Medical education in the Pacific

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Introduction

My being here in Pohnpei today is clear testimony of the interactive and strengthening linkage and professional association between the Pacific Basin Medical Officers Training Program (PBMOTP) and the Fiji School of Medicine (FSM). Most of you who are gathered here will also recall that my former Deputy (Dr. Annette Robertson) also spent two years as Community Health Coordinator for this program. As you know Dr. Jioji Malani, Associate Director of the PBMOTP is from Fiji. He will most likely return to the FSM. This means an even stronger link and association between the FSM and PBMOTP in the future.

When Dr. Dever first told me the title of my address will be "Medical Education in the Pacific by the end of the Century" I felt a little apprehensive and unsure. I was not quite certain about the explanation or purpose behind the selection of that title. Given our long association as medical educators, colleagues and close personal friends, he could be sincere and genuine in his request and was actually providing me the opportunity to show everyone how good a medical educator I am. On the other hand, also given the fact that some years ago, I had informed him of an embarrassing event which clearly demonstrate that I would be equally as good as fortune-tellers peering at their crystal balls or astrologers gazing at stars at night, to accurately predict where medical education is heading or likely to be by the end of the century, he may be giving me enough rope to hang myself yet again.

* *Dean, Fiji School of Medicine. This was the keynote address at the 4th Pacific Basin Medical Officers Training Program graduation, February 7, 1996, Pohnpei, FSM.*

Medical education

When I first visited Pohnpei over ten years ago, Dr. Eliuel Pretrick, who was a fellow medical student at the Central Medical School in Fiji during the early fifties, asked for my opinion and advice about the feasibility of setting up a Medical School here in Pohnpei. Without hesitation and, with all the arrogance of someone who had only been involved with the Biomedical Model of Medical Education and training, I said "You must be crazy!" Nevertheless, a little over six months later, I was back in Pohnpei and helping Dr. Dever and Dr. Gullick to set that crazy idea in motion.

" For a long time, medical education in the Pacific virtually meant the FSM as it is now known; the Central Medical School as it was called between 1928 and 1995; the Suva Medical School before that. Established in 1885 and graduating its first three "Native Practitioners" in 1888 ... [the FSM] is 110 years old."

Since arriving in Pohnpei this time however, I have learned that the title has been slightly modified to "Medical Education in the Pacific." I am less anxious and relieved because I can talk about what has happened, where we have progressed to at this stage, and what is likely to happen in the future because of where we have been and the direction we are now taking.

For a long time, medical education in the Pacific virtually meant the FSM as it is now known; the Central Medical School as it was called between 1928 and 1995; the Suva Medical School before that. Established in 1885 and graduating its first three "Native Practitioners" in 1888, that medical training institution is now 110 years old. Its first regional graduates came out in 1916 in the form of two Union Islanders, now called Tokelauans. By 1995, that institution had graduated a total of just over 1,000 physicians and just a little less than 1500 allied health workers in Dentistry, Dietetics & Nutrition, Environmental Health, Medical Laboratory Technology, Pharmacy, Physiotherapy and Radiography.

Over one third of those medical and allied health worker graduates came from 21 different Pacific communities, including PNG and Dutch PNG, as Irianjaya was then known. There was even one graduate who came all the way from British Honduras during the early sixties. PNG went on to

establish its own medical school in the late fifties and progressed rapidly to a degree programme by the seventies, followed later by postgraduate programmes in the eighties. FSM established academic association with the USP in the late sixties, then progressed towards degree status by the early eighties. In 1995 it established its first postgraduate training programme, with two more taking off in 1996.

Much later in its establishment, but certainly much more significant and important in its development, is the PBMOTP here in Pohnpei during the late eighties. This development again clearly demonstrated the importance of adhering to and complying with a prerequisite concept for success in the development of human resources for health. It was in fact the same concept which was responsible for the launching of the FSM more than 110 years ago; a concept which unfortunately became progressively ignored and then totally abandoned over the years.

That concept is simply this; evaluate and understand what your health care needs are; determine and define the qualities and capabilities for the kind of health care workers who can effectively resolve those needs; then design and develop an educational and training programme that will give your health care workers with those necessary qualities and capabilities.

