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MEDICAL TRAINING IN THE SOUTH PACIFIC

By 1928 DWH had again accumulated two years leave to enable him to pursue his medical examinations, hopefully, to a final conclusion. To this end he went to London alone, his wife and daughter spending the time between Suva and Auckland. It was an even more concentrated period than before. He was at Charing Cross Hospital, having applied for admission there because they were prepared to allow him to forego the summer vacations in order to concertina the set hours of clinical work into the available time. Unfortunately the programme took its toll in the form of a duodenal ulcer which was complicated by an acute haemorrhage just prior to the final examinations. Consequently, DWH was a patient himself at the time he had hoped to complete the course and he had to resign himself to the fact that it would take another five years before he would have again accumulated sufficient overseas leave to be able to return again. Nevertheless it was a turning point in his career. The development of a Central Medical School was under way in Suva. The man, who was both an educationalist and partially medically trained, stood out as a suitable choice for the position of full time organiser of the school. Those interested in the project were keen to have DWH and he in turn, saw the CMS as a logical choice for himself. He had to wait until his medical qualification in 1935 to be appointed Principal but meanwhile in 1929 a compromise was made by the appointment of Mr D.W. Hoodless as the first full time tutor.

In 1946 DWH retired from his position as Principal of the School and found time to write a history of the school for the Public Relations Office, Fiji. The first Medical School in Fiji was founded in 1886, but the reasons for its establishment go back still further. In 1875, the year after Fiji became a British Colony, a devastating epidemic of measles slaughtered 40,000 Fijians, who had not previously encountered the disease and had therefore built up no immunity to it. In 1878, four years after Cession and only three years after the measles epidemic, the first batch of Indian immigrants arrived in Fiji and it was at once realized that there was a serious danger that outbreaks of smallpox and other introduced diseases could arise unless adequate preventive measures were taken.

The Chief Medical Officer was Dr (afterwards Sir William) McGregor. Impressed with the necessity for action, and limited by the extremely small financial means at his disposal, Dr McGregor conceived the novel idea of training a few native Fijian youths to help in solving the problem. In an official paper laid before the Colony's Legislative Council in December 1883, the scheme was explained.

"It not infrequently happens that sickness of an epidemic form breaks out in a remote part of the Colony or at a spot which, while geographically near, is in consequence of the infrequency or difficulty of communication virtually remote and that tens and scores of natives are swept off before any confirmation can reach the seat of Government . . . Dr McGregor proposes to form a class of students, carefully selected from among the most intelligent of the Fijian people, who, after completing a course of practical instruction in the hospital, including nursing, may be sent out to assist in healing the sick and arresting the progress of disease in those parts of the Colony . . . These students will also be taught to vaccinate and it is probable that those among them who evince any aptitude or inclination for it may be taught to dispense the simpler forms of medicines."

If Fijian young men were to be trained as public vaccinators, and if simple quarantine measures were to be performed by them it was evident that proper legal cover was necessary. Accordingly in June 1888, the Native Practitioners Ordinance was passed. This Ordinance provided that any native who had attended as a medical student for three years at a public hospital in the Colony and had at the end of that period passed an examination in medicine and surgery should be entitled to a certificate as a Native Practitioner. He might then practise medicine and surgery in a district specified by the Chief Medical Officer. He was to reside in the village directed by the senior native official of the Province, who should cause a house to be built for him and a garden to be planted for him yearly, but the Native Practitioner must care for the garden after it had been planted. The Chief Medical Officer was to be his official chief, but he was to obey his native superiors, who were in turn to remember that his services as a Native Practitioner were of much more value to the people than any work he could perform as an ordinary villager. He was to be paid not less than five pounds a year by the Province, and, as Provincial Vaccinator, two pounds ten shillings a year by the Government. He was not allowed to demand any reward for his services, but might accept any gift offered to him.

The first NMP certificates were signed in November 1888, by Dr B. Glanville Corney, as Acting Chief Medical Officer. If the credit for inaugurating the system of training native medical assistants is given to Dr McGregor then it is even more essential to record appreciation of the work done by Dr Corney who from 1888 to 1906 was responsible for putting the system into effect. It is doubtful if any European official has ever been better known and more beloved by the Fijians than Dr Corney, and under his direction the training of Native Medical Practitioners developed steadily.

Viewed from present-day standards the medical training of the early students was extremely rudimentary, but it was essentially practical. After serving as dressers in the Colonial Hospital for three years the students were able to treat practically all the cases they were likely to meet in their districts. One might be tempted to say that there was a serious risk that they might have done more harm than good. Actually, there was a minimum of risk. Each Native Medical Practitioner was visited by a European Medical Officer three or four times a year, his records were inspected, and the manner in which he had carried out his duties and maintained his hospital or dispensary was constantly watched. Under the communal system as practised by the Fijians a Native Medical Practitioner who neglected his duties or mismanaged his cases

would soon come under the notice of his Fijian superiors, and an adverse report would be sent to the Native Commissioner in Suva.

