May 28th, 2026

Statement from NordÖl (The Nordic Council of Senior Physicians) regarding planning and design of new hospitals

At our annual meeting, this year in Stockholm, Nordöl, representing senior hospital physicians from Sweden, Norway, Denmark and Finland, issues this updated joint statement on the planning, design and construction of hospitals in the Nordic countries. This statement replaces and expands our 2022 statement on the same subject.

A hospital is not only a place of treatment. It is also the workplace where doctors and other health professionals spend their careers. The building shapes what we can do for our patients. A well-designed hospital supports clinical work, teaching and research. A poorly designed one costs time and quality every working day.

Experience from recent hospital projects across the Nordic countries shows a recurring pattern. In Sweden, the New Karolinska in Solna opened with a shortage of around 1 200 administrative workstations for doctors, insufficient changing rooms, and open-plan office solutions that conflict with medical confidentiality; the local doctors' association filed formal complaints with the Swedish Work Environment Authority. In Norway, the New Kirkenes Hospital received twelve notices of non-compliance from the Norwegian Labour Inspection Authority after opening, including missing changing rooms, missing break rooms, and staff fetching drinking water from a toilet. The New Østfold Hospital at Kalnes had large areas cut late in the planning process. Both Kalnes and Karolinska later had to lease external office space at high cost due to these types of cuts. In Denmark, the new Aalborg University Hospital was inaugurated in May 2026; within days, eight unions, including Yngre Læger, filed a joint complaint to the Danish Working Environment Authority and the Patient Safety Authority over high noise levels in operating theatres, indoor temperatures above 30 degrees, missing lockers, and a lack of space for journal documentation. Finnish hospital projects face similar pressures.

The pattern repeats in all four countries. Hospitals are planned with optimistic assumptions about how mobile and how digital our work will be. Areas are cut late in the process, almost always from non-clinical functions: offices, workstations, on-call rooms, meeting rooms, break rooms, and changing rooms. Real involvement of clinical staff is replaced by formal consultation. The cost arrives later as expensive retrofits, leased external buildings, staff turnover, and lost time for patients.

We have made these points before. We are making them again because the same mistakes keep being made.

NordÖl proposes that

- **Future hospitals are built with sufficient space.** A hospital is more than beds, operating theatres and outpatient rooms. It must also have enough offices, workstations, meeting rooms, on-call rooms, break rooms and changing rooms for the staff who keep it running. These non-clinical areas are part of the clinical infrastructure, and their dimensioning should follow from planned activity, not from what is left over after everything else has been costed.
- **Physicians must have dedicated workplaces that protect confidentiality and concentration.** Open-plan offices and shared "clean desk" workstations are incompatible with a doctor's

daily work. We handle confidential patient information, take difficult phone calls, dictate, review imaging, and make decisions that require quiet. Offices and workstations must support confidentiality and concentration, and be located close to the clinical activity they serve. This is particularly important for doctors who have several workplaces.

- **Hospitals must provide proper on-call rooms and rest facilities.** Doctors on in-house call must have access to dedicated on-call rooms with a real bed, blackout, an openable window, and a lockable door. These rooms must be designated fixed resources and may not be repurposed during the day. Adequate rest is a condition for safe clinical decisions.
- **Break rooms and changing rooms must be treated as basic requirements.** Staff need dedicated break rooms close to the clinical areas, in addition to a staff canteen or a screened section of a shared canteen. Changing rooms must be sized for the number of staff who use them, with secure storage, showers, and proximity to the workplace. Several recent hospitals have failed on these basics.
- **Sufficient space must be planned for education, supervision, training and research.** A university or regional hospital that cannot deliver teaching, simulation training and research is not fulfilling its mandate. Meeting rooms, teaching rooms and dedicated simulation facilities must be planned from the start and protected from conversion into ad hoc offices.
- **The hospital building's design should support the workflow.** The planning process and decision-making must focus on functionality, and the building should promote health. Optimal environments for communication and doctor-patient interaction must have the highest priority.
- **Doctors' and other healthcare professional unions must be closely involved from the early stages of planning, with real influence.** Representatives must be given sufficient time and resources to participate. Involvement means the possibility of influencing decisions, not only being informed about them. Late-stage cost cuts must trigger a new clinical risk assessment, not a sign-off process.
- **Future hospitals must be built with sufficient numbers of beds, both in general wards and in intensive care.** Hospitals should also have flexible solutions for multiple-occupancy rooms in the event of disasters, war, or pandexmics. The Covid years showed how thin the margins are.
- **Hospitals should be built close to existing infrastructure** to avoid unnecessary travel for patients and medical staff.
- **Hospital planning must have a long-term focus on future healthcare needs and on sustainability.** Planning should promote flexible solutions that meet both current and future needs. Hospitals are major producers of waste and consumers of energy, and should set an example by adopting climate-smart solutions.

A hospital that fails its staff will, in time, fail its patients. Good working conditions for doctors are a precondition for good patient care. We call on governments, regional health authorities, hospital owners and planners across the Nordic countries to take this into account, so that the next hospital does not open to the same complaints as the last one.