



Lack of coordination between health policy and medical education: a contributing factor to the resignation of specialist trainees in Fiji?

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Abstract

Aim Specialist training was established in Fiji in 1998. This study explored whether health policy, and in particular mismatches between existing policy and the new realities of local specialist training, contributed to decisions by many trainees to ultimately leave the public sectors, often to migrate.

Method Data was collected on the whereabouts of all specialist trainees. Semi-structured interviews were carried out with 36 of 66 Fiji trainees in order to explore reasons for continuing or not completing training, as well as the reasons behind subsequent career choices.

Results Overall, 54.5% of doctors remained in the public sectors or were temporarily overseas. Completion of specialist training was particularly associated with improved retention. Policies that contributed to frustration and sometimes resignations included a lack of transparency in the selection of doctors to enter training pathways, and unreliable career progression following completion of training. Doctors who left training before completion mentioned family stresses, which were exacerbated by delayed age at entry into training and a lack of certainty in regards to the timing of improved working conditions through career advancement.

Conclusion Policy adjustments to expedite entry into training, as well as to establish predictable career progression as a reward for training may increase training completions and overall retention.

The World Health Organization estimates that there is a global shortage of over 2.5 million health care workers. These shortages are most acute in developing countries, and are exacerbated by the migration of many health workers to developed countries. Shortages of health workers and human resource issues are receiving increasing attention at an international level because of their link to poor health outcomes.^{1,2}

The “scaling up” of health professions education has been proposed as a means to increase the numbers of health professionals in developing countries.^{1,3} As a component of this, in-country or regional postgraduate medical specialist education can play a role not only in providing a specialist workforce trained in the settings where they will be spending their professional lives, but can potentially improve doctor retention by overcoming the need for aspiring specialists to spend many years training in developed countries.⁴

The availability of local postgraduate training can also potentially serve as an incentive or reward for clinical excellence as well as for rural service. To date, few studies have been published about postgraduate programs in developing countries,

and these have generally not focused on the impact of postgraduate training on migration and retention.⁵⁻¹¹

Regional postgraduate specialist training was established in 1998 in Fiji, a small developing Pacific Island nation (see Table 1), in order to address a continuing dependence on expatriates, as well as a failure of most overseas-trained Pacific Island specialists to return home. This training consisted of a 1-year Diploma, followed by an additional 3 years leading to Masters of Medicine (MMed) specialist qualifications in obstetrics and gynaecology, paediatrics, internal medicine, surgery, and anaesthesia.¹²⁻¹⁵

It was believed at the time that offering training in the Pacific that awarded a local specialist qualification not recognised elsewhere would limit migration.¹⁶ Nevertheless, within a few years many doctors who had started training were leaving the public system to migrate or to enter private practice.

Table 1. Population¹⁷ and health-related statistics¹ for Fiji

Population	849,000
Gross Domestic Product (GDP) per capita	\$US 3280
Under 5s mortality	18 per 1000 live births
Life expectancy at birth	68 years
Annual health expenditure	\$US 104 per capita

The establishment of postgraduate training coincided with a worldwide period of openness of developed countries to the migration of doctors from developing countries, and migration was exacerbated in Fiji around the time of a coup in 2000.

This study was carried out in order to determine which factors were leading to resignations of doctors from the public sectors, and whether these factors could be addressed locally. In particular, preliminary discussions raised the issue that health workforce policy had not fully adjusted to take into account the existence of local postgraduate training, and that this could potentially be a factor leading to disappointment and disillusionment among trainees.

Methods

Quantitative data were collected on all 120 doctors who undertook training to at least the Diploma level at the Fiji School of Medicine (FSMed) by 2004. Data on gender, race, highest educational attainment, and working location as of December 2006 were obtained from enrolment and graduation records from FSMed, from local specialist coordinators, and from publicly-available medical registration information in New Zealand and Australia.

Whereabouts were confirmed for all 66 Fiji doctors (the experiences of 54 trainees from other Pacific Island countries are not presented here). These data were analysed using Epi-Info software,¹⁸ with statistical comparisons utilising Chi-squared testing.

