The Establishment of the Central Medical School, Fiji

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Abstract

The purpose of this report is to introduce Rockefeller Foundation involvement in the early histories of the Central Medical School in Fiji. The Central Medical School was established to deal with the dramatic fall in the population of native Fijians. The fear of so-called "race extinction" motivated the British colonial government to pay greater attention to native healthcare by training select Pacific Islanders in basic medicine. The Central Medical School was run by the colonial government of Fiji, staffed by British-educated tutors, attended by students from across Oceania, assisted by the Rockefeller Foundation, and jointly operated by participating colonial administrations: Britain, Australia, New Zealand, France, and the United States. This collaboration between imperial administrations and the Rockefeller Foundation shows the importance of indigenous healthcare in the Pacific islands during the early decades of the 20th century

Planning for the Central Medical School

The genesis of the Native Medical Practitioner (NMP) system can be traced through the growth of Fiji's connections to the British imperial world. Following the cession of Fiji to the British Empire in 1874, Fiji was constantly exposed to introduced epidemics. After the 1875 measles epidemic that killed nearly a quarter of the Fijian population, ships carrying Indian indentured labourers brought in smallpox and cholera. Many more Indian indenture ships, arriving in the following years, triggered the fear of disease among Fijians. In a desperate attempt to fight the introduced epidemics, the Suva Medical School was established in 1885 to train native youths as vaccinators.[1] In a sense, this school was the forerunner of the Central Medical School.

Upon graduation, students were each appointed to a district as "native practitioners" (in practice, they were called "native medical practitioners" - NMPs). The main duties defined in the ordinance of NMPs were inspection, treatment, vaccination, and reporting. Every town in each district had to be visited at least once every month with special attention to sanitation. If necessary, an assistant was provided to carry the practitioner's luggage and take care of food needs. The NMPs were obliged to submit diaries of every day's activities and quarterly reports of work where cases of dysentery, typhoid, and leprosy were to be reported. It was important that they abstain from interfering in provincial matters unrelated to medical practice. The NMPs were occasionally sent out to other British territories in the South Pacific. One NMP serving in the Gilbert and Ellice Islands was so highly praised that Europeans in Funafuti assured that they will have him operate on them in emergencies, just as they trust other fully qualified doctors.[2]

A cooperative discourse for an enlargement of native healthcare began in the early 1920s after the South Pacific suffered several critical epidemics. It started as a vision for centralizing medical governance in the Western Pacific High Commission territories (WPHC) of Fiji, British Solomon Islands Protectorate, Gilbert and Ellice Islands (current day Kiribati and Tuvalu), New Hebrides, and

Tonga. Hopes were raised by the WPHC to embrace the New Zealand and Australian territories.[3]

The Rockefeller Foundation (RF), represented by Dr. Sylvester M. Lambert, was charged with devising the cooperative scheme and bringing efforts together. The Rockefeller Foundation had been leading medical programmes in the South Pacific since they established the International Health Commission (later International Health Board) in 1913. The RF regarded the British Empire as a strategic partner to work on tropical diseases. With the support of the Colonial Office, Lambert travelled across British, Australian, and New Zealand territories to further the eradication of hookworm and yaws.[4] Lambert soon persuaded New Zealand to join the discussion for combined effort in Western Samoa, Cook Islands, and Niue. Australia did not favour participating. The scheme to attack disease was placed under the control of native medical practitioners who were trained through a centralized medical education program. The Fijian NMP model, which was affordable and proven effective, was going to be adopted as the future native healthcare system in the South Pacific.

The first step to centralization was to transform the Suva Medical School from a small national school to a larger imperial institution. It was too small to accommodate far more students from Fiji and the surrounding islands. In Fiji, the need for more NMPs was acknowledged as early as 1921. A constant increase of indentured labourers left Fiji a large Indian population that required specialised medical attention. The chief medical officers reported that there were sixty thousand Indian residents in Fiji by 1924.[5] By this time, the number of Indians matched the Fijian population, also reaching 60,000.[6] Training more youths as NMPs was thus closely linked to providing healthy labour force in a changing multicultural society.

The colonial government agreed that a larger native medical practitioner service would benefit Fiji. At the suggestion of the resident medical officer of the Colonial Hospital, the acting governor approached the Rockefeller Foundation. The government of Fiji did not want to bear the cost of a new school by itself. Considering the RF's previous funding of medical colleges across the world,

colonial authorities had hoped that the Rockefeller Foundation would assist medical education in Fiji. In 1922, the Rockefeller Foundation was asked to provide up to £10,000 to build a new medical school. The new medical school was imperial in nature and the possibility of training Fijians for service in other territories was mentioned.[7] The RF's response was not very enthusiastic. On a different channel, the administration of Western Samoa approached the Rockefeller Foundation in 1924 with a similar suggestion. Western Samoa was "anxious to keep Samoa for Samoans, but this will not be possible unless they become a healthy and increasing race".[8] Again, the Division of Medical Education of the Rockefeller Foundation was doubtful if the remoteness and scarce population would make it economical. Moreover, the Rockefeller Foundation preferred to fund university-level medical colleges, such as the Peking Union Medical College that opened in 1921. Medical schools of lower qualification could not be considered to invest in. They viewed the Central Medical School more as a public health project than as an institution for medical education.[9]

The movement for establishing a cooperative medical education accelerated after 1924. The Colonial Hospital was newly renovated as the Colonial War Memorial Hospital to commemorate the loss of Fijian soldiers in the First World War. It was equipped with 100 beds and modern facilities to serve the largest centre of population in the South Pacific. The connection of a medical school to the hospital would facilitate an ample flow of resources.[10] Following the suggestion of Islay McOwan, the British agent and consul in Tonga, the premier of Tonga proposed to the high commissioner for the Western Pacific cooperation with various island governments to establish a medical school in Fiji, in February 1925.[11] Following this proposal, the matter of establishing the Central Medical School in connection with the Colonial War Memorial Hospital was officially opened between the WPHC and New Zealand administrations.

The Rockefeller Foundation played a meaningful role in devising the scheme. Lambert was already leading public health programmes in various islands in the South Pacific as the representative of the Rockefeller Foundation. Through his extensive travels, he learned that the scattered nature of South Pacific islands had prevented a cohesive healthcare policy. As far as Lambert was concerned, it was not merely necessary to build a school but to have a comprehensive development

plan for improving native healthcare under centralized control. It was not easy to bring about the cooperation needed to achieve this, even though most administrations acknowledged the need for native healthcare. Lambert argued that "it would be Imperially [sic] unsound and a short-sighted policy to refrain from establishing a Central Native Medical School even at double the initial cost to that now proposed." For better management of disease conditions, a South Pacific Health Service in the WPHC territories was suggested. Preventable diseases such as hookworm and yaws were identified as the main cause of depopulation. Training NMPs would allow many of them to be stationed in local small hospitals, thus improving native health standards. The currently scattered health services made it very difficult to coordinate NMP activities throughout the South Pacific. Unification of health services seemed to be the solution to prevent efforts from being wasted.[12] Materialising such an extensive programme required large external funding and promised contributions from other administrations.

The Founding of the Central Medical School

The formal proposal for the establishment of the CMS was submitted in 1925 as an enlargement of the existing Suva Medical School. The International Health Board of the Rockefeller Foundation agreed to offer financial aid. For the school's founding in 1928, £2,000 was donated on condition that no less than £8,000 would be spent on the establishment of the CMS for the training of 40 students. After the school's establishment, the RF shared the cost of the maintenance budget for the first four years, in decreasing proportion. Out of the budget of £7,260, the Rockefeller Foundation contributed £5,445 (75%) in 1928, £4,356 (60%) in 1929, £3,267 (45%) in 1930 and £2,178 (30%) in 1931.[13] The RF also offered £9,472 for new public health programmes in the WPHC territories on the condition that the medical administration was centralized under one body, with its headquarters in Fiji. The chief medical officer of Fiji would assume the role of director of the joint medical service. This was called the "Maximum Rockefeller

Scheme." Central administration, central treatment, and central education were key elements.

