

Improving Transnational Health-care Encounters and Outcomes: The Challenge of Enhanced Transnational Competence for Migrants and Health Professionals

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Backdrop to 21st-Century Medical Encounters

The planet's most likely political and population scenarios for the 21st Century forecast continued increases in people, transnational interactions, dislocations, and cross-border movement. For people in spatial transition, the person-to-person medical encounter remains the crucial health-promotion opportunity. The transnational medical encounter constitutes the principal subject for this discussion.

In our era of unprecedented human mobility, most migrant patients are cared for by health professionals who possess different national, ethnic, and (sub)cultural backgrounds. Even though non-mainstream patients already keep certain hospital units open in Europe, the unique context and health-care challenges of refugees and other migrants remain to be addressed effectively in Northern countries (Weinstein, et al., 2000).

The discussion begins by identifying three building blocks for migrant health care and health promotion:

- patient voice – an irreplaceable and frequently untapped source of expertise (Gerrish, et al., 1996, p. 36)
- effective therapeutic alliances – based on skillful participation in medical encounters by migrants as well as by physicians and nurses
- transnational competence (TC) – which facilitates the establishment of and participation in effective patient/provider alliances

The Transnational-competence (TC) Framework

Transnational competence encompasses five skill domains – analytic, emotional, creative/innovative, communicative, and functional. The generic TC framework, along with its interdisciplinary roots, is elaborated in Koehn and Rosenau (2002). Potentially, the framework can be applied to a multiplicity of focused transnational interactions. Table 1 outlines one adaptation of the generic model to direct health-care interactions (also see Koehn, 2004).

Transnational Medical Encounters in Finland

In summer 2002, as part of a Fulbright New Century Scholar project that explored transnational competence in medical encounters, I conducted 235 interviews with 93 adult patients (41 political-asylum applicants (ASY) and 52 resident foreign nationals (RFN) along with their principal attending clinician(s) (71 physicians and 71 nurses). These interviews

included confidential intersubjective assessments used in constructing an overall index of each encounter participant's TC (for details, see Koehn, forthcoming).

TC Comparisons

In the Finland study, most patients (both RFN & ASY) were treated by physicians *not* judged to possess high overall TC. A larger percentage of attending nurses (45 per cent) and patients (44 per cent) were judged to be highly competent overall in comparison with attending physicians (19 per cent).

Selected Outcomes

Study findings confirmed that the structural context of medical attention makes a difference. ASY proved much more likely to be dissatisfied with the care they received at reception centres than RFN did with municipal-health-centre care (Koehn, forthcoming). Another outcome finding is that most physicians did not recognize the role that in-Finland experience plays in migrant depression. However, high-TC nurses did. We also found that high patient TC facilitated clinician understanding of the value that asylum seekers place on ethnocultural approaches to health care. Nevertheless, less than 1 in 4 physicians (23 per cent) accurately assessed the extent to which their patients actually engaged in ethnocultural health-care practices in Finland. Most of the accurate doctors were high TC. In addition, high physician TC was related to patient satisfaction with health care. While 85 per cent of the patients attended to by high-TC doctors were satisfied or very satisfied, only 45 per cent of those consulting with less-TC doctors reported that they were (very) satisfied with the results of their principal attending physician's care.

Implications and Suggestions for Medical-encounter Training

Given the diverse and unfamiliar patient experiences, cultural orientations, and socioeconomic backgrounds encountered by health-care providers practicing in the 21st Century, effective TC training is likely to be valuable in the education of physicians and nurses. In ethnoculturally discordant encounters, one can expect the most fruitful medical interactions and the most positive health outcomes to result when the entire team (including the patient) possesses high TC.

In order to build successful therapeutic alliances across ethnocultural divides, therefore, patient TC learning is as essential as student-doctor learning. A number of studies have shown that patient training results in enhanced doctor/patient interactions and a variety of improvements in health-care outcomes (for instance, Ferguson & Candib, 2002; Post, 2002, p. 350). Most migrant patients want to avoid being incompetent or helpless in transnational medical encounters.

In plenary, the author presented illustrative suggestions for clinician and migrant-patient training based, in part, on study findings regarding skill deficits in the five TC domains. These suggestions are summarized in Table 2.

The presentation also addressed internal and external structural provisions that enable trained encounter participants to promote positive health outcomes. Internally (e.g., within a hospital or health centre), it is important to provide *transition* services and programs that enhance patient

self-reliance. While a patient is transitioning to self-reliance, valuable services include the provision of trained medical interpreters and cultural mediators, transportation assistance, additional time with attending physicians, and family counseling and consultation. Concomitantly, efforts should be made to prepare patients for direct and self-reliant interactions with ethnoculturally different doctors, nurses, receptionists, interpreters, accountants, and other staff through focused educational programs (e.g., TC training), first-language videotapes and written guides, and mentors who facilitate TC learning. Complementary efforts to promote TC and commitment to a more equitable patient/service provider power balance among all hospital personnel through staff professional-development training, diversity-hiring practices, incentives and rewards, quality-assurance measures, and outcome assessments by individual patients and ethnic communities should not be ignored.