Table 2. Characteristics of Fiji School of Medicine specialist trainees 1996–2004 (Fiji doctors only, excluding regional trainees)

Variables	All Fiji specialist trainees	Trainees interviewed	% interviewed
Total	66	36	54.5%
Gender			
Males	39	22	56.4%
Females	27	14	51.9%
Race			
Fijians	41	23	56.1%
Indofijians	20	10	50.0%
Others	5	3	60.0%
Specialty			
Anaesthesia	11	6	54.5%
Medicine	12	8	66.7%
Obstetrics and Gynaecology	14	6	42.9%
Paediatrics	18	9	50.0%
Surgery	11	7	63.6%
Highest educational attainment (at Dec '06)			
Diploma	42	14	33.3%
Masters or MMed student	24	22	91.7%
Working status			
Public sectors (Ministry of Health, FSMed, or UN)	32	21	65.6%
Temporarily overseas	4	4	100%
In Fiji – private practice or not working	10	4	40%
Permanent migrants	20	7	35%

Face-to-face interviews were carried out with 47 doctors who had worked in specialist departments in Fiji, including 9 senior specialists, 2 pre-training specialist registrars, and 36 of 66 who had undertaken specialist training through FSMed. Interviews took place between April 2004 and September 2006 during four trips to Fiji and three trips within Australia.

The interviews lasted ½ to 1½ hours and were semi-structured. Doctors were purposively selected for interviewing in order to obtaining broad representation on the basis of race, gender, specialty choice, highest educational attainment, and migration status (see Table 2). Due to geographic scattering, migrants, private doctors and doctors who had not completed an MMed were underrepresented. Only two doctors (both migrants living in Australia) declined to be interviewed.

As part of the interviews, doctors were asked to describe the decisions they made about completing or leaving training, and about remaining in the public sectors or resigning. The interviews were audio taped, professionally transcribed and coded into at least one of several dozen codes utilising QSR-N6 software.¹⁹

Analysis was carried out using a constant comparative method, with emerging themes being tested and refined through returning repeatedly to interview transcripts. Findings were presented for comment and feedback to interview participants and other stakeholders at the annual Fiji Medical Association conferences in 2005, 2006, and 2007.

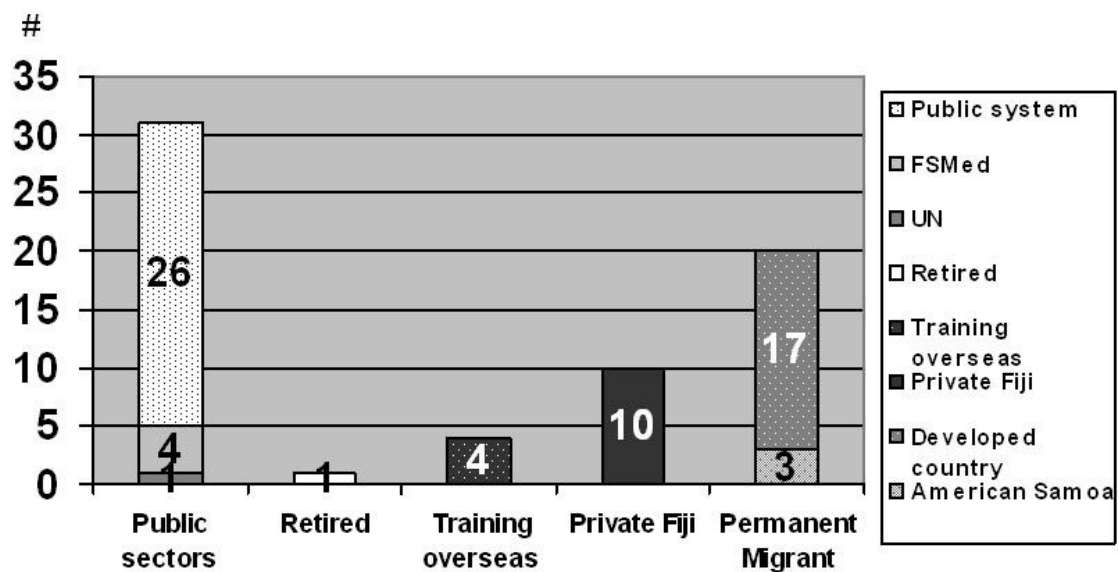
The principal author (KO), who played a major role in establishing postgraduate training in internal medicine as part of her employment at FSMed between 1998 and 2001, carried out all of the interviews. The implications, benefits, limitations, and potential for bias arising from this semi-insider status were acknowledged, reflected upon, and discussed with supervisors during the analysis and interpretive processes.

