

Initial perspectives of New Zealand doctors: developing capacity and a training programme in the Cook Islands

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ABSTRACT

FROM 2012 to 2014, 18 New Zealand general and rural medical practitioners worked in the Cook Islands on a visiting programme to achieve the following objectives: (1) assess and assist with the capacity of the Cook Islands medical workforce; (2) assist with the infrastructure to improve clinical records and audit; (3) assist with developing a General Practice training programme for the Cook Islands; and (4) develop a training post for the Division of Rural Hospital Medicine in the Cook Islands. Each visiting doctor spent a minimum of 4 weeks in the Cook Islands. This study presents the results of a questionnaire undertaken to evaluate their experiences. There were challenges, but for most, the experience was overwhelmingly positive. There were synergies with rural practice in New Zealand. Working alongside local clinicians and being immersed in the Cook Islands health system led to better understanding of the Cook Islands perspective of rural and remote medicine. The findings provide insight into the early phase of an ongoing programme between the Cook Islands Ministry of Health and New Zealand, which has led to the development of a reciprocal training programme for generalist doctors.

KEYWORDS: Pacific communities; Cook Islands; rural medicine; general practice; workforce; health systems

Introduction

The essential feature of rural medicine is a broad scope of practice in rural or remote settings with limited resources, including access to specialist investigations and treatment.^{1,2} This gives rural medicine synergy with medical practice in many Pacific Island countries.

The Cook Islands, a South Pacific nation, comprises 15 islands spread over 2 million km². The population of 13,000 is dispersed across the islands, but concentrated on Rarotonga, the centre of governance and commerce. The Cook Islands has been a self-governing nation in free association with New Zealand since 1965, and the two countries have a special relationship founded on historical ties, unique constitutional arrangements and a common citizenship and

currency. Cook Islanders can journey freely between the two countries and their respective health systems.

In the Cook Islands, tourism provides the economic base, with New Zealanders making up 60–70% of visitors. In New Zealand, the Cook Islands population is the second largest Pacific people's ethnic group.³ Auckland is the main tertiary referral centre for the Cook Islands health service, with ~130 patients transferred each year to New Zealand.⁴ The Ministry of Health is the main provider of health services in the Cook Islands. Health services range from public health (including primary care) to secondary care. Services are provided across all the islands through a system of clinics, health centres and hospitals. The main hospital in Rarotonga is the

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secondary care centre for the Outer Islands. It provides in-patient care as well as conventional ambulatory care in outpatient departments. The General Outpatient Department serves as an Accident and Emergency department, but at the same time also functions as a walk-in health centre for patients with chronic conditions and minor illness, and is open 24/7.⁵

Since 1994, the New Zealand government has funded medical specialist visits to the Cook Islands to provide services not available there. From 2008, these visits have taken place under the Health Specialist Visits scheme now managed by the Cook Islands Ministry of Health. In 2011, in the context of an increasing non-communicable disease burden on health services, and with preventive and primary care featuring strongly in the Cook Islands National Health Strategy,⁶ broadening the Health Specialist Visits scheme to include primary health care was recommended. This, together with more emphasis on local capacity building, is consistent with global and regional recommendations.^{7,8}

In March 2012, the Health Specialist Visits scheme improved primary care services' programme commenced with support from the Division of Rural Hospital Medicine (DRHM-NZ), a chapter of the Royal New Zealand College of General Practitioners (RNZCGP). As part of the programme, New Zealand Fellows of Rural Hospital Medicine and/or General Practice spent a minimum of four consecutive weeks in the Cook Islands. The doctors volunteered, with their travel and accommodation costs covered. The programme provided the Cook Islands with doctors to fill service gaps and contribute to continuing medical education for local staff. In return, the visiting doctors extended their experience in generalist medicine, working and living in the Cook Islands. Fundamental to the programme is the concept of the visiting doctors working alongside their Cook Islands colleagues. During the first year, doctors were based on both Rarotonga and the Outer Islands. From 2013, all visiting doctors were based on Rarotonga.

The Cook Islands may present challenges to New Zealand doctors, similar to challenges documented regarding medical care by first

WHAT GAP THIS FILLS

What is already known: There is no previous research investigating general medical practice in the Cook Islands. There is no post-graduate training pathway in general practice for Cook Islands doctors.

