Approaches to the Training Of Foreign Medical Graduates

Alvin M. Gelb, M.D., and Eric Cassell, M.D.

The French and Polyclinic Health Center consists of a 576-bed hospital located in two pavilions in the heart of New York City. The house staff is composed primarily of foreign medical graduates (FMG's), as is the case with other nonuniversity community hospitals. Faced with many unsatisfactory teaching procedures and problems with patient care (not unique to this health center) which were in part traceable to poor interaction among house staff, attending physicians, and other hospital personnel, those responsible for graduate education came to realize that a great number of the traditional approaches used for the internship and residency training of the American medical graduate are inadequate. Part of the problem was that in the past it was the tacit assumption of many people that the problem of the FMG was temporary; in addition, like most physicians, members of the attending staff had had little or no training in educational methods and tended to use the techniques by which they were taught. It is the purpose of this paper to present the authors' current view of the problem of training the FMG as well as some of the changes in approach that this precipitated.

Dr. Gelb is director, Department of Medicine, French and Polyclinic Medical School and Health Center, New York City.

Dr. Cassell is an attending and section chief, French Pavilion, Department of Medicine, French and Polyclinic Medical School and Health Center.

Classically, the American-trained student begins his internship not only with a sound basic medical knowledge but also with substantial clinical experience. Thus, immediately he can assume responsibility for arriving at diagnostic conclusions and start courses of therapy. This is not the case with the FMG, who has been trained in a more didactic fashion and has had much less exposure to clinical situations.

Equally important, though unrecognized by either new house staff members or their superiors, the American intern understands the ethics and the social structure of the American hospital. He quickly learns from his peers and teachers what is expected of him with respect to knowledge and to his role as a member of a team with a history of pride in and loyalty to the institution. He is respected unless his skills are found to be inadequate by the attending staff members, many of whom, remembering their own days as house officers, adopt a fatherly, protective attitude toward him. He speaks English; but, even more important, he understands the nonverbal communication of the hospital's professional personnel. For all of these reasons, the anxieties of the new intern or resident generally abate with the passing weeks, and it is likely that he soon will be totally integrated into the system.

Under the best of circumstances, the

FMG is at a disadvantage. His English is usually poor, and so he has to strain to understand. He knows little of the social structure into which he is entering. He does not know his role, and he often has much less medical knowledge than his American counterpart. Experience in differential diagnosis and basic procedures is either nonexistent or severely limited. The attending physicians do not identify with him, and their respect is often withheld until he proves himself. If the training program is well structured and he is only one of a few foreign physicians, he imitates his peers, avoids being conspicuous, and becomes an accepted member of the group. Otherwise, he may be overwhelmed by the unfamiliar role, the large work load, the fatigue, and his own increasingly apparent inadequacies (1–3).

In addition, the FMG is often away from his country and family for the first time. He must cope with such basic living problems as shopping in a supermarket and using credit cards; these and other experiences that we take for granted may be new and frightening to him. Another aspect of the problem is that whereas in his own country he might have represented the apex of the social structure, in the American hospital he is often treated with condescension by both nonmedical and medical personnel (1–3).

Because of these factors, the new FMG house staff member frequently becomes passive and withdrawn. His initial anxiety often turns into depression. The attending physicians, accustomed to the aggressive give and take of American teaching, become subtly disrespectful of the abilities and judgement of the FMG or are especially hard on him and concentrate primarily on patient care rather than on teaching; even in this area, and particularly on the private service, they often ignore the FMG or assign him to some menial task. As a result, patient care becomes increasingly poor as the intern or resident begins simply to give in. This leads to the attending physicians' becoming frustrated and the house staff member's learning only a few catch phrases and a few routine treatments and procedures which barely allow him to survive professionally (1–3).