Securing Rockefeller Foundation assistance was not easily done. In her research, Annie Stuart described it as Lambert's personal political achievement.[14] However, it was not Lambert's sole effort that gave birth to the Central Medical School. Only after the advancements made by Fiji's new Colonial War Memorial Hospital, Tongan government's support, Western Samoa's approach, and the WPHC's plan to extend the NMP service did the Rockefeller Foundation approve a financial contribution. In case the RF withdrew from the scheme, authorities planned that Fiji would establish the CMS regardless. External assistance from the Rockefeller Foundation would reduce the financial burden falling on Fiji, that was already appropriating more than 10% of the total revenue for the medical services. Even Lambert admitted that it was not his own bright idea but was "in the air and everyone had it just under the surface of their mind."[15] Therefore, founding the CMS was a product of a multi-channel endeavour.

The British Colonial Office only approved of the scheme after having the course syllabus reviewed by colonial medicine specialists. The Colonial Office further advised the Western Pacific High Commission to approach Australia for participation. However, Australian leadership considered that subordinating itself to another administration in any joint scheme was intolerable. The Australian government also viewed peoples of Australian territories, Papuans and New Guineans, as lacking the intelligence to undertake a four-year course. Therefore, the only participants in the beginning were the British WPHC and New Zealand. The secretary of state for the colonies approved the proposal in principle in April 1927. Soon after the Colonial Office decision was granted, an advisory board for the Central Medical School was appointed. The board was to advise the governor of Fiji on all matters related to administering the CMS. In practice, the advisory board was the school's principal decision-making body.

Following approval, the Fiji government donated the grounds adjacent to the Colonial War Memorial Hospital for the construction of the Central Medical School. Construction began in August 1927.[16] After more than a year, the CMS formally opened by the High Commissioner Eyre Hutson with ceremonies on 29th

December 1928.[17] The joint administration of the CMS was signed for ten years to be renewed upon agreement. The Rockefeller Foundation assisted for four years from 1929 to 1932, apart from the grant for building the school in 1928. The administrative running cost was to be borne by all participating administrations in proportion to the number of students they sent.

The Rockefeller Foundation made considerable contributions to the Central Medical School even after the initial five years. In 1934, £2,200 was appropriated for additional assistance in building a new wing of the CMS with a bacteriological laboratory, pathological laboratory and post-mortem room. When the funds proved insufficient for the construction, the RF granted additional £1,500.[18] The Rockefeller Foundation donated used medical books to the CMS and arranged additional bibliographical donation from the New York Academy of Medicine.[19]

The biggest innovation of the Central Medical School was internationalization of medical education in the South Pacific. Initially the students came from Western Pacific High Commission- and New Zealand-administered islands: Fiji, Solomon Islands, Gilbert and Ellice Islands, New Hebrides, Tonga, Western Samoa, and Cook Islands. A few years later, Niue, Nauru, and American Samoa joined. This development made the CMS truly international as it brought the British, New Zealand, Australian, French, and American imperial governments to cooperate in one medical scheme. The Central Medical School could accommodate 40 students at a time, more than triple the size of Suva Medical School that could only afford twelve students. Each administration was designated a quota of students according to the population. Fiji occupied up to half: 20 students for both Fijians and Indians. Solomon Islands, Gilbert and Ellice Islands, Tonga, and Western Samoa sent four students at a time, while New Hebrides and Cook Islands had two students.[20]

Admissions were not run centrally. Selection of students was left up to each country to decide, as long as they met the minimum requirements. There were three conditions the CMS required. The first one was moderate fluency in English. The course was taught in English by British tutors. Being able to read, speak, and write in English was vital in undertaking the coursework. The second condition

was that students had to be medically apt. General physical fitness had to be examined before leaving. A more rigid medical test was introduced after the death of a native medical practitioner within a year of graduation.[21]

There were obvious limitations to the Central Medical School and Native Medical Practitioners system. It was unable to break through the institutionalised racism of the colonial period. Many students came from an elite background in the colonial South Pacific. They were chiefs themselves or sons of chiefs who could afford primary and secondary education in English. The WPHC viewed them only as useful intermediaries between the British authorities and the colonised islanders. It was made clear that the CMS would not turn into a medical college with full degrees. Unless the native communities found their own way to qualify as a doctor in Australia or New Zealand, there were no institutions that offered medical degrees in the Pacific islands. The CMS policy of preserving native customs implied that natives should remain unequal to Europeans. Also, the NMP services could not be upgraded into a regular medical service. As Lambert advised, European doctors cared for the Europeans, administered the hospital, and conducted quarantine work while the natives were cared for by NMPs.[22]

Conclusion

The establishment of the Native Medical Practitioners system and the Central Medical School, despite being medical institutions, were predicated on the needs of the imperial authorities rather than simply being humanitarian objectives. It was an inter-imperial experiment in which European powers cooperated to tackle the problems of population decline, while still competing for leadership in the Pacific. The American and French presence in the scheme allowed the CMS to be inter-imperial by extending the scope to reach beyond the British Empire. The strategic importance of the Native Medical Practitioners system and the Central Medical School can be affirmed by noting the fact that the medical schools in other small-island colonies of the British Empire – in the Caribbean and the Indian Ocean – were only founded after the Second World War. The CMS started as an

experiment, but bolstered by foundation support, it later developed into a more extensive medical cooperation in the South Pacific.

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[1] David Hoodless, *Central Medical School, Suva, Fiji* (Suva, 1947). p. 3.

[2] Medical Care of South Sea Natives, Rockefeller Foundation Archives (RF) RG1.1 S419 FA386b B1 F5, Rockefeller Archive Center (RAC).

[3] From C. H. Rodwell to Lambert, 29 September 1923, RF RG1.1 S419 FA386b B1 F5, RAC.

[4] Annie Stuart, *Parasites Lost? The Rockefeller Foundation and the expansion of health services in the colonial South Pacific, 1916-1939*, PhD Thesis, University of Canterbury (2002) pp. 30-48

[5] Fiji Medical School for Medical Students, 3 April 1924, RF RG1.1 S419 FA386b B1 F6, RAC

[6] Fiji Medical School for Medical Students, 3 April 1924, RF RG1.1 S419 FA386b B1 F6, RAC.

[7] Enclosure No.1 of *Council Paper No.56 Central Medical School, 1926*. WPHC4/IV.1926. 3569/1926. Western Pacific Archives, University of Auckland (WPA).

[8] From George S. Richardson, the administrator of Western Samoa to Dr. Victor G. Heiser, 3 September 1924, RF RG1.1 S419 FA386b B1 F6, RAC.

[9] Victor Heiser, 11 November 1924, RF RG1.1 S419 FA386b B1 F6, RAC.

[10] 1st Annual Report, Western Pacific Health Service 1928. RF RG5 S3 FA115 B161 F1977, RAC.

[11] From the Premier to the British Agent and Consul, 7 February 1925, RF RG1.1 S419 FA386b B1 F6, RAC.

[12] Enclosure No.2 of *Council Paper No.11 Central Medical School, 1927*. WPHC4/IV.1926. 3569/1926. WPA.

[13] Minutes of the International Health Board, 4 November 1926, RF RG1.1 S49 FA386b B1 F5, RAC.

[14] Stuart, *Parasites Lost*, pp. 223-253.

[15] From Lambert to International Health Board, 20 July 1924, RF RG1.1 S419 FA386b B1 F6, RAC.

[16] From Lambert to Heiser, 31 August 1927, RF RG1.1 S419 FA386b B1 F7, RAC.

[17] 1st Annual Report, Western Pacific Health Service 1928, RF RG5 S3 FA115 B161 F1977, RAC.

[18] Minutes of the Rockefeller Foundation, 1–2 November 1935, RF RG1.1 S419 FA386b B1 F5, RAC.

[19] From Acting Chief Medical Officer to Lambert, 28 November 1934, RF RG1.1 S419 FA386b B1 F10, RAC.

[20] 1st Annual Report, Western Pacific Health Service 1928, RF RG5 S3 FA115 B161 F1977, RAC.

[21] Central Medical School, Suva, Fiji. Annual Report for 1931. RF RG5 S3 FA115 B162 F1983, RAC.

[22] Personal Note from Lambert to Mr. Berendson, 18 January 1934, IT1 150 EX8/24 Part 1, Archives New Zealand.