



Family Medicine In Hawaii

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Introduction

The medical specialty of Family Medicine has evolved in Hawaii in response to the changing health care demands and changing public health concerns in the state. During the last 30 years, significant changes have occurred in Hawaii's population structure, demography, morbidity/mortality patterns, and health economics which have generated a new set of health care concerns. Hawaii requires a contemporary paradigm of health care delivery to keep pace with the emergence of different illness and disease patterns, and the increasing demand of individuals for an integrated approach to one's health care. The discipline of Family Medicine is uniquely positioned to work with the present health care delivery system to develop, and transition into, an appropriate paradigm for health care delivery in Hawaii.

Hawaii has traditionally been a medical specialist oriented state. Most people in the state, including physicians, do not understand what family medicine is and what the family practitioner does. A brief history of the development of family medicine would be helpful. Physicians were all generalists at the advent of the modern era of medicine. As technology and medical procedures evolved, specialties such as surgery, obstetrics, and radiology came into being. As a greater understanding of the human life cycle developed, medical expertise was divided by age groups (pediatrics, internal medicine, geriatrics). Subsequently expertise in specific body systems evolved and specialties such as cardiology, hematology, neurology, psychiatry came into existence.

Family medicine grew out of a realization that effective medical care should be carried out through integrating not only the vast knowledge required for medical diagnosis and therapeutics but also life cycles, body system and technology. The human body, mind, and environment operate in an interdependent fashion and an artificial separation into areas of medical expertise did not serve patients and families well. Hence, the generalist was reborn, however, as a more highly trained practitioner of medicine called a Family Medicine physician or family practitioner.⁶

The delivery of health care in the Family Medicine environment is performed utilizing the science of medicine (biomedical model) in context of the family, social, and cultural background of the patient (biopsychosocial model). This delivery is provided in a longitudinal fashion in the patient's environment, with consultation of home and community environments. Family physicians are trained in this new paradigm of health care delivery which acknowledges that the predominant determinants of the individual's health care are not only biological or psychological, they are familial, cultural, environmental, and social.⁶

Hawaii has several unique demographic and cultural aspects which makes health care delivery challenging and difficult. Access to adequate health care by the indigent and those living in the rural areas of Hawaii remains problematic. The health care system is often not

sensitive or cognizant of the specific health care needs of various cultural groups residing in Hawaii. The Kanaka Maoli (Native Hawaiians), Samoans, Vietnamese, Filipinos, Micronesian communities are growing and all have disproportionate burdens of illness.

The Kanaka Maoli (Native Hawaiians) have significantly higher rates of diabetes and breast cancer than the other ethnic groups in Hawaii. Their longevity is shorter, poverty levels are higher, and morbidity patterns are significantly worse even if socio-economic status is taken into account.^{1,7} In our neighboring U.S. associated Pacific Countries (Republic of the Marshall Islands (RMI) the Federated States of Micronesia, American Samoa, and the Republic of Belau), the health status of the people is dire. In RMI, for example, the infant mortality rate is 7 times that the U.S. and the adult longevity is 18 years less than that of the average American living in the United States. There is a significant dependence by these Pacific jurisdictions on Hawaii's health care system.^{2,3,8}

Examination of Hawaii's social and public health indicators reveal that: tuberculosis rates are 2 1/2 times that of the United States, Hawaii has the 8th highest infant mortality in the U.S., 3rd highest rate of teen deaths by accidents, 3rd highest high school drop out rate, 11th highest rate for children in poverty, the highest rate of single parent families. Hawaii's has an aging population which is 2 1/2 times that of the U.S. Interestingly, there are only 9 states in the U.S. which have fewer family physicians per 100,000 population than Hawaii.^{4,5}

In response to the health care needs of the state, the John A. Burns School of Medicine (JABSOM) developed a Department of Family Medicine and Community Health. Additionally, Wahiwa General Hospital (WGH) developed a Family Medicine Residency Program (FMRP) in association with JABSOM. The mission of JABSOM and the WGH FMRP is to train physicians to provide onsite care for the peoples of rural Hawaii and the Pacific.

Before the FMRP began, only 1-2 of 55 JABSOM graduates would enter family medicine training programs. Presently 14-17 or 25% of the JABSOM graduating class enter FP residency training programs. Hawaii's FMRP actively selects and train physicians who are Kanaka Maoli, Micronesians, Samoans, Filipino, Vietnamese, and those with known interests in serving the Kanaka Maoli and disenfranchised populations of Hawaii. The program is new, graduating 16 family practitioners to date. Thirteen of the 16 have settled in rural areas of Hawaii, practice on the neighbor islands of Hawaii, or have been retained as junior faculty. Two graduates, are Kanaka Maoli and work with the native Hawaiian Health Systems on Moloka'i and Maui. There are 3 residents of Kanaka Maoli descent in the present residency class—one of whom is committed to practicing on Molokai and another who will practice in Waianae. One graduate was of Chamoro descent, and one resident is the second U.S. trained Marshallese physician, who will be returning to practice in the RMI.

The FMRP infrastructure was designed to carry its mission. The faculty are familiar with Kanaka Maoli health issues, psychosocial medicine, rural medicine, the Pacific Basin, and working with disenfranchised people. Two of seven faculty members were born and raised in Wahiwa/Mililani, two are from Hawaii ethnic minority groups, one faculty member lived in Saipan for four years and subsequently worked at Kookia Kalihi Valley for three years, another was the medical director of preventive services and public health in the RMI for 9 years, and yet another worked for 7 years in a medically under served people in a community health center environment prior to becoming faculty. There is a full-time staff behaviorist to develop behavioral/psychosocial curricula. A faculty member has written a book on cross-cultural health care in Hawaii. The faculty have consulted with Kanaka Maoli health issues, including working with Papa Ola Lokahi, health care projects on

Moloka'i, and examining the impact of the paucity of Kanaka Maoli physicians in Hawaii.

In order to emphasize rural health care, the FPRP is based at WGH, a community based/rural institution. Additionally, the residency has program teaching sites at Hilo, Waimanalo, Hana, and the North Shore of Oahu. Recently the FPRP developed and staffs a continuity clinic in the RMI to care for its radiation affected people through a five year contract with the U.S. Department of Energy. The FRP residents have also completed training electives in Republic of Belau, American Samoa, Fiji, and Kiribati.

The family practitioner learns the rigorous methods of the science of medicine (biomedical model) as well as the delivery of care to the patients' psychological, sociological, familial, and cultural environments (biopsychosocial model). It is the only specialty that has effectively integrated a biopsychosocial model of health care delivery with the biomedical model.

Biomedical training includes learning about treating health care needs during all parts of the life cycle, and in an integrated fashion with all body systems. The FMRP also develops a physician's ability to assess the impact of his or her practice of medicine on the community served. This is done through instituting curricula to perform Community Oriented Primary Care Research (COPC). The training methods of the FMRP are unique and develop physicians who are able to meet the health care dilemmas of Hawaii and the Pacific.

Conclusion

Health care delivery strategies by physicians in Hawaii need change to positively affect health care outcomes. The utilization of a biopsychosocial model by practitioners of health should be an integral part of physician training. Training new physicians to deal with Kanaka Maoli health issues, caring for disenfranchised populations and rural populations is a priority. Family Medicine and the Family Medicine Residency are key elements to making this change.

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