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FIJI SCHOOL OF MEDICINE

This document summarizes the results of a review conducted in response to resolution WPR/RC41.R1, which required the Regional Director to submit the review findings within three years. It covers the major components of the progress made in developing the Fiji School of Medicine and presents progress in the implementation of the 1989 Plan of Action, specifying redevelopment efforts in curriculum reform, faculty development, management structure and support, and physical facilities. Of particular importance is the curriculum reform, which now includes a problem-based medical course, as well as management training and development of communication skills.

The report urges Member States to assess the impact of the new training on their respective health services, and suggests, *inter alia*, that the Regional Office should sustain its support for the Fiji School of Medicine and other institutions in the Pacific, especially in the planning of the succeeding stages of development, in order to sustain the momentum of the programme.

The continuing support from concerned governments and donor agencies is gratefully acknowledged, and the Member States are asked to seek further financial, technical and material support.

1. INTRODUCTION

At the request of the Fiji Government, the Regional Committee at its thirty-ninth session in 1989 discussed the problems faced by the Fiji School of Medicine, particularly the dwindling number of regional students completing the medical course and the related shortage of health personnel.

A Plan of Action designed to revitalize the School was drawn up after extensive consultations involving senior members of the Fiji Government, the faculty of the School of Medicine and a panel of temporary advisers convened by WHO for the purpose. It was recognized that the graduates must be suitably trained to tackle the health needs in their own countries and that the curriculum must therefore be carefully amended to that end.

At its forty-first session the Committee adopted resolution WPR/RC41.R1 calling, *inter alia*, for a review of the progress made in implementing the plan and requesting the Regional Director to report on its findings within three years.

1.1 Regional shortage of health personnel

The Regional Committee discussed the problems of the school of medicine during its thirty-ninth session. These concerned the reduced number of regional students completing the medical course, the wastage represented by high failure rates during the early years of the medical course, as well as other difficulties, which were magnified in 1987 by the loss of a substantial number of faculty members. These factors aggravated the shortage of health personnel, a problem common throughout the Pacific.

The instability facing the Fiji School of Medicine intensified the difficulties of recruiting replacement faculty members who could ensure that the School remained operational. This situation hampered the School in the role it had played for almost a century of providing trained health workers for the Pacific islands.

1.2 Plan of Action

The initial momentum for the Plan was provided by resolution WPR/RC39.R9. A series of initiatives then ensued, leading to the adoption of the 1989 "Plan of Action for the Development of the Fiji School of Medicine as a Centre for the Education of Health Personnel in the Pacific". The plan emerged under the auspices of the WHO Regional Office for the Western Pacific in

collaboration with senior staff of the Fiji Ministry of Health, the Fiji School of Medicine faculty and a panel of temporary advisers who participated in a series of consultative meetings in Manila and Suva in March - April 1989.

The Plan of Action, subsequently accepted in principle by the Interim Government of Fiji in 1989, set out a package of institutional reforms in four major areas: curriculum reform; faculty development; management structure and support; and physical plant and equipment. The findings of the three-year review are presented in this document following the original framework and structure of the Plan of Work.

2. PROGRESS REPORT

This year, the first graduates will emerge from the first level of the School's new medical course. There have been substantial increases in admissions to the School's allied health courses since 1991, following the improvements in course content, teaching methods and staff composition. In order to ease the shortage of dormitory space and teaching rooms, several properties were acquired and interim construction projects were undertaken.

2.1 Curriculum reform

WHO provided support for two related projects which developed a comprehensive disease pattern profile for South Pacific countries. The first, a survey of morbidity in the different countries in the Region, began in 1991. The second, launched in 1992, sought to develop a module on health research methodology using the activities of the medical students in the communities. These surveys contributed to the development of the School's problem-based curriculum.

The main focus of curriculum reform was the medical course, reflecting the efforts to convert both the format and methodology into problem-based techniques.

2.1.1 New medical course

The Fiji School of Medicine started problem-based teaching with the 1991 intake of 32 medical students, one year ahead of schedule, as agreed by the Fiji Cabinet in 1990. Four WHO-supported training workshops over an 18-month period provided the teaching staff with the necessary reorientation for problem-based learning and curriculum development.

The curriculum is two-tiered, the first tier being a three-year course in primary health care. Students spend about half their time learning theory and the other half in health centres and community settings. There are three strands in this learning process. The first involves problem-based studies, consisting of: (a) problems involving basic etiologies of common disorders in the Pacific Region; and (b) problems based on body systems and medical units. The second strand covers professional skills such as communication, clinical examination and history taking. The third strand involves community health and health promotion.

Students are guided into an understanding of the structure and function of the Pacific island communities in which they will be working. They are introduced to the epidemiological aspects of diseases. They have to learn the importance of lifestyle in the promotion of health, and the principles and practice of health education. They also come to understand the basic administration, record-keeping and accountancy skills needed in running a health centre. The students are therefore prepared for work if necessary in isolation in small communities and should be able to diagnose and manage most of the community health problems. They are trained to recognize danger signs in disease or life-threatening conditions and to transfer the patients concerned to the nearest referral hospital.