Ethics approval was obtained from James Cook University and the Fiji National Research Ethics Review Committee. The funding sources played no role in the collection, analysis, and interpretation of data, in the writing of the report, nor in the decision to submit the paper for publication.

Results

By 2004, 120 doctors had undertaken specialist training at the Fiji School of Medicine (FSMed), of whom 66 were from Fiji and 54 from other Pacific Islands. By the end of 2006, 36 (54.5%) of the Fiji trainees were either currently working in the public sectors (32) or were training overseas with stated intentions to return (4). Ten (15.2%) who resigned were still living in Fiji (mostly in private practice), and 20 (30.3%) were believed to have migrated permanently (see Figure 1).

Figure 1. Working situations of 66 Fiji specialist trainees (at Dec 2006)



Policy and entry into specialist training—While health policies supported the establishment of postgraduate training in Fiji,¹⁶ and significantly opened up locally available career options, Fiji doctors reported that existing policies provided little clarity in regards to what the impact of training should be in terms of career advancement.

The policies on the early years after graduation remained unchanged. New MBBS graduates were told that after a 1-year internship, they would be required by the Ministry of Health to work outside of the major hospitals, often in a smaller town or

rural area. The prerequisites for entering formal specialist training included working a minimum of three years following graduation, including one year as a pre-training specialist registrar.

In practice, many more years often elapsed before the required pre-training specialist posting was offered by the Ministry of Health, which also controlled the awarding of government scholarships for undertaking specialist training. A few doctors, however, seemed to be exempted from rural service and were invited immediately after internship to join a specialist department at one of the main hospitals.

I would have loved to do postgraduate training immediately after internship. The idea that we had after internship was that you have to do 3 years rural attachment before you come back to the hospital. Somehow that applies to some but does not apply to others. But I think we need to push to identify people from internship the first year out and say 'you need to go here and here'. And then get the career identified very early on rather than leaving it towards the end, you know when you're supposed to have specialised and you're starting your postgraduate training.

The lack of timely advancement into specialist training was of concern to staff at FSMed, some of whom described a lack of transparency in how doctors were selected for specialist training. They wondered whether the lack of clarity about how to pursue specialist careers led to frustration, lack of hope, and eventually to resignations.

Policy and Masters (MMed) graduates—The new MMed qualifications allowed specialist status to be granted 2 years after graduation. Previously, specialist status could be obtained either through overseas training or through working in specialist departments for 15 or so years. Specialist status, while allowing limited private practice for public sector doctors, was separate from and did not guarantee promotions to senior roles, and there were no written policies in place in regards to the impact of an MMed on actual career advancement within the public service.

By 2006, 21 Fiji doctors had been awarded a Masters degree, of whom 18 (85.7%) were still working in public sector roles (15) or were temporarily overseas (3). Of the 11 doctors from the first two graduating MMed classes, 7 of 8 who were working in the public sectors had moved into senior roles. Three other graduates in this group had either migrated to Australia (2) or entered private practice in Fiji (1), and described neither having been promoted in a timely manner, nor having confidence that they would be promoted in the future.

And there was also a time when there were a lot of people migrating out of the country leaving their jobs, so there were a lot of vacancies at that point in time. It was really quite easy for me to slot myself in, given that I was the only one who was passing exams. That's why my promotion relative to most other people has been quite quick.

I had the sense of getting nowhere and I felt 6, 8 years down the line and I'm still gonna be just a registrar. It's going back and forth and yet the Ministry was not even recognising the programme itself, so I said 'Hey, I've just got to get out of this!'

For the 10 doctors who received their MMed qualifications between 2003 and 2006, only 2 had been appointed to senior posts. Of the other 8, many described their prolonged junior postings as being frustrating given that their postgraduate training seemed to have no impact on their career status.

