The PBMOTP - towards an inspirational accomplishment

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Introduction

The PBMOTP has been an important undertaking for many reasons. Though we are sad it will close its doors after this last graduation in late 1996, we should remember that its short life span and accomplishments are nothing less than inspirational.

The idea to train doctors in Micronesia - for Micronesia and American Samoa - sprang to life against conventional wisdom. Many people said it could not and should not be done. They said it was too expensive. It was unrealistic. But the need was great, urgent, and persuasive - not just in terms of producing doctors but in addressing health problems that plagued our region for years. And with careful planning, hard work, and perseverance, we proved that conventional wisdom is not always best or right.

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One of the greatest benefits of the program was that it brought scores of bright young islanders to a single place within the region, to study without straying far from home. It gave vitality back to our health care systems when it was badly needed. Our young doctors no longer will practice in isolation. They trained together and, as a result, they have counterparts at every major island health care facility. These young men and women understand their own and each other's health systems as few others do. And their knowledge is powerful. They are among the future leaders of our health systems and it is they whose help we need to resolve common health issues in our region.

Because of its community orientation and problem-based approach, the PBMOTP has become - in its own right - an educational model that outsiders want to study and emulate. Its successes are important lessons. We can wisely apply its model to new initiatives in health and other sectors, to meet the needs of our far-flung islands and the region. This is especially important to all of us because, in terms of geography, we islanders live in a part of the world that is truly immense. Though our homeland seems big to us, it is , in reality, small and barely visible on the map.

The Pacific

Our backyard, the Pacific Ocean, covers about a third of the planet's surface. It, not this island or yours, is the predominant feature. Because the ocean is so big, it is a fact that the hundreds of islands and atolls located within it - and we who live on them - can be easily overlooked

One method frequently used by people to remember that there are inhabited islands scattered in the middle and at the fringes of the ocean, is to divide the huge area into racial and ethnic regions. Most of us come from the part known as the South Pacific. Micronesia is home to many of us, and it is a subregion that extends well to the north of the equator. Our portion of ocean includes the Marshall, Caroline, and Mariana Islands, and it is often referred to as the US Pacific Basin. It is here that we find the Republic of Palau, the Federated States of Micronesia (FSM), the Republic of the Marshall Islands, Guam and the Commonwealth of the Northern Mariana Islands. To the west of us lie the high islands of Melanesia and the islands of Polynesia to the east and south. American Samoa is the only US Pacific jurisdiction that lies south of the equator.

Distance and isolation are our reality. Living on an island in the middle of the ocean affects us in ways we know all too well. Our closest neighbours in the developed world are hundreds, if not thousands of miles away. Were it not for ocean going vessels and air planes, the isolation from goods and services would be devastating. Many of us travel vast distances several times a year, not for pleasure but to access places of business and institutions of higher education that people who live on the large continents take for granted. We know we need to be self-sufficient but we also know there

* *Secretary of Health, Department of Health Services, Federated States of Micronesia.* *Keynote speech at the final PBMOTP graduation, Pohnpei, December 14, 1996.*

are times when we cannot or should not go it alone. There are times when regional cooperation is essential to deal with common problems and common issues.

Although separated by great distances, all of our small islands are downsizing government-run health operations in the face of decreasing public finances, rapid population growth, and increasingly complex health care problems. Infectious diseases were once the predominant cause of morbidity and mortality. Although their incidence has decreased, they have not disappeared. With our people travelling frequently on planes, we face a growing potential for epidemics that can quickly move from island to island. We should be able to deal with these conditions, but our work and resources have been stretched to the breaking point by a rapid rise in chronic problems such as heart disease, diabetes, and substance abuse.

Health service in Micronesia

From the very beginning, we knew we needed local doctors whose knowledge of community medicine could make a difference in the health of our citizens. These young graduates could make community-based primary care, disease prevention, and health promotion effective interventions. Thankfully we have them now but they cannot do the job alone. Our health care systems are still developing and we need other kinds of health workers, strategically placed and accessible to our communities, to make primary health care a reality. Right now, we are still too oriented to providing acute care and to sending our people away for expensive off-island medical referrals. Our total work force still requires higher levels of training. And regional cooperation is critical for our workers' development and retention.

