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The district medical officer's placement

EDITORIAL

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Having the district medical officer closely linked to the municipal administration makes for good emergency preparedness.

Compared to many other countries, Norway coped well with the pandemic. This is partly thanks to district medical officers who stood firm during the tempest. They handled the media, coordinated contact tracing and vaccinations, and provided advice to municipal leaders, services, businesses and the public. Hardly any other profession was as exposed during the pandemic, and municipal leaders have seen how important it is to have the backing of expertise in community medicine. The time when no one knew what a district medical officer was, far less what we did, is over. In this issue of the Journal of the Norwegian Medical Association, Vik et al. take a closer look at the district medical officer's role in municipal crisis management teams (1).

The municipalities are free to organise the role of the district medical officer. There are no national requirements for full-time equivalent (FTE) percentage or specialist training. Many positions are small, many are transferred to management work, and many have no locums, while there is a clear expectation that the officers will be constantly available (2).

During the swine flu pandemic it became clear that in most municipalities, the district medical officer was the key actor in the handling of the pandemic. FTE percentage and close collaboration between actors internally in the municipality were factors that had a positive effect (3). We may safely assume that the district medical officer's presence in the crisis management team is important.

Emergency preparedness work is based on principles of responsibility, closeness, equality and collaboration – simply put, everybody needs to work as closely as possible to the way they work in peacetime (4, 5). In larger municipalities it is especially important for the district medical officer to be clearly visible so that we can perform our duties, both statutory and delegated, across sectors (6). In smaller municipalities, where all the employees know each other, placement is less crucial for performance of the role, but the FTE percentage is all the more important (7). It is essential to have easy access to decision-makers that can ensure the availability of necessary resources (8).

Not all large municipalities place the district medical officer among the staff of the chief municipal executive. Hence, they will have no access to community medicine competence in the leadership and the overarching emergency preparedness work (7). Three district medical officers in Bergen resigned from their posts in the midst of the pandemic because their placement rendered them unable to perform their jobs properly (8). The article by Vik et al. describes municipalities where the district medical officer is included in the crisis management team (1). It would be interesting to compare these with municipalities that have no district medical officer in a central position.

Throughout the pandemic, collaboration remained important not only internally in each municipality, but also between municipalities and with health trusts and central-level agencies such as the county governors and the Norwegian Institute of Public Health. Many collaboration arenas already existed, and others were added over time, often with the county governor in the role of facilitator. Furthermore, the pandemic highlighted the importance of direct dialogue between the district medical officers and the specialists in the Norwegian Institute of Public Health – without having to go via health trusts or county governors. The infection control hotline is the district medical officer's best friend in peacetime and during pandemics.

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The constant changes to the infection control rules during the pandemic were at times more burdensome than the contact tracing work itself. The changes needed to be well communicated to the public, and the interviews with local media and quotation checking were time-consuming. Many have been on continuous standby for months and years, without knowing whether or not they will be paid for their extra work (9). Family life had to be given less priority, and the pandemic stole two years of many district medical officers' lives. The closet gnome was finally out of the closet (7).

The district medical officers played a key role as the link between the local community and national authorities and were essential for building public trust (8). Our professional standing was on display. The municipal administrations in Vik's study appreciated the community medicine competence of the district medical officer as a premise-setter and coordinator during a period marked by a lot of fear and uncertainty (1). The Coronavirus Commission concluded that

the district medical officer's role should be strengthened and made visible in the municipal organisation and preparedness plans, and that work contracts should reflect the responsibility that we have in an epidemic crisis (8). Will the district medical officer continue to have a clear role after the pandemic?

Now, many will have to fight their way back into meeting schedules, collaboration and management groups, consultation rounds and committees that have forgotten us after two years of pandemic, but where our knowledge remains crucial. We must be placed where we can be involved and contribute to a societal development that promotes safety, well-being, welfare and good health for all.

After the swine flu pandemic we saw that municipalities have short memories and little inclination for preparedness. Can we nevertheless hope that more municipalities see the benefits of being prepared, that they make sure that expertise in community medicine is available to the municipal leadership, and that locum arrangements are in place? Many district medical officers stayed in their posts throughout the pandemic, but I am not certain how many of us could stand another round. It will come, we just do not know when.

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