During a one-year internship or in-service training in their respective jurisdictions, students complete a community-based research project as part of the requirements for entry into the second tier of the course. This tier is largely hospital-based and while it will still consist of problem-based learning, the division of hospitals into specialist units may mean that some teaching is likely to be traditional bedside instruction and tutorial.

Terminal assessments are to be made at the end of each tier. The medical qualification will be given upon completion of the second tier.

2.1.2 Graduate primary care practitioners (PCPs)

The first group of 28 PCPs will graduate in December of this year from the first tier of the new medical course and will receive the external Diploma in Primary Health Care from the University of the South Pacific. The School expects another 40 PCPs to graduate each year in 1994 and 1995. Beyond that, the School may be able to increase the number graduating to over 50 PCPs every year once the shortage of student accommodation is solved. By the year 2000, therefore, the new medical course will produce from 300 to 350 PCPs trained specifically for the health needs of the Pacific. In November 1990, the School created a Board of Postgraduate Studies to be chaired by the Permanent Secretary for Health. Plans were drawn up for postgraduate training in all major disciplines, based in Fiji and other parts of the Region.

The problem-based approach has been adopted in the oral health programme of the School, so that starting this year an integrated five-tiered curriculum for dental technologists and dental officers is being offered by the School. In addition, the School's faculty in nutrition and dietetics has been collaborating for the last two years with various agencies in Fiji and New Zealand for the same purpose. A curriculum for nutrition and dietetics using problem-based techniques is expected shortly. Currently under consideration is a proposal for restructuring the curriculum in physiotherapy along the same lines.

2.2 Faculty development

When the new medical course started in 1991, there was a full complement of students enrolled in the medical school and working towards their MBBS. This meant that there would be two courses running simultaneously, thus straining the faculty's resources severely.

2.2.1 The PCP tutors

This situation gave rise to the concept of the PCP Tutor, a relatively young medical officer who has graduated from the School and has had two or three years' experience. A total of twelve posts for PCP Tutors have now been incorporated into the establishment of the School of Medicine.

2.2.2 Career path

A complete plan and structure for the medical faculty at the Fiji School of Medicine is also now in place. It stipulates that about half of the medical teaching staff should be composed of PCP Tutors and hospital registrars with a complete career pathway before them.

2.2.3 Regionwide network of health supervisors

The mechanism for supervising the one-year field internship of the PCPs is also already in place. Members of the health services from American Samoa, Fiji, Kiribati, Tonga and Solomon Islands have been selected to form the first group of preceptors, duly accredited by the Fiji School of Medicine. This initial group of supervisors attended the Second Regional Workshop on Problem-based Learning held in Fiji in July, and went on to a two-week workshop at the school of medicine for training in health research methodology. The network of PCP preceptor-supervisors will need sustained reorientation and strengthening in the coming years.

2.3 Management structure and support

2.3.1 Alternative configurations

The original concept of institutional autonomy that was envisaged in the 1989 Plan of Action centred on an independent Fiji School of Medicine Council enjoying fiscal autonomy through a one-line budget but retaining accountability through audit to the Minister for Health. The Council would then assume full authority for personnel selection and appointments, with due consultation with health officials for appointments in clinical and allied health disciplines. Nevertheless, a full range of institutional configurations have been explored since 1989, among which are:

- (a) the Fiji School of Medicine as a professional unit of the University of the South Pacific;
- (b) the Fiji School of Medicine to obtain independence as a statutory institution;
- (c) the Fiji School of Medicine to become a fully regional institution.

2.3.2 Regionalization and autonomy

The concept of a regional status for the School stems from the suggestion that the Fiji School of Medicine should be responsible for training the medical personnel of the various Pacific island States and would administer the School. With regionalization these island States would take over from the Fiji Government the ownership and management control of the Fiji School of Medicine, although the School would continue to be supported by and located in Fiji. It would be necessary for part of the funding for the institution's operation to come from the island States.

It became apparent in 1991 that the full regionalization of the Fiji School of Medicine would have to be tackled at a later date. The School's existing Council then directed its attention to attaining a degree of autonomy.

As the Fiji School of Medicine Council includes representatives from the Ministry of Finance, the Public Service Commission, the Ministry of Health and the University of the South Pacific, discussion of issues related to autonomy is facilitated, though it is difficult for the representatives of the ministries to reconcile the School's proposals for independence with the usual constraints on the use of public funds. The Council's chosen course is to pursue autonomy through the provision of a one-line budget, powers of employment and other managerial prerogatives such as determining the number of lecture hours for the faculty, salary rates, recruitment procedures independent of the Public Service Commission, and so on.

2.3.3 Directions indicated

It has been considered that there would be no serious objections to the establishment of an independent school of medicine in Fiji under special legislation. This would involve establishing the institution as a statutory body with its own corporate identity, to function under the guidance of an independent Council, subject to the powers of special and general direction of the Minister for Health.

