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District Medical Officers are doing the splits

EDITORIAL

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Local authorities should make better use of their District Medical Officers' expertise.

District medical officers have received much attention during the coronavirus pandemic. We have seen that when combined with local knowledge, public health expertise has ensured efficient handling of the pandemic at the local level. However, infection control is only one of several jobs assigned to district medical officers. Municipal executives have paid tribute to the efforts of infection control specialists during the pandemic, but they tend to be less familiar with the benefits that the localised public health expertise of district health officers can bring to the planning and running of the municipality's day-to-day operations. This is highlighted by the study conducted by Bettina Fossberg and Jan Frich which is published in this current issue of the journal (1).

The Local Authority Health Care Act of 1984 put local authorities in charge of local health services (2). Every municipality is required to employ one or more district medical officers to meet the local need for public health advice. The legislation defines the work that should be assigned to the district medical officer, but it is up to the local authority to decide how the post is best placed in the municipal hierarchy. This has given rise to considerable local variation in how different local authorities facilitate the work of their district medical officers.

Small and medium-sized municipalities, in particular, have been disregarding the role of district medical officer for some time. The doctors who held these posts in earlier eras have now retired, and there has been a generational shift. Whereas these officers often used to rule the roost in the municipal administration, they now commonly have a dual role in that they also work in clinical settings as general practitioners. Whenever this is the case, the role of district medical officer is only minor and there is a lack of clear content. This has meant that local authorities have not been calling for public health expertise, nor have they put in place arrangements for professional development or made adequate resources available. Many local authorities provide no job description for the role.

The problems involved with recruiting general practitioners mean that district medical officers spend all their working hours on clinical work. Proximity to the primary health service may be an advantage, but such close ties may challenge the district medical officer's professional independence. During the pandemic, this has proved to be a vulnerable model that gives doctors an intolerable workload. Dual-role doctors have been handling infection control and vaccination roll-out on top of long working days as general practitioners or on-call doctors. Additionally, they have been charged with 24-hour infection control duties, often without clearly agreed recompense.

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In many municipalities, the full-time equivalent of the district medical officer's job is only 20 % or less, despite the fact that the agreement between the Norwegian Association of Local and Regional Authorities (KS) and the Norwegian Medical Association recommends at least 50 % FTE for the district medical officer's job, even in small municipalities (3). Although many district medical officers have had their contracted working hours increased during the pandemic, it is uncertain whether local authorities will decide to continue the expanded hours once the pandemic is over if they previously defined their need for public health expertise to be as little as 2.5 hours per week.

In the cities, more hours are generally allocated to the job and the procedures are better organised. But even here the pandemic has generated unreasonable workloads over a long period of time. Few local authorities have emergency plans in place that provide continuous public health preparedness and agreed pay deals. Many large municipalities place the role of district medical officer outside the Chief Municipal Officer's staff and they have thus been unable to call on their public health expertise from within the crisis management team and emergency programme.

Bettina Fossberg and Jan Frich have conducted a qualitative study of district medical officers' perception of their own role, seen from a managerial perspective (1). The study was conducted before Norway was hit by the coronavirus pandemic. The district medical officers describe a challenging balancing act between acting as chief public health advisor to local authorities

while also seeking to meet expectations of involvement with individual cases in the municipality's health and care sector. The study demonstrates that the extent to which the district medical officer is able to fulfil expectations, depends on the role's seniority within the municipal hierarchy and the municipal management's understanding of the need for public health medicine.

It is difficult for district medical officers, particularly in small and medium-sized municipalities, to avoid spending their working hours on addressing clinical problems. The district medical officers feel invisible to the municipal administration. They appreciate their own autonomy but miss a community of peers and access to important decision-making arenas. While ambiguous municipal frameworks and expectations grant a freedom to shape the position according to personal preferences, they also account for considerable local variations.

The study's findings are consistent with other people's experiences. District medical officers feel they are doing the splits as they find themselves divided between the need for autonomy and the need for influence. While in some municipalities they are struggling to gain access to ambitious municipal executives, district medical officers in other municipalities are striving to protect their independence and integrity. Large municipalities tend to have several district medical officers and can provide a community of peers, which makes it possible for individuals to build up competence within specific public health areas. In small and medium-sized municipalities the district medical officers take on the role of general-purpose public health medics who need to address a wide range of different problems. During the pandemic, the benefits of formal and informal meeting places for the exchange of knowledge and peer support have become abundantly clear.

Heightened awareness among local authorities would see district medical officers put to better use. Structural matters affect the officers' ability to take action. Essential factors include proximity to the municipal management and adequate working hours. It would be a wise municipal move to call for public health expertise in all sectors, and to give the district medical officers clearly defined tasks while protecting their autonomy.

LITERATURE

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