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Before World War I, Germany exercised political control over this sub-region but did little or nothing to alter our traditional systems. Immediately after the war, however, Japan took over the administration of all islands except Guam and American Samoa, under a League of Nations mandate. In Pohnpei, a house was constructed and designated as place to isolate and control amoebic dysentery, which was the most common cause of mortality at that time. Under Japanese administration, hospitals were constructed for the first time in the administrative centers to provide basic out-patient and in-patient medical care services. As time went on, a few private clinics were established. All health providers were Japanese and, for the most part, the people served were also Japanese.

After World War II, the United Nations conferred trustee responsibilities for the Marshall Islands, Caroline Islands and Saipan in the Mariana Islands to the United States, through the Department of the Navy and later to the Department of the Interior. Guam became the central jurisdiction for training and education for other islanders. Hospitals were built immediately and medical care services were provided to the indigenous people, concentrating on emergency health.

Medical education

US administrators importantly realised that there were no trained indigenous workers in the islands who could administer those services. Wanting to rectify the anomaly, the military established two regional training programs in Guam in 1946 - one was a four-year nursing school and the other was a four-year medical assistant school. Participating in these two programs were students from the Marshall Islands formally called the Marshalls District, the District of Ponape of which Kosrae was a part, the Truk District, the Palau District including Yap, CNMI formerly known as Saipan District, and the US Territories of Guam and American Samoa. Both schools operated until the end of 1950 after graduating its second class. Nurses and assistant medical students who successfully completed training, returned to their respective home districts and established themselves as graduate nurses and assistant medical practitioners.

By the end of 1950, more than 55 medical and dental students were still needed to be graduated. Arrangements were made to make all remaining students eligible to enter Fiji School of Medicine to continue their studies. The final count of students who transferred to Fiji was 52. At the end of the training of the first group that transferred from Guam to Fiji, 20 graduated as medical officers and 19 as dental officers. When the initial groups of medical and dental students from FSM graduated and returned, there was a total of 33 Medical Officers who constituted the core medical staff for all our jurisdictions, excluding Guam and American Samoa. The nursing school in Guam continued until all those already in school were able to complete their nurse training.

These men and women were true pioneers. They worked tirelessly and become the backbone of our young health care systems. They took on the initial task of providing medical and nursing care for the people of their respective jurisdictions, and we are truly grateful to them. Sadly, those first medical and dental officers and nurses who trained in Guam have now retired but the legacy of their hard work will stay with us forever.

In the 1970s and 1980s, the government of the Trust Territory of the Pacific Islands realised that training of additional health providers would have to be undertaken in the United States. Once that became the standard practice, we found that it was not easy for our youngsters to compete with US students in their medical education system. As a result, for many years, there were very few successful candidates who graduated and returned to the islands. In the meantime, the number of active physicians who are trained in Fiji, gradually reduced as they themselves grew older. A number of them switched professions to other fields such as politics, government appointed positions, and business. The rest retired or died of illness. As recent as ten years ago, there were only a handful of us left who graduated from the Fiji School of Medicine. We had reached the point where Micronesian physicians were almost extinct and added to the endangered species list in the jurisdictions.

This unhappy trend made the Trust Territory Government rethink its strategy. Administrators felt that maybe they should send medical and dental students back to Fiji for training. Unfortunately, because the Fiji School of Medicine (FSM) was then in the middle of implementing a series of changes to meet its own demands for health workers, our students' attrition rates became much higher than we could afford. As the islands' population increased, the demand for quality health care also increased. We had no recourse but to increase the number of expatriate physicians and other workers, to replace those individuals retired and to fill newly needed health care positions in the jurisdictions.

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The University of Hawaii Schools of Medicine and Public Health responded to our critical work force shortage through Imi Ho'ola and the Health Careers Opportunity Program. Both were attractive and promising special programs established by the State of Hawaii for native Hawaiians, and students from our jurisdictions also became eligible to enrol. Many islanders enrolled in this program but the turn-over rate was still high. Few of the young men and women who completed the course and then enrolled from the John A. Burn School of Medicine, made it. Of those who did, some decided to remain in the US to practice medicine. The few who successfully completed their training and returned, are now among the health leaders in their jurisdictions but the numbers are still not enough. Other alternatives needed to be explored.