" ... we must design and develop our own postgraduate education and training programs to be run in the Pacific and to cater for the needs of the Pacific. "

Because the FSM failed to live up to its mandate during the sixties, seventies and eighties, not only was it putting out graduates with qualities and capabilities that were not totally appropriate for the health care needs of Pacific, it was not even putting out graduates at anywhere near the numbers required. The last Pohnpeian doctor to graduate from FSM is Dr. Mai-Ling Perman who followed Dr. Aminis David, almost thirty years later.

Towards the end of the sixties, reform in medical education had been building up world wide, culminating in the revolutionary step which the University of MacMaster took in 1969. The University of Newcastle in Australia introduced it in the late seventies and the PBMOTP progressively adopted it during the late eighties. The combined influences and experiences of both Newcastle and the PBMOTP finally convinced FSM that this is the way to go in 1991.

The success of the PBMOTP is there for all to see. What was developed from the PBMOTP and Newcastle experiences is yet to be fully tested, although what is already obvious at this stage is that it will be a great success. The first lot of graduates from that new programme in Fiji will come out at the end of 1995. They will also possess more appropriate and desirable professional qualities and aptitudes as well as potential for further development. Physician shortage will soon be a thing of the past.

Postgraduate medical education

Mere numbers is however not enough. Although primary health care and community based care are now adequately emphasised and focussed on by both the FSM and PBMOTP curricula, hospital based care account for most of health care cost. As has been clearly articulated by the Governor, referral costs must be curtailed[1]. To do so however means developing our own capability for effective hospital based care which requires specialist physicians who have to be recruited from outside, again at great expense.

The need to have indigenous specialists is urgent and undeniable. Our liability so far to overcome this need has been because of the trilogy of the "too few" as elegantly espoused previously and elsewhere by Dr. Dever....."too few are qualified for specialist training; too few succeed and graduate; and too few return to work in their own communities." If we therefore apply the concept under which the PBMOTP (1987) and FSM (in 1885) were successfully established, then the answer is obvious, - we must design and develop our own postgraduate education and training programs to be run in the Pacific and to cater for the needs of the Pacific.

During the week of the very first PBMOTP graduation, Dr. Dever and I decided to try and push through the plans for the implementation of the post graduate training for graduates of both institutions, as broadly recommended by a WHO funded Workshop on this issue in 1990. A project proposal was then discussed with Ms. Darla Knoblock, the representative of the Department of Interior (DOI) who was attending the graduation, and later submitted for consideration. Because it would be DOI funds, it has to be awarded to the PBMOTP and then channelled onto FSM, thereby establishing a visible and more meaningful link between the two institutions.

This project is now a reality and the postgraduate programme is in place, with funds specifically ear-marked to facilitate the development of such programmes. WHO funded another two more Workshops in 1995 to reiterate the need for postgraduate training to be instituted at the FSM[2,3], and by specifically focussing on the development of strategies for implementation. Various donor agencies including AusAid, New Zealand, United Kingdom etc., have actually

provided support. In November of 1995, a Diploma program in Anaesthetics started enrolling trainees. Distance learning programs in Child Health and Obstetrics from Otago are also being offered through FSM this year[4].

By the end of this century therefore, postgraduate education should be well and truly established and the need to recruit relatively expensive expatriate specialists will be a thing of the past. Hospital based care will have been upgraded to the extent where the need for overseas referral can be virtually eliminated, and the cost of hospital based care reduced appropriately.

Conclusion

Economists, managers and planners for health care as well as community health physicians and educators in Public Health, will tell us however that the best run and most effectively managed hospital in a developing community will only have a minimal contribution, if at all, to the improvement of the overall health status of that community, because it is community and public health that must be upgraded if the standard of health of the community is to be improved[5,6]. Focussing on postgraduate education must not therefore be at the expense of ignoring primary health care and the role of the community health worker.

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In Micronesia, the Medex and the health assistant are crucial to the improvement of community health. Their education and training has not been adequately supported in the past, and with the winding down of the PBMOTP as formulated for its present role, there is an ideal opportunity for modifying that role to cater with mid level health care human resource development.

This will therefore complete the chain of interlinking level appropriate, multi-entry, multi-exit training programs where the best medical assistants can progress to medex training in Micronesia, the best medexes can progress to hospital based training at FSM and graduate as physicians, and the best physicians to go on to postgraduate training and come out as specialists. This scenario can be put in place and repeated for both Polynesia and Melanesia without any more rhetoric or excuses.

References

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" Medical education is not completed at the medical school: it is only begun. "

William H. Welch (1850 - 1934)

Bulletin of the Harvard Medical School Association, 3:5, 1892