If proof were needed of the success of the early type of medical training the record of NMP Sowane Puamau who qualified in 1899 would be sufficient. After his training period he served for a short time in Fiji and was then transferred to the Gilbert Islands. He was a complete success. Even the Europeans in the Islands regarded Sowane as their doctor, and his medical knowledge and conscientious performance of duties endeared him to all races alike.

Another example was NMP Asaeli Tamanitoakula who qualified in October 1891, and was appointed dispenser at the Suva hospital where he remained until his retirement on pension in September 1913. As well as the dispenser he was the anaesthetist, and for some years he carried out the duties of Government Pharmacist, the Colony's stock of drugs being kept at the hospital. He was a remarkable man, and had everyone's respect for his close adherence to duty.

The success of this early medical training rested not with Dr Corney alone. It is doubtful if the scheme would ever have succeeded if the Colony had not been fortunate in having at the same time a Matron of outstanding character and ability. Miss May C. Anderson, R.R.C. was Matron from 1896 to 1919. Her knowledge of the Fijian language and customs and her patience and tact enabled her to achieve success to an astonishing degree. Fijians do not as a rule take to supervision by a woman and it speaks volumes for the good work of Miss Anderson that there was never any question of her authority, and her orders were obeyed by every medical student "as though she were the Chief Medical Officer himself".

Dr Corney was succeeded in 1906 by Dr G.W.A. Lynch who continued as Chief Medical Officer until February 1919. During that period 43 more certificates were awarded to qualified Native Medical Practitioners. Dr Lynch was a hard task-master; he never spared himself, and he expected good work from all subordinates. The salaries of NMPs had been increased to £18 to £50 in 1905 under Dr Corney, and Dr Lynch was able to bring in a new three grade scale in 1917, viz., £45 to £75, £75 to £120, and £120 to £150.

During Dr Lynch's period of service the modern injection treatment of yaws by arsenical compounds was discovered in Europe. If any added impetus were required to maintain the success of the NMP service nothing could have been more fortunate than this. Previous to 1907 it was a common sight in every Fijian village to see several children covered with yaws, and many adults suffered from large yaws ulcers of a most disfiguring character. These signs disappeared like magic after one or two injections of N.A.B. and the people quickly realized the efficacy of the new treatment.

Dr Lynch retired in February 1919, and during the last four months of his term Fiji suffered from the world-wide epidemic of influenza. Of a population of 92,000 Fijians at least 7,000 died, and the death rate among the Indian population was equally serious. At that time there were 48 Native Medical Practitioners, and all of them did splendid work. Three died within a month while acting as dispensers at the Colonial Hospital; and eight in all died out of a total of 48, but in no case was any complaint made that a Native Medical

Practitioner had not stuck to his work as long as he was physically capable of doing it.

Dr A. Montague was Chief Medical Officer from 1919 to 1930. During this period the same system of medical training was continued, and a further 50 N.M.P. certificates were awarded.

In 1923 the Colonial War Memorial Hospital was opened, and soon after that the idea began to grow of developing the old Fiji Medical School into a Central Medical School.

The Fiji Medical School had been in operation for forty years. Actually it was a medical school in name only, for there was no school building, and the teaching staff served part-time. There was no attempt to give the students a pre-medical course in chemistry, physics, etc., they began training straight away as dressers in the hospital. One of the rooms at the Hospital was used as a class-room and about five lectures were given each week. And yet in spite of these limitations, no less than 138 Native Medical Practitioners had been trained and certificated, and about 55 of them were in practice, forming a very valuable auxiliary medical service under direct Government control. The reasons for their success were not difficult to find for these trained men were not merely "dressers." During the three years of training each student assisted in many post-mortem examinations, he gave scores of injections in his final year, he assisted at operations, gained practical experience in the hospital dispensary, and was "on duty" in all the different wards of the hospital. Over and above all this practical training the students themselves were keen and enthusiastic and anxious to learn.

The opening of the Colonial War Memorial Hospital in Suva in 1923 marked a turning point in the development of the Medical Department in Fiji. It soon became obvious that the Medical Superintendent of the Hospital required extra assistance, that a reorganization of the training of the native medical students was necessary, and that a properly equipped bacteriological laboratory was long overdue. The good work done by Native Medical Practitioners in Fiji was known in the neighbouring island groups, and the time was ripe for a co-operative scheme of training medical students.