One short-term alternative was the recruitment of young US physicians under the National Health Services Corps program for medically undeserved areas in the Pacific Basin entities. They did well to make up the shortfall of physicians However, many became frustrated by the shortage of modern medical equipment and supplies and other situations existing in their assigned jurisdictions, and most of them moved on to other locations.

The conception of PBMOTP

In 1982, I was part of a visiting team of experts that was exploring sites to set up PEACESAT communication in the region. During our stop in Majuro, I roomed with a gentlemen who happened to be the Dean of the John Burns School of Medicine at the University of Hawaii — Dr. Terence Rogers. He was a pleasant gentlemen who kept me awake most of the time because of his interesting stories and jokes. Having confined ourselves in the hotel room, as there was no place to go after working time, we started talking about medical manpower needs of the Pacific Basin jurisdictions. Both of us understood that many of the islands already faced a serious crisis because of the shortage of physicians It would grow worse unless something was done — and done soon. Despite the high priority given to having young people enter health fields, keeping them enrolled in US-based medical schools or bringing them home after graduation was also a serious problem.

In thinking about what could be done, we developed the idea to set up a short-term way to train medical officers, and have that training take place in the region rather than sending them out for medical education elsewhere. We felt this would not only take care of the severe homesickness that many islanders experience, but make the many years required to complete medical school would seem less disheartening and more attractive.

We thought this was a wild idea but the more we talked about it, the more we felt it could very well be the way to solve the problem of producing qualified Micronesian physicians. Based on our discussion, Dean Rogers then began to seek out experts to developed an appropriate curriculum and explore possible funding sources. My role was to seek the political support of the jurisdictions for such a training program.

At the outset, it was not a popular proposition. Health care services were provided mainly by graduates of the Fiji program, but in the eyes of both public and professionals alike, these doctors were considered second class. The general feeling was that a program established within the region would only produce the same type of physicians if we did not make sure that students received appropriate certification and if training did not include locally focused skills. An understanding was therefore reached that if such a program

was started, it should be problem oriented. We also agreed that the level of training and quality of physicians also should not be less than that of the Fiji School of Medicine.

The professional staff of John A. Burns School of Medicine quickly started problem-oriented curriculum development for the proposed training program. Dean Terence Rogers continued to explore possible sources of funding for the program. In the beginning, the proposal was not well received by the US Public Health Service. Administrators there felt that supporting the Fiji School of Medicine through US AID would be a better solution for students from the Pacific Basin jurisdictions. Looking ahead, however, we realised it would be five years before the first graduating class joined the health work force. It was difficult to convince them that if we went with Fiji as the option, it would take many more years to produce the same numbers we could with a dedicated, locally-based program. Health care in our islands and the well being of our people could not wait.

Thankfully, the US Congressional delegation from Hawaii and especially Senator Inouye were very much in support of this proposal. Through their efforts, a 10-year medical training program was authorised and the US Public Health Services was designated to administer the program.

In a special trip to Washington to review collaboration on leprosy control program between the US Public Service, WHO and the FSM, I found myself surprised and honoured to be escorted to meet with the then US Surgeon General, Evrett C. Koop, M.D., in his Office. Dr Koop raised the question whether the proposed training could be part of the Fiji School of Medicine. My response was that it certainly could but it would not be successful, and I explained why. He then asked whether it was the jurisdiction's decision to have the training in the FSM. My response was "yes". Given that assurance, he stated that he would support the decision of the medical Directors of the jurisdictions. I extended my warmest "thanks" to Dr. Everett Koop, the US Surgeon General, for his understanding. In that short conference with him, I felt confident that funding would be available for the program to be in one of the jurisdictions.

The next hardest part of our planning was to identify a Director for the program. It was not an easy task. The person would have to be extraordinary — someone who could work with local authorities to find the site for the program facilities, carefully select faculty and staff, and subsequently recruit candidates for the program.

The delivery of PBMOTP

The first appointed Director lasted only for three months. A new Director had to be identified. When one searches for such a person, it is usually easy to spot the tallest person in the crowd. Instead Dean Rogers found Dr. Greg Dever, someone short in stature but probably with the biggest heart and the crabbiest mind to accept the job. Without this unique gentlemen, who has worked tirelessly on our behalf, the program would not be what it is today. We easily can count many of the good things that have happened since. The program already turned out 48 physicians and today we are here to congratulate the last class of 20 graduates All together, 68 medical officers have emerged from this 10-year program. All 68 will be practicing throughout our islands. Additionally, next year three more students will also be eligible to graduate.