It is expected that the legal papers containing the Council's proposals will be completed within the third quarter of 1993. These will include the covering memoranda, the Cabinet Paper, and the draft legislation. Before the end of 1993, the item concerning institutional autonomy for the school of medicine will have been included as an agenda item for discussion in the Fiji House of Representatives.

2.4 Physical plant and equipment

2.4.1 Integrated facilities

In mid-1992, the School completed an integrated proposal for physical facilities. For the first time, the total requirements for building space have been assembled into a complete project proposal calling for the construction of about 16 200 square metres of roofed-over area, including laboratories, support units, library and learning resource spaces, and even residential quarters for senior teaching staff, administrative staff and visiting professors.

The progress is estimated to require about F\$ 26.8 million. The Plan has been formally submitted to the different Government agencies, particularly the Central Planning Office. The project is also being channelled through the Ministries of Finance and Foreign Affairs to match it with possible sources of aid funds and other donor grants, which are handled by the office of the Permanent Secretary for Health.

2.4.2 Asset acquisitions and building programme

The building expansion programme has been in response to chronic shortages in student accommodation, a long-standing need to upgrade library facilities and classroom spaces, and a requirement for tutorial blocks as a result of the new medical course. These needs were made more pressing by the decision to implement the new medical curriculum one year in advance, and the unprecedented increase in student numbers. The increase in facilities for the School in the last three years, which is unprecedented in the School's history, include renovation of two wooden structures to serve as interim housing and dormitory; acquisition and renovation of a house to be used as a

teaching block containing tutorial and common rooms for the PCP Programme; construction of two 20-bed prefabricated dormitories, additional washrooms and another tutorial structure;¹ acquisition of a property to be used exclusively for the medical school; and construction on this lot of "Kivi House",² a complex of two reinforced concrete structures to serve as dormitories.

Thus there has been a dramatic increase in accommodation and training facilities despite tight budgetary constraints.

3. RESPONSES OF PACIFIC ISLAND COUNTRIES TO THE PCP PROGRAMME

The new medical course started in 1991 with 34 students. Two opted out after two months to accept overseas scholarships. There were ten slots reserved for applicants from other island countries and areas. Eight of the 15 regional applicants were eligible: two from Tonga, one each from Solomon Islands and Kiribati, and four from American Samoa. One candidate from Tonga accepted a scholarship in Australia. The remaining slots were therefore given to Fijians.

Two students from this first batch were retained for further tutorials in Year 1 while another two were retained in Year 2, leaving a total of 28 students who will complete the PCP course in December of 1993.

The intake for 1992 increased to 40, divided equally between Fiji citizens and regional candidates. There were about 60 applications from the Region. The limited number of tutors necessitated a curb on student intake. The Government of Fiji requested 25 slots but the number of requests from the Pacific countries was overwhelming. The 1992 intake included seven from Samoa, four from Tuvalu, three from Tonga, two from Cook Islands, and one each from Kiribati, American Samoa and Vanuatu. Only two from this group are held back in Year 1.

There were even more applications for the 1993 intake, but continuing staff shortages and limited student accommodation did not allow further increases in student intake for the PCP programme. Solomon Islands wanted ten slots but only six qualified. Vanuatu sent four applicants but only two were accepted. American Samoa requested five but only three were admitted. Samoa

¹Financed through the Lady Alport Barker Trust grants.

²Financed in collaboration with a matching grant from the New Zealand Government.

had two slots, and one each went to Tuvalu, Tokelau, Kiribati and Cook Islands. Three slots were given to Tonga, but the candidates are reported to have accepted scholarships in New Zealand.

4. EVALUATION

Unlike previous years, the wastage rate directly attributable to academic failure has been close to zero. Attrition in the PCP ranks has been due to the students opting for other alternatives, mostly scholarships in the metropolitan countries. Formerly, by the start of the second year about half of the medical students would already have dropped out of school. It is evident that so long as the basic criteria for admissions are met, students accepted will respond positively to self-driven learning, and will perform well in assessments that measure actual levels of competency instead of their faithful recall of information.

The scheme is now operational, and a steady stream of PCPs will soon emerge whose qualifications are recognized throughout the Region. A regionwide network of health research supervisors is also now in place, and adequate interest in the School has been stimulated among the island countries and areas of the Pacific.

A coordinated system is emerging of undergraduate and postgraduate education relevant to the Region, covering the training of doctors and a wide array of allied health professionals. Already this year the Fiji School of Medicine is instituting a Diploma in Maternal and Child Health, and is starting a regionwide network of health research supervisors for the PCP students' one-year internship. Also under development are the links with the John A. Burns School of Medicine, University of Hawaii-Manoa, which will second its Director for Postgraduate Education to Fiji.

Member States, donor agencies and other interested parties are urged to recognize these new developments, evaluate their possible impact on the effectiveness of health service organizations at local levels, and devise adequate responses. Technical and material support for the Fiji School of Medicine and other institutions in the Pacific has to be mobilized on a continuing basis, especially in the planning and implementation of the succeeding stages of development, in order to sustain the momentum of the programme.