I guess part of the frustration would be the way the Ministry, how their structure doesn't allow for people to progress. If you do self-developmental things, and keep getting higher and higher recognitions, part of the frustration of that is recognising that the people who get

promoted have no interest in eventually pursuing further postgraduate training and stuff like that, but by virtue of years of service...

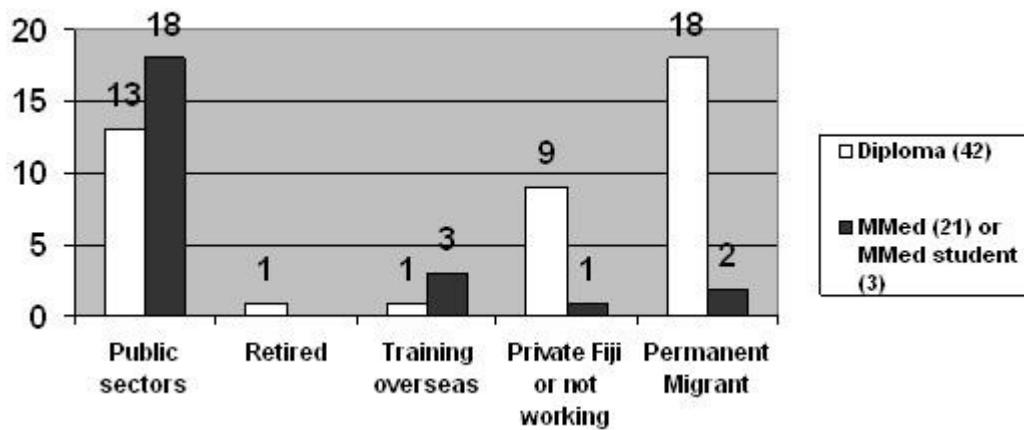
But I understand there was an agreement that if you finish your Diploma you automatically become a senior medical officer...and once you completed your Masters you qualified to go up as chief medical officer. But because of the fact that we have a lot of expatriates who were brought in and occupying the higher posts, and the posts are all occupied so you still have to settle with the medical officer post (lowest career grade).

It is of some concern that six MMed graduates have undertaken or were planning to undertake overseas placements. This is because in the past, the few doctors who have returned or attempted to return to Fiji after completing specialist training overseas have faced considerable frustrations, given that no specific policies or procedures were in place then (or now) to track their status while overseas or plan for appropriate senior roles on return.

I was tempted to stay away but it was basically because I didn't get any response from the Ministry of Health when I started writing, to say that 'I'd finished my specialist training, if there was a job I'd like to come to it', and they didn't respond for 8 months. My story isn't unique, man, a lot of people report this story. I suppose I persisted a bit longer than others but it was just matter of 2 weeks. If that letter hadn't come, 2 weeks later I would have taken up a job in England as a consultant.

Policy and Diploma graduates at a decision point—While most MMed graduates have continued working in public sectors, the majority of specialist trainees (42 out of 66, or 63.6%) left training with a Diploma as their highest qualification, and of these, only 13 (31.0%) are still working in public sector roles (see Figure 2).

Figure 2. Working situation by highest qualification attained (at Dec 2006)



Over time, Diploma graduates became increasingly aware of how difficult Masters training was, and concerns were often expressed about the quality of supervision, the workloads, and the failures to address problems with low staffing levels in specialist departments. A lack of coordination between the demands of academic and hospital supervisors was particularly cited as adding to an already stressful working environment.

It was very difficult and I guess a lot of people had bent under that, a lot of our registrars...because of a lack of commitment from our local counterparts, our local supervisors and our local consultants...what I mean by bent under, is they just can't cope with it, the stress is too much. They've just given up because they haven't found a way out and probably the only way out is get out of the system so that the system doesn't destroy you.

In addition to educational concerns, family commitments were a very powerful driving factor behind the career decisions that Diploma graduates made. Due to policies that did not serve to expedite entry into specialist training, many doctors started specialist training a number of years above the minimum required after medical school, and the majority had started or were planning to start families.

Both men and women faced challenges related to the difficulties of undertaking training on top of already challenging jobs. They often stayed for prolonged periods at junior postings, earning low salaries. Women in particular struggled to find time to devote to their families at a very demanding time in their careers.