Resources and support that empower patients to address the external challenges they face in the host society also are essential for positive health outcomes. Such support might include facilitating access to traditional healers, medicine, and nutrition; facilitating access to lay (community) health workers; assisting with the development of host-country language proficiency; promoting further education and credential (re-)certification; facilitating employment; promoting the maintenance children's healthy practices; encouraging legal/policy coalition building and advocacy with host-society institutions and transnational NGOs; and acting as the patient's advocate with government agencies and community associations.

Conclusions

The opportunity to realize one's full physical and mental-health potential is at once a human right and a global public good. The security, prosperity, and fulfillment of all members of today's global community are impacted by the health status of our least-healthy members.

Effective interpersonal interactions in medical encounters are essential for launching "a virtuous cycle of health governance" (Kickbusch, 2003). Transnational competence training for *all* participants in ethnoculturally discordant medical encounters promises to advance health-care alliances and to enhance global/local health in an era of human mobility.

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Table 1

Selected Health-care-related Skills: By TC Domain

<p style="text-align: center;">Analytic</p> <p>Ability to understand:</p> <ul style="list-style-type: none"> ➤ conditions that led the patient to leave country of origin ➤ health-care conditions the patient faces in host society ➤ the influence of transnational identity & ties and conditions in the sending country that continue to affect the patient’s mental health & well-being ➤ the other’s personal beliefs regarding the causes, treatment, & prevention of illness ➤ effects of migration & post-migration experiences on the patient’s current & prospective physical/mental health status & needs <p style="text-align: center;">Emotional</p> <p>Ability to:</p> <ul style="list-style-type: none"> ➤ empathize with & validate the other’s health-care beliefs & practices (biomedical, alternative, ethnocultural, & lay expert) ➤ value & reinforce resilience ➤ maintain personal interest in & concern about the other ➤ demonstrate openness to meriting acceptance in the other’s culture <p style="text-align: center;">Creative/imaginative</p> <p>Ability to:</p> <ul style="list-style-type: none"> ➤ contribute/encourage specific problem-solving ideas ➤ articulate complementary combinations of biomedical & ethnocultural approaches ➤ recommend health-care practices & structural strategies suitable for local conditions 	<p style="text-align: center;">Communicative</p> <p>Ability to:</p> <ul style="list-style-type: none"> ➤ use other’s first language or mutually understood third language ➤ use interpreters effectively when necessary ➤ demonstrate culturally appropriate nonverbal behavior ➤ express (encourage expression of) health-care questions & worries ➤ express (encourage expression of) health-care doubts & disagreements <p style="text-align: center;">Functional</p> <p>Ability to:</p> <ul style="list-style-type: none"> ➤ demonstrate genuine caring for the other’s personal situation ➤ avoid treating the other in an upsetting manner ➤ relate in a way that builds the other’s trust ➤ take into consideration the influence of family/community on patient’s health/illness ➤ give/request alternatives & choices before decisions reached ➤ activate host-society & migrant-community resources likely to enhance patient’s health by addressing social-context inequities and power differentials
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Table 2

Suggested TC Training Foci (By Skill Domain) for Ethnoculturally Discordant Medical Encounters: Clinicians and Patients

Clinician Training Objectives	Patient Training Objectives
<p><u>Analytic</u></p> <ul style="list-style-type: none"> • <i>Discern</i> effects of pre- & post-migration experiences, and distant & proximate health-shaping inequities, on patient’s physical/mental health status • <i>Recognize</i> variations in: <ul style="list-style-type: none"> - socioeconomic backgrounds (Kagawa-Singer and Kassim-Lakha, 2003, p. 579) - health-care skills (Betancourt, 2003, p. 560) - health beliefs/behaviors • <i>Identify</i> patient’s capabilities & resources amidst vulnerabilities & power deficits 	<p><u>Analytic</u></p> <ul style="list-style-type: none"> • <i>Familiarity</i> with host-society health-care system, processes, & rules • <i>Familiarity</i> with basic biomedical principles • <i>Discern</i> connections among pre- & post-migration experiences • <i>Recognize & appreciate</i> provider skills
<p><u>Emotional</u></p> <ul style="list-style-type: none"> • <i>Empathize</i> with ethnoculturally discordant patient’s expectations, vulnerability, & resilience • <i>Respect</i> different beliefs/practices (lay expertise) (Popay & Williams, 1996; Stacey, 1994) 	<p><u>Emotional</u></p> <ul style="list-style-type: none"> • <i>Openness</i> to learning from biomedical info/approaches • <i>Show concern/ compassion</i> for care provider’s <ul style="list-style-type: none"> - family - workload -treatment challenges (Fadiman, 1997, pp. 213, 252)
<p><u>Creative/Innovative</u></p> <ul style="list-style-type: