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District medical officers should work more closely with chief executive officers

INVITERT KOMMENTAR

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New guidelines on the role of chief public health officers (CPHOs) reflect lessons learned from the pandemic and reinforce CPHOs' position as key decision-makers in infection control. Nevertheless, one in five CPHOs are not part of the local authority's crisis management team.

The role of CPHOs before, during and after the COVID-19 pandemic has been explored in qualitative studies in which CPHOs described their experiences, understanding of their role, placement in the organisational structure and opportunities to exert influence on the municipal leadership.

Fossberg and Frich interviewed CPHOs before the pandemic about their role understanding, visibility and autonomy, and found that both role clarity and visibility as public health doctors were perceived as challenging (1). Placement in the organisational structure (in large municipalities) and position percentage (in small municipalities) were considered important factors for exerting influence.

> *«CPHOs before the pandemic found that both role clarity and visibility as public health doctors were challenging»*

Hungnes et al. examined the role of CPHOs in municipal crisis management during the pandemic and found that CPHOs and the municipal leadership had a good understanding of the role (2). The CPHO was described as the most important advisor in crisis management and was actively involved in the pandemic response. Public health expertise was sought after and valued by the leadership, population and media. Most people recognised the value of having a public health doctor in the crisis management team, and the CPHOs gained broad recognition among the public. However, it also became clear that the organisation of the CPHO role was not conducive to managing a prolonged pandemic (3).

In 2024, Vik et al. examined the impact of the COVID-19 pandemic on the role of the CPHO in the post-pandemic period (4). They noted the potential vulnerability of the role when it relies on personal relationships and when CPHOs have to take the initiative to identify issues requiring public health advice. Hagestuen and Feiring studied CPHOs' perceptions of their role after the pandemic and recommended drawing up guidelines aimed at the municipal leadership, with clear specifications of responsibilities and of situations in which CPHOs should be involved (5). In May 2025, the guidelines on the role of CPHOs were finally complete (6).

The article by Mowinckel et al. published in this edition of the Journal of the Norwegian Medical Association, is based on a national survey conducted in autumn 2024 (7). Their study provides a long-awaited quantitative overview of position percentages, placement in the organisational structure and public health expertise among CPHOs throughout Norway. The proportion who are specialists in, or currently studying public health medicine, is increasing and is substantially higher than during the pandemic (8).

However, more than 60 % still hold another position in addition to CPHO, which may limit access to and a sustained focus on the public health perspective. Combined appointments can lead to role conflicts, create potential conflicts of interest and result in the prioritisation of clinical duties (6).

> ***«Combined appointments can lead to role conflicts, create potential conflicts of interest and result in the prioritisation of patient-facing clinical duties»***

One way to address these challenges is for local authorities to collaborate more closely on the CPHO role (6). Particularly in smaller municipalities, inter-municipal cooperation can improve quality and strengthen professional networks. The vulnerability associated with a single CPHO being responsible for several municipalities can be mitigated through broader municipal collaboration and by having CPHOs who can deputise for one another.

The importance of close and effective collaboration between CPHOs and the municipal leadership was a key lesson from the pandemic. A concerning finding in the new study is therefore that one in five CPHOs are still not part of the local authority's crisis management team, despite this being clearly recommended in the guidelines (6). It is also emphasised that local authorities

are required to ensure adequate capacity and continuity in the CPHO role, both under normal circumstances and during acute and prolonged crises. They are also required to appoint a deputy (6).

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Mowinckel et al. found that more than half of CPHOs do not have a deputy or substitute (7), and that fewer than one in three reported to their local authority's chief executive officer. Most are lower in the organisational hierarchy, which poses challenges for cross-sectoral public health and preparedness efforts. Public health expertise is particularly important in municipal planning, and the competence of CPHOs is relevant across all municipal service areas.

The guidelines on the role of the chief public health officer recommend placing the municipal medical officer 'close to the chief executive officer' (6). Permanent placement within the local authority's central administration makes it easier to maintain oversight of relevant issues and take early action where a critical public health perspective is required.

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