About this time Dr S.M. Lambert of the Rockefeller Foundation of New York arrived in Fiji, and started various public health projects in association with the Medical Department. To assist him, Dr Lambert was given the services of a Fijian NMP. In his previous work in Queensland and Papua Dr Lambert had relied on European assistants, and he had never before had the benefit of a trained native medical helper. To his astonishment and delight Dr Lambert found that his Fijian assistant could carry out all his medical instructions with accuracy and precision, and at the same time explain fully to the Fijian patients exactly what was required of them. When Dr Lambert went to Tonga and Samoa for similar public health projects there he asked permission to be allowed to take NMP Malakai with him to continue to help him. Dr Lambert visited most of the island groups in the South Pacific. As he travelled an idea grew in his mind, and on his return to Fiji he put forward a scheme for the co-operative training of medical students in Suva. The Rockefeller Foundation promised a grant of £8,000 to assist in the capital and maintenance expenditure.

Negotiations for the proposed school continued during 1926 and 1927, and finally it was agreed that the four island groups under the jurisdiction of the High Commissioner for the Western Pacific (Tonga, Solomon Islands, New Hebrides and Gilbert and Ellice Islands) and the two groups (Western Samoa and Cook Islands) under the New Zealand Government would all join with Fiji on a quota system. Each Administration would maintain a definite number of students at the new school, the original scheme providing for 20 from Fiji, 4 each from Tonga, Gilbert and Ellice Islands, British Solomon Islands and Western Samoa, and 2 each from the Cook Islands and the New Hebrides, making a total of 40 students. The staff was to consist of one full-time tutor along with at least eight honorary lecturers, and the students were to live in two dormitories. The necessary buildings were erected in 1928, and the Central Medical School was officially opened by the Governor of Fiji, Sir Eyre Hutson on 28 December, 1928.

In a speech at the opening ceremony, the Governor paid special tribute to Dr Lambert "for his strong faith in the scheme and his able and persistent advocacy of the proposal with the governing body of the Rockefeller Foundation which happily resulted in a decision on their part to offer substantial and generous financial support". The contributions from the Foundation were paid on a sliding scale during the first four years, 1929-1932.

In addition to the six Administrations which originally co-operated with Fiji in the formation of the Central Medical School in 1928 two more Administrations, Nauru and American Samoa, joined in 1935. With the change from the former Fiji Medical School to the new Central Medical School the opportunity was taken of admitting one Fiji-born Indian and an average of one new Indian student a year was maintained for many years thereafter. Arrangements were made with the Australian Government for the admission of students from Papua in 1947.

The opening of the Central Medical School not only doubled the number of students, but it also made necessary several alterations in the medical training. The medium of instruction had now to be English as students from the other groups did not understand Fijian. The students were divided into three classes with appropriate lessons, lectures and practical work for each year, and regular examinations were arranged. Mr D.W. Hoodless was appointed as a full time Tutor, his duties being to co-ordinate the various parts of the medical training, to maintain discipline among the students, to report progress to the Advisory Board, and to ensure that the School was running smoothly and efficiently. The title of Tutor was later changed to that of Principal.

No serious difficulty arose in changing over from the old Fiji Medical School of 18 Fijian students to the new Central Medical School of 40 students of eight different races. The students soon adapted themselves, and there was always plenty to do — in the class-rooms, or hospital wards, or on the playing fields. During the years the Central Medical School has now been in existence there has never been any significant racial friction or lack of co-operation among the students.

As soon as the Central Medical School started to put into effect the new syllabus of studies it was seen that the old three years' course was too short. This was confirmed by information received from the Principals of other Medical Schools in Uganda and at Singapore. The difficulty was explained to

each of the six participating Administrations and in 1931 the period of medical training was increased to four years.

In the first six months of the training the student was taught the basic facts of elementary science, emphasis being laid on aspects with a direct bearing on future medical training. There was a very wide range in the educational standard of the first year students. Some of the Polynesian students from the Cook Islands, Samoa and Tonga had reached a fairly high standard before coming to Fiji, but that of the Micronesian and Melanesian students was much lower. It was not considered advisable to insist on a common entrance examination for all new students, for the immediate effect of such a rigid entrance test would be to exclude all students from the Solomon Islands, New Hebrides, and probably those from the Gilbert and Ellice Islands also.

The first six months of instruction were therefore devoted not so much to achieving a high standard of scientific knowledge as to acquiring a facility with written and oral English and an elementary knowledge of chemistry, physics and biology. A qualifying examination was held in June each year, and any student who failed more than one of the three subjects had his studentship terminated.

The second part of the Central Medical School course consisted of a year's instruction, theoretical and practical, in anatomy and physiology, during which time the student sat three class examinations in each subject and then was ready for a second qualifying examination. Every student was required to be able to give a lucid demonstration to his fellow students on any anatomical region.