What this research adds: New Zealand doctors value being part of a sustained programme assisting with developing workforce capacity in the Cook Islands. There is synergy between medical practice in rural New Zealand and medical practice in the Cook Islands.

world-trained doctors working in low resource countries.⁹⁻¹¹ In some New Zealand rural settings, similar challenges exist, but with different dimensions because of the better resourced environment in New Zealand. In the Cook Islands, New Zealand doctors encounter different healthcare delivery systems and work in a setting where funding and resource constraints will inevitably affect clinical care.

While New Zealand has well-recognised pathways for medical training in generalist scopes of practice (general practice, rural hospital medicine, emergency medicine), this is not the case for Cook Islands doctors who have had few opportunities to formally train in these scopes. General medical practice in the Cook Islands was expected to be more closely related to New Zealand rural practice than general practice in New Zealand urban settings. No previous research was found relating to general practitioners (GPs) or primary care systems in the Cook Islands.

The aim of this study is to review the personal views and experiences of New Zealand doctors regarding their time in the Cook Islands in the early phases of the programme. A separate study, led by the Cook Islands Ministry of Health, will examine Cook Islands doctors' views of the same programme.

Methods

A short questionnaire was developed by the DRHMNZ and the Health Specialist Visits primary care team in 2012. All 18 doctors

visiting for the first time between April 2012 and October 2014 were asked to complete this questionnaire on their return from the Cook Islands. Questions included reasons for joining the programme, challenges faced, whether they would recommend the programme to colleagues, and how the work in the Cook Islands related to their work in New Zealand, if at all. Two doctors visited a second time during the study period; these return visits were not included. Responses from completed questionnaires were grouped into themes for analysis and reporting. Responses are reported as summaries and quotes.

This study did not require ethics approval, under the terms of the Health and Disability Ethics Committee scope.¹² The DRHMNZ and the Cook Islands Ministry of Health supported the study. Participants were advised that information from questionnaires may be analysed and published, and doctors completing questionnaires gave their permission for their information to be used.

Results

Of the 18 visiting doctors, 15 completed questionnaires (83% response). Twelve respondents lived and worked in rural NZ, and three in urban centres. Six doctors were fellows of both general practice and rural hospital medicine, six were fellows of general practice, and three were fellows of rural hospital medicine. During their time in the Cook Islands, five doctors were based in the Outer Islands, one in the Northern Group (Manihiki) and four in the Southern Group (three on Aitutaki and one on Mangaia).

Why they joined the programme

All 15 respondents reported wanting to undertake volunteer work in a low-resource setting. At the same time, several (six) also preferred to volunteer somewhere close to home or familiar. The Pacific region was regarded by four respondents as 'our backyard'; for example:

"...to help out in less resourced place but somewhere safeand close to home." [Dr 7]

"Good to be outside comfort zone - but not too far." [Dr 10]

Seven respondents mentioned the Cook Islands' links with New Zealand as an attractant; for example:

"I was interested in working outside first world nations ... and liked the prospect of the Cooks because of the strong links with NZ." [Dr 3]

Three respondents mentioned the importance of being part of something bigger, and likely to be sustained; for example:

"...to support the New Zealand Rural Hospital Doctor initiative in increasing the interaction between Cook Islands, and in particular Cook Islands doctors, and New Zealand rural doctors." [Dr 6]

What was good?

All participants listed 'the place and the people' as the best thing about their time in the Cook Islands. Seven respondents valued working with and being accepted by local staff. During the second year, providing collegial support became a stronger theme. Most (10) felt that four weeks was a very short time to experience a different health system; for example:

"...six weeks has been just long enough for a taste.... a handshake." [Dr 1]

Most (nine) saw relationship building as key and 14 expressed a wish to return:

"If we can continue for the long haul it will be a very worthwhile project." [Dr 10]

Challenges

Challenges fell into two main categories: a different system (with limited resources) and role ambiguity.

A different system:

Six respondents reported that they needed time to adjust; for example:

"Getting my head around a different system, a different way of doing things..." [Dr 2]

“...the feeling that there was so much to understand and so little time to do so.” [Dr 3]

Many respondents (six) became more aware of the differences in systems and infrastructure between the two countries; for example:

“I have a heightened appreciation of the quality of our primary care services in New Zealand.” [Dr 15]

“The primary health care system in the Cooks is quite different from the New Zealand model.” [Dr 8]

Two respondents commented on the Cook Islands ownership of the health service; for example, “It is their place” [Dr 3]. All respondents commented on the resource differential, though not all viewed this as a challenge. Four doctors found information technology (IT) aspects particularly challenging; for example:

“The most frustrating part of the job had to be the slow computer system and the computers themselves.” [Dr 1]