These problems have not received adequate attention by researchers; in fact there have been no revealing studies on the processes involved in the house staff training of American physicians. There is, thus, little knowledge of how the beliefs and value structures of individuals entering this phase of their training are modified by their educational experiences. The approach to training to be described deals with this aspect as well as with the manifest content of the educational endeavor.

Initial Orientation

In previous years, the initial orientation of the French and Polyclinic Health Center house staff members consisted of lengthy introductions of key personnel and detailed presentation of the rules, regulations, and procedures relating to matters as disparate as the laundry and the death of a patient. This was done even though it was obvious that the newly arrived house staff officer understood little, retained less, and started off overwhelmed by the situation he had entered.

At least one function of such orientations seems to be to impress upon the house staff member that he is but a small part of an important hospital with a long tradition. To the FMG all too often it signifies that he is too much of an outsider ever to be accepted as a member of the institution.

During the past two years, the orientation has been redesigned to alleviate this

problem and in subtle and general terms to prepare the new interns and residents for prospective difficulties. In a receptive and warm atmosphere, accompanied by a minimum of rules, problems that may arise with the attending staff, the nonmedical aspects of the hospital, and the training situation are discussed and routes of communication are made clear.

Included in the initial orientation is a frank discussion with a member of the psychiatric staff. He reviews the problems of the initial anxiety that the house staff member will (or is) experiencing and warns of the period of depression that may follow. The phenomenon of cultural shock often experienced by FMG's is discussed.

The results of the change in orientation procedure are difficult to assess. There appears to be, however, a distinct improvement in the integration of the staff into the hospital activities and fewer problems of adjustment.

Teaching Fellows

A partial solution to the previously discussed problems in the relationship between an attending staff and an FMG staff which prevailed at the health center was discovered accidentally. At one of the center's pavilions, which had lost its American Medical Association approved residency program, the medical service was staffed not by house staff but by physicians who had completed their residency or fellowship training at other institutions. These individuals were themselves graduates of foreign schools and had been exposed to the American hospital system for so many years that their adjustment was already made. Their capabilities were sufficient enough that the attending staff developed confidence in their abilities and judgment. A year ago, after the French Hospital merged with the New York Polyclinic Hospital to form one hospital in two pavilions, residents were rotated through the French pavilion under the supervision of these physicians. It was soon apparent that each FMG intern and resident was relating to his supervisers far better than he had related to the attending staff. The former had backgrounds similar to his and understood and were sympathetic to his problems in a way that the attending staff could not be. As a result the house staff members brought their problems, both medical and personal, to these men; and those on the attending staff, having confidence in the supervisers, were more successful in their attempts to teach. By chance the large gap between the attending and the house staff had been bridged by the interposition of a "junior attending," or teaching fellow, as he is called.

This accidental solution has been so successful that it will be extended to the other division of the hospital. The teaching fellow will supervise the details of patient care on the services so that the attending physicians may be free to teach at a higher level. Hopefully, this will stimulate the attending staff to do more creative and intellectually valuable teaching.

Section Chiefs

In the one pavilion, the teaching service is divided into four sections, each under the supervision of a section chief, whose task is the traditional one of supervising patient care. His time is devoted primarily to the problems of the patients. In the second pavilion, there were no section chiefs appointed prior to the time of the reorganization of the health center. Each attending physician was assigned for a fixed period and functioned independently. There was more cohesion in the first pavilion, but there still were problems

there in the relationship of the attending physicians to the house staff.

After the reorganization, sections were formed and section chiefs were appointed in the second pavilion; their mission was to improve communications between the attending and house staffs and foster the integration of medical functions within the pavilion. The initial approach was improvised. The first section chief began by holding weekly luncheons with the house staff in which medical problems were discussed. More importantly, and sometimes covertly, social and cultural problems were brought into the open. He identified house staff members who seemed to be having trouble and helped them individually as necessary. He utilized the teaching fellow as a bridge to the house staff. It was found that the luncheon aspect was important and contributed greatly to the relaxed atmosphere necessary for the house staff to bring forth bothersome material. Because these open-ended luncheon meetings were so well received, they have been continued and have been extended to the other pavilion on a biweekly basis.