Yes, the program is ending today. But the need does not stop here. Because the populations of our jurisdictions are increasing, we will require more health personnel. Our task is to continue to seek educational opportunities that will sustain the appropriate number of physicians and other kinds of workers we must have. This will take our unwavering commitment. We have been assured of continuing education and specialised post-graduates study for medical officers hoping to further their education. But we also must ensure an adequate dental work force, enough nurses, health educators, and other primary care professionals who live in and serve our communities. We need to understand our health care needs and find ways to meet them without bankrupting our countries' health budget We need to project the kinds and numbers of workers we need, and how they are to be trained in the most economical and advantageous way possible. Lastly we must find ways to make sure all our health workers keep current, whether this be through continuing education, inservice training, or post-graduate or advanced study. In this respect, continuing regional cooperation is important because a single territory may not be able to mount that kind of program alone.

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In conclusion, I would like to express my sincere "thank you" and appreciation to some of the people who were directly or indirectly involved in the decision making, or

influenced the decision making of this program. The list is endless but allow me to mention a few:

1. **The first President of the FSM, President Tosiwo Nakayama**: When I reported to him about this plan he said "Eliuel, you must know that FSM does not have the luxury to support such a specialised program. Our limited resources need to be used for education of primary and secondary schools in the FSM. However, if you can find other financial resources, I would give you my full support".

2. **Former Governor of Pohnpei State, Resio Moses,** who on behalf of Pohnpei State, invited the program to be established in Pohnpei. He supported the program by designating the appropriate land for the training site.

3. **Dean Terence Rogers** - who committed his energy and power in taking on the program and went out of his way to solicit financial support. Years ago when I mentioned this proposal to another official, the response was, "I don't think you will succeed, but with Dean Rogers behind, who knows, it may be possible."

> **"I do include all of you in my final words:** *Kalahngan en kupwuramail karuhsie!*"

4. **US Congressional Delegation of Hawaii**, especially **Senator Daniel K. Inouye** for supporting the authorisation and appropriation of funding for this program. Other US Congressmen noteworthy of mentioning here for their direct or indirect support included **Senator Lowell Weiker**, who helped sponsor the appropriation bill; **Senator Edward Kennedy** who was able to have one of his physician staff visit Pohnpei Hospital to see what kind of facilities it had to support such program; and **Senator Orin Hatch** who was able to send one of his young physician staff to visit Pohnpei to observe our medical needs. These activities helped in the decision-making process of the program.

5. **FSM Congressmen Peter Christian** and the former **President John Haglelgam** who both travelled with the health directors during the beginning when decision was needed to establish the program.

6. To all **Pacific Island Health Officers Association** members who were united in supporting this program. These Health Ministers, Health Secretaries, and Medical Directors, though representing different government entities, were able to agree on issues of support for the program that led to its successful conclusion.

7. **Dean Christian Gulbrandsen, Associate Dean Satoru Izutsu,** and the faculty and staff of the John A. Burns School of Medicine who kept the program alive and well even in the face of external criticism and funding threats.

8. **Director of PBMOTP, Dr. Greg Dever**, who single-handedly carried out the responsibilities of the school operation in Pohnpei, including enrolment of students, the recruitment of excellent staff, and much more. I thank you. My special thanks also goes to those who served in the capacity of Associate Directors: namely **Dr. Jimione Samisoni**, now the Dean of Fiji School of Medicine; **Dr. Sitaleki Finau**, now a senior lecturer at the School of Medicine, University of Auckland, New Zealand; **Dr. Rex Hunton**, now a curriculum coordinator at the Fiji School of Medicine; and **Dr. Annette Sachs Robertson** who is pursuing a Ph.D. at the Harvard School of Public Health. The current Associate Director, **Dr. Jioji Malani**, a tall gentleman in his own right and a member of a noble Fijian family is currently in charge of monitoring the Internship programs in the jurisdictions.

9. **All the faculty members of the school** including all the **support staff**. I thank you all for a job well done.

As I said, the list is endless and, if I failed to mention your name, it is because of the constraints of time. However, I do include all of you in my final words: ***Kalahngan en kupwuramail karuhsie!***

References

Available from the author on request. □