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We must learn from the COVID-19 pandemic

EDITORIAL

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Experiences of nursing home doctors during the COVID-19 pandemic should lead to strengthening of the role of the district medical officer.

The managing of the COVID-19 pandemic is now in the evaluation phase. The Norwegian Coronavirus Commission has presented its second evaluation report (1), and researchers are contributing with several studies that are providing a great deal of useful information.

In situations where the best interests of the community are not necessarily the same as the best interests of the individual, it is particularly challenging to bear decision-making responsibility at an individual level. This is one of the main findings of a new qualitative study into the ethical challenges faced by nursing home doctors during the COVID-19 pandemic, which is being published by McLean et al. in the Journal of the Norwegian Medical Association (2). There was a great deal of uncertainty during the first phase of the pandemic in particular. Although both national and local infection control authorities had issued guidelines and policies at a group level, several nursing home doctors felt that they were alone in making challenging decisions about individual residents. Visits or no visits? Increased doses of palliative treatment or not? Often the best interests of a resident conflicted with preventive infection control measures for the benefit of the community.

Qualitative research can make a valuable contribution to the evaluation of how we handled the COVID-19 pandemic as a country and as a health service. With a systematic and scientific approach to the experiences and observations, this

research can provide knowledge that is important for the organisation of health services, management and quality improvement (3). Can we prevent experiences such as those described in the study, or are they inherent in the nature of a crisis?

> ***«Evaluation should provide knowledge, and knowledge should lead to action»***

The regulation on municipal emergency preparedness states that municipalities must evaluate their crisis management (4). The evaluation should look at areas such as coordination, cooperation and authorities' decision-making (5). How have central and local advice and decision-making affected operations? Has the crisis management revealed a need for clearer roles and responsibilities in terms of other parties?

Evaluation should provide knowledge, and knowledge should lead to action. These are two important steps in the quality improvement cycle that all municipal health services should work towards (6). Studies illustrating experiences from the pandemic are useful for this evaluation, but little will change unless municipalities use these results for corrective action and improvement of their operations.

In Norway, we have the option of decentralised infection control management, with district medical officers and local politicians being able to adopt stricter rules than those that apply nationally. This has been highlighted as a strength in the handling of the pandemic (1). Decentralised management allows bespoke measures, but this can also lead to disparities. In crisis situations, disparities will often cause uncertainty, which in turn increases the need for communication. Therefore, decentralised management in crisis situations requires considerable resources, particularly if lines of responsibility and lines of communication are not clear for all involved.

> ***«It is easy to see that overstretched district medical officers provided less specialist support to the nursing home doctors»***

The district medical officer should perform the municipality's tasks in accordance with the Norwegian Act Relating to the Control of Communicable Diseases and is a natural point of support for nursing home doctors in situations involving infection. In its report, the Norwegian Coronavirus Commission points out that district medical officers experienced a lack of frameworks from municipal management and were very overstretched during the pandemic (1). This is supported by studies into the role of district medical officers before the pandemic (7, 8). It is easy to see that overstretched district medical officers provided less specialist support to the nursing home doctors. Therefore, one improvement in the conditions for nursing home doctors highlighted by the study from McLean et al. (2) may be to establish less ambiguous frameworks and better organisation of the role of district medical officers. Municipal management must get involved in this.

The Norwegian Directorate of Health is currently working on a memorandum to the Norwegian Ministry of Health and Care Services about the role of district medical officers. It will be interesting to see whether the health authorities follow up the knowledge we have gained through evaluations of the management of the pandemic with decisions requiring the municipalities to act. Municipal self-governance is a democratic value, but has meant differing organisation and little support for the district medical officers. This impacts the specialist support provided to other doctors in the municipality. Without a clear commitment from the municipal healthcare management, the knowledge from the evaluations will be difficult to translate into action.

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