis in *Space, Place and Mental Health* (2010). There is a quite recent journal entitled *Health & Place*, and the journal *Space and Culture* has articles on health and other subjects, while the journal *Scope: Contemporary Research Topics in Health and Wellbeing* published a thematic issue on "Place" in 2017.

3) Johannes Frandsen: *Sundhedsvæsnet 1927-191*. Oplevelser og erindringer. Nyt Nordisk Forlag 1961.

4) John A. Hall, Ove Korsgaard, Ove K. Pedersen (ed). *Building the nation - N. F. S. Grundtvig and Danish National Identity*. McGill-Queen's University Press. 2015.

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