

Approaches to the Training Of Foreign Medical Graduates

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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 non-university 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.

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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 non-medical 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