Until he completed his first year and a half at the Central Medical School the student was much more of a "learner" than a "doer". Thereafter the position was reversed and he entered his clinical duties as an integral part of the staff of the Hospital. From 8.30 a.m. to 12.30 p.m. each day he performed one or other of the clinical duties allotted to him in the hospital, and each afternoon he returned to the Medical School for an hour's lecture in one of the senior subjects. A staff of honorary lecturers in ten subjects arranged for instruction in Materia Medica, Bacteriology, Medicine, Forensic Medicine, Surgery, Anaesthetics, Diseases of Children, Obstetrics, Dietetics and Book-keeping: and as each course of lectures was completed, the student had to pass a written and/or oral examination in that subject.

In the wards, each student was allotted cases in rotation. Regular clinics were held in the wards which all attended, and each student was required to stand to his cases during the ward rounds of the medical officers to give an account of the progress of his patients. No student prescribed treatment, but he was expected to follow the lines of treatment laid down by the medical officers. In the operating theatre the final year students received training, both theoretical and practical, from the Theatre Sister in theatre ritual, sterilization methods, preparation of lotions and of irrigation fluids etc., besides acting as assistants or as anaesthetists under supervision.

The Sister of the Obstetric Ward trained them, in their fourth year, in ante and post-natal work and in infant welfare, and in the conduct of normal labour. Each student was required to have delivered five cases prior to qualification. During the final year, also, students were instructed by the

Medical Officer of Health in the practical aspects of public health work, such as sanitary inspections and the inspection of meat.

Training in the dispensary consisted of instruction and practice in practical pharmacy. In the out-patients department special attention was paid to the care of cases of those types most likely to be met by the students in their work as qualified Native Medical Practitioners, and the work included practical training in minor surgery and the administration of intravenous and intramuscular injections. In the ophthalmic department instruction was given only in the routine treatment of milder eye diseases and injuries.

While attached to the medical ward, students were required to attend and assist at all post-mortem examinations performed, and were thus instructed in the method of conducting such examinations and in the keeping of proper records. Here too, lessons in gross pathology were given, and anatomical knowledge was revised. Practical training in simple laboratory methods was given during the final year in the Pathological Laboratory. Some graduates of the School were, at the request of their Administrations, sent to the Central Leper Hospital at Makogai for a special course in the diagnosis and treatment of leprosy.

When after qualifying a student had completed not less than six years of medical practice he was entitled to apply for permission to return to Suva for a post-graduate course. However, the number to whom it was possible to extend this privilege was limited, owing to lack of living accommodation and tutorial facilities.

When a student qualified he was appointed to a district as a native Government official. Usually at first he was sent to a station under the immediate supervision of a Medical Officer, but as he gained experience he was sent to any district where his services were required. Even in a more or less isolated district, he was visited if possible three or four times a year by a Medical Officer. His records were regularly inspected and his work supervised.

Native Medical Practitioners were not allowed to practise except as native Government officials. If he resigned he could not practise medicine or surgery as an independent general practitioner. A number of Native Medical Practitioners resigned for one reason or another, for example, to be appointed as a local district chief. Provided their records were satisfactory, these ex-NMP's were invited to volunteer for special medical service in cases of epidemic or any emergency where the local NMP alone was unable to cope.

The duties of a Native Medical Practitioner include all minor surgery and general medical treatment. If an immediate operation is necessary, and it was impossible to take the patient to the nearest fully qualified Medical Officer (who may be miles away by sea), the NMP was expected to exercise his own judgment in taking life-saving measures. If possible he obtained the services of another NMP or of an ex-NMP to give the anaesthetic; then, if he considered himself able to perform the necessary operation, he did so.

In 1946 the South Pacific Health Service came into being and the future of the Central Medical School was linked to the development of this co-operative organisation. At its first meeting the South Pacific Board of Health recommended that, the term "Assistant Medical Practitioner" should be adopted for all graduates of the Central Medical School. It was agreed that

the then form of medical training in Suva should be gradually improved, but the chief retarding factor was the low standard of preliminary education of about a third of the students, particularly the Melanesian entrants from the Solomon Islands and New Hebrides, who, together with prospective students from Niue and Pitcairn, would be automatically excluded if an entrance examination of a high standard had been introduced.

One of the stated aims of the Central Medical School was "to train a limited number of students as Native Medical Practitioners in order that they may carry out medical and health work in their own group of islands and thus not only bring medical help within the reach of the large number of their countrymen who are out of reach of other medical assistance, but also by preventive measures raise the general standard of health throughout the islands".

The Central Medical School produced for various South Pacific territories almost the full number of Native Medical Practitioners needed to meet their immediate requirements. Elsewhere, however, there remained much to be done.