From the time of his appointment to the present, the section chief has met periodically with the attending staff members. He listens to their problems and relates to them information he has gleaned from his meetings with the house staff. In turn, he conveys to the house staff the problems and complaints of the attending physicians.

Dissatisfactions which can not be resolved directly by the section chief are brought to the attention of the director of the department for action wherever possible. It is felt that it is important to demonstrate to both the attending physicians and house staff members that an attempt is being made to solve their problems and improve the condition of the service.

It is the authors' feeling that the section chief has contributed greatly to the cohesion and morale of the service. It is intended to extend these new functions of the section chief to the other pavilion.

Educational Program

Realizing the lack of experience of the FMG house staff members in diagnosis and treatment and their relative inability to correlate their knowledge with the problem at hand, it was decided to try several educational techniques.

The traditional case method presentation during rounds was modified. The attending physicians were urged to communicate their thought processes and attempts at differential diagnosis as the history and physical findings were being presented. As the patient's story unfolded, the house staff members were asked to participate by making their own differential diagnosis. In keeping records emphasis was placed on the "problem method" of writing the history and physical findings and making progress notes (4) in the hope that the intellectual processes involved would become habitual. The active participation of the house staff members also was encouraged during rounds, at which time stress was placed on reinforcement by the repetition of essential material. As a result of these innovations, there has been a distinct improvement in the clinical abilities of the house staff.

Conferences

In the past, the major conferences were a problem because it was not clear to either the speakers or the audience whether they were aimed at the house staff or at the attending staff. They were enjoyed by neither group. The conference often took the form of a lecture, and the audience was sparse and inattentive. It was decided

that in order to regain the interest of the attending staff members the conference should be geared to their level. Even if the house staff members did not comprehend completely the subject discussed, it was hoped that they would be stimulated to either read or ask questions. These same topics were presented again at the resident conferences.

The format of the conference was scrutinized since there is question concerning the degree of retention of material presented in lecture settings. It was decided to make the attending conferences informal. Each week a subject was designated and a moderator assigned. Chairs were placed in a circle and coffee was served. After the case presentation the moderator initiated the discussion. The audience was encouraged to interrupt frequently with questions and comments. Tangents to the main stream of the conference were encouraged and developed. Active participation by the audience was also encouraged. The department director and section chief kept the conferences sufficiently under control to prevent them from bogging down or straying too far from the theme. There was no attempt to cover every aspect of a subject. Rather, the essential information was stressed in order to facilitate retention. For the same purpose the subjects under discussion were related to situations actually encountered by members of the audience. Using these techniques, the conferences became more lively and interesting, and the attendance improved.

Social Contact

The FMG is able to distinguish between those attending physicians who have genuine esteem for him and those who are superficially polite; and, of course, the former response is a crucial factor in helping him to develop pride in his department and in the hospital and in facilitating his professional growth. Such a relationship is fostered by encouraging social contacts between house and attending staffs at luncheons, informal parties, and more formal gatherings sponsored by the hospital. It is intended that the attending staff become well enough acquainted with the FMG's in order to realize that they are intelligent, cultured, and well-meaning persons with great hopes and aspirations (3).

Conclusion

The approaches to maximizing the value of the educational and social experiences of the FMG that have been discussed have yielded gratifying results. Patient care is of an increasingly higher quality. Attending physicians have been stimulated by the improvement in the teaching setting and in their relationships with the house staff. The house staff members in turn are happier, and their professional performance has been greatly enhanced. These achievements are self-perpetuating since the esteem and approval of the attending staff are rewards that serve to reinforce the learning of the FMG and spur him on to even greater efforts. Thus, the innovations, introduced tentatively and experimentally, appear to be working and the theories upon which they are based seem sound.

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