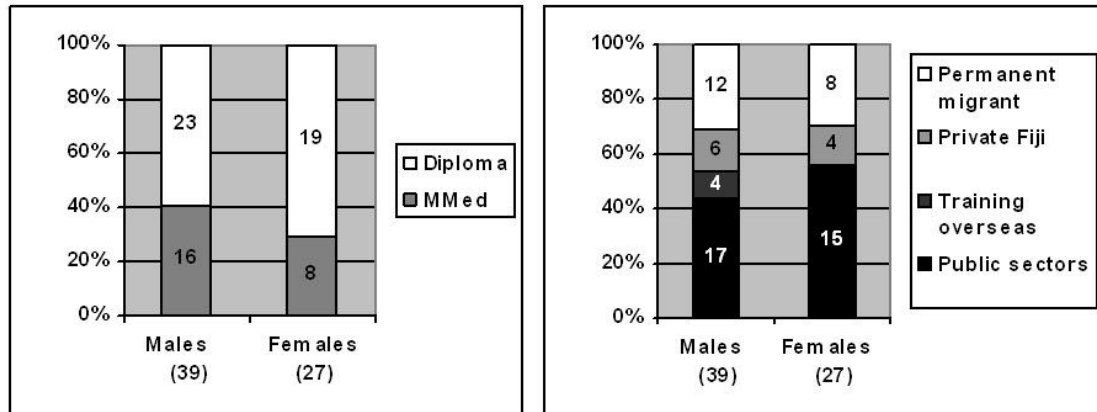
Men also struggled with a desire to spend more time with their families, but they particularly mentioned financial stresses related to supporting young families. Interestingly, there was little difference in resignation rates between men and women (see Figure 3).

I was so frustrated! Why I left was, my number one thing was for my family. I thought I wasn't giving enough time. I have three kids, so that was my main reason leaving. I'm not that ambitious, but the main thing is that I have to get my children started off and then see my husband do something, then for myself.

One of them, he couldn't cope with his two children, and his wife was a nurse and he had just bought a house. For them to be able to look after their financial commitments, both of them needed to work, true. But they had two small children. So then they decided it wasn't going to work. They wanted to bring up their children properly, so his wife, he didn't want his wife to work, just to sort of stay home and look after the children, and that was the main reason he moved to American Samoa. 'Because I could do that over there.' And he earned enough to support them. And pay off his house as well. The money was good. That was the main reason he left.

The interviews suggested that in Fiji, both female and male doctors faced a "biological clock", or perhaps a "family clock", which was probably exacerbated by delayed entry into training. The fact that there were no policies in place to guarantee timely promotions as a reward for undertaking training (with their associated better working conditions and higher salaries) made "hanging in there" at times of stress much more difficult. On the other hand, quick relief was readily available through local private practice, and while migration posed its own uncertainties, opportunities to migrate were readily available.

Figure 3. Highest qualification earned and working situation by gender (at Dec 2006)



Discussion

The establishment of postgraduate training in Fiji has created new conditions and situations that pose both opportunities as well as challenges. The interviews with doctors who undertook local specialist training in Fiji suggested that the structures and policies in the public system have not adjusted to take into account the realities of local specialist training, and that this may be having a negative impact on retention.

While it is unlikely that additional resources will be come available in the near future to substantially increase salaries and improve overall working conditions, there are some changes that could be made in health policy that may improve the retention and satisfaction of specialist trainees without large outlays of funding.

Firstly, although this study did not focus on doctors prior to entering specialist training, overall retention may be helped by developing a more transparent process of selecting doctors to work in specialist departments. Available positions should ideally be advertised at least yearly, and include more predictable intakes of pre-training specialist registrars (at least every 2 years in each specialty).

Potential trainees should ideally be judged according to merit by a panel with representatives from the Ministry of Health, the Fiji School of Medicine, and other important stakeholders. In the interest of rewarding service, priority should be given to those who have spend the longest time working in regional or rural areas.

Because the retention of Masters graduates has been much greater than for doctors with only a Diploma, interventions should focus not only on providing career paths for doctors who leave training with a Diploma, but on retaining as many trainees as possible through to MMed graduation.