For two respondents based on the Outer Islands, isolation was the biggest challenge; for example, “knowing that help was a long way away in the case of an emergency.” [Dr 6]

Role ambiguity

More than half of respondents (nine) were comfortable with the expectation they were there, at least initially, to fill a clinical gap. However, seven respondents indicated that they had difficulty understanding their role. Three also commented that this lack of clarity was an essential part of the learning process; for example:

“They were short staffed during my visit and I feel I was able to take some of the pressure off the local doctors.” [Dr 15]

“I was not always clear exactly what my role was and what was expected ...if I was just there to fill the roster or more ... thinking back this feeling,

which was unsettling, was probably an important part of the whole learning process.” [Dr 13]

“The business at times was challenging ...not being sure if I was accepted as a teacher rather than just filling in.” [Dr 4]

Preparation

When asked about preparation to help future doctors on the programme, five respondents indicated that ‘going there’ was the best or only worthwhile preparation. Two would have liked more information about the health system in the Cook Islands. All respondents mentioned specific practical things relating to acute aspects of clinical work; for example, acute paediatric life support (APLS) course, emergency management of severe trauma (EMST) course (five respondents), orthopaedics (eg plastering (two respondents), obstetrics (six respondents)); for example:

“Everyone has to go through the first few weeks of familiarisation with new country, new system, warm climate, adapting to the Cooks, General Outpatient way of working.” [Dr 12]

Relation to rural medical practice in New Zealand

Most respondents, including all five who were based on the Outer Islands, appreciated the synergies between practice in the Cook Islands and rural practice in New Zealand; for example:

“There are some things that we do in New Zealand that are different but there are a lot of similarities that ... we have in rural New Zealand.” [Dr 4]

“Good ‘fit’ between rural practice in New Zealand small rural hospital and Outer Islands, crossing from general practice into the hospital...small team; wide scope of practice; flexibility.” [Dr 13]

“...hearing... [comments from other doctors on the programme]...just highlighted how little work some of the doctors have done in rural New Zealand,

when the power is out, the computer system is down for the morning, or very slow.” [Dr 9]

Recommendation to others

All 15 respondents would recommend the experience to other colleagues. Almost half (seven) also added a comment here around flexibility; for example:

“Absolutely. I would suggest that someone should expect to encounter a practice of medicine that is different to what they are used to.” [Dr 1]

“Need to be able to improvise if required and understand where the people are coming from.” [Dr 9]

Discussion

This study is the first to report on experiences of New Zealand generalist doctors working in the Cook Islands. The most obvious finding is that visiting doctors want to contribute, like the experience, want to return, and recommend it to others. They support the sharing of ideas through exposure to professional colleagues, and feel that the programme is a useful support in terms of managing clinical load. The study strengthens the idea of synergy between medical practice in the Cook Islands and medical practice in rural New Zealand.

Results are consistent with previous research findings in that working in a different cultural context requires orientation, time and ‘bedding in’ to local systems¹³⁻¹⁵ and that, in this context, being part of something sustainable is valuable.⁹ While the proximity of the Cook Islands to New Zealand and the close association between the two are draw cards for New Zealand doctors, there is not necessarily good awareness of health system differences between the two countries. The overall philosophy of the programme has been about establishing what general medical practice in the Cook Islands is, how it is different from general practice in New Zealand, and how it could look in the future.

This study is limited by the methodology; a questionnaire alone lacks the depth that could be gained from other research methods.

The Health Specialist Visits primary care programme has continued since this study was completed. Several New Zealand doctors have returned to the Cook Islands, some for their third visit. It would be useful to look at wider reciprocal effects on doctors and health systems over time as the programme and relationships develop.

This programme has subsequently provided the platform to launch the Cook Islands Fellowship in General Practice, a Cook Islands Ministry of Health initiative established in 2015 in partnership with the University of Otago and the RNZCGP. A training post has also commenced at Rarotonga hospital for New Zealand registrars participating in the Rural Hospital Medicine training programme. Reports and evaluations of the Health Specialist Visit primary programme are outside the scope of this study and are available elsewhere.¹⁶

Conclusions

This study was undertaken to evaluate the experiences of the New Zealand visiting doctors in the first two years of the Health Specialist Visits primary care programme. It suggests that the developing collegiality between Cook Islands and New Zealand doctors is leading to an exchange of ideas and values that provide New Zealand doctors with a better understanding of the Cook Islands perspective of rural and remote medical practice. An in-depth study will be undertaken to assess the long-term reciprocal effects of the programme as it develops.

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COMPETING INTERESTS

None declared.