Interventions should include improving coordination between the hospital and the academic components of the training programme, and supporting the working environment through actively recruiting into established but unfilled posts in specialist departments. The availability of part-time work and training may increase the retention of doctors with young families, especially women.

Because the conflict between family and working roles can be particularly stressful, the expediting of specialist status and working in senior roles could provide considerable relief and encouragement. In addition to earlier entry into specialist training, trainees would likely be encouraged through receiving automatic promotions both when they receive their Diploma and their Masters.

Overall, attention to the promotions process should increase transparency, should reward merit, and should facilitate promotion to senior postings for Masters graduates. Granting eligibility for specialist status at Masters graduation (which allows limited private work for public sector doctors), rather than 2 years later, may provide for welcome and predictable financial relief.

Finally, specific steps should be taken to plan for the return of doctors who have undertaken overseas training, whether for full specialist training or shorter attachments. Retention of these doctors may be improved by actively tracking their overseas progress and allowing, in some instances, overlapping senior postings when they return if an expatriate is in a senior position but has not finished his or her contract.

This study adds to the limited current literature about the outcomes of establishing local postgraduate training in developing countries, and has a number of strengths as well as limitations. Interviews were carried out with over 50% of Fiji specialist trainees, and the exploratory nature of the interviews allowed for novel or unexpected insights to arise.

A particular strength of the study is the identification of possible interventions that can be made at a policy level without large increases in funding, though the potential for success of these interventions is not guaranteed, and would merit further study. The involvement of the interviewer for almost a decade in Fiji, as well as her role in helping to establish these courses is both a strength and a limitation, as it was likely to have allowed for a deeper understanding of the situations of the interview participants, but could have potentially lead to some degree of bias.

The under-representation of migrants, private practitioners, and doctors who left training with a Diploma may also contribute to bias. The overall narrowness of the study is another limitation, and the experiences of medical students, new medical graduates, and non-specialist doctors were not explored. Generalisation to other countries may also be limited.

Doctor salaries in Fiji are arguably “livable” though modest, so this study may have limited applicability to more impoverished nations.

This study may provide some insights for individuals and institutions that will be increasingly called upon to help scale up postgraduate training in developing countries. It is reassuring that even with disappointing losses of trainees to resignation and migration, postgraduate training at FSMed has succeeded in adding 15 Masters-qualified specialists to the public sector workforce, with three more planning to return from overseas. This compares to only 5 Fiji doctors with overseas specialist qualifications currently working in the public sectors.

Health educators need to keep in mind that their interventions to strengthen medical education take place within a health system, not in a vacuum. Health policies can have

a profound impact on the success or failure of educational interventions, and failing to advocate for adjustments to health policy to take into account the existence of new training programs may undermine such programmes.

On a more personal level, those who support the scaling up of medical education, especially outsiders, should attempt to develop a full understanding of the stresses their students are facing.

“Survival of the fittest” approaches are probably inappropriate or counterproductive in situations where many doctors end up dropping out and then resigning from the public sectors, often to migrate. Compassionate approaches based on genuine understanding, especially if coupled with a willingness to be an advocate for trainees with government departments and funding bodies, may also lead to improvements in retention and satisfaction, and ultimately to stronger health workforces.

Competing interests: I, Kimberly Oman (principal author) have the following conflicts of interest: I worked at Fiji School of Medicine (FSMed) from 1998–2001 and was employed initially by the FSMed and was later by AusAID through the Royal Australasian College of Surgeons, which was contracted to establish postgraduate training in Fiji. Part of this study was funded by consultancy fees from the Royal Australasian College of Surgeons in 2002 for two follow-up visits to oversee the progress of the postgraduate training in internal medicine. Neither the FSMed as an institution (apart from individuals as co-authors or supportive colleagues) nor AusAID had input into the planning, data collection, analysis and interpretation of data, in the writing of the report, nor in the decision to submit the paper for publication. I have no other conflicts of interest to declare.

I, Robert Moulds, have the following conflicts of interest: before being appointed Professor of Medicine at the FSMed, I was the external advisor for the establishment of the internal medicine component of the AusAID-funded postgraduate program at the FSMed. I have no other conflicts of interest to declare.

I, Kim Usher, have no conflicts of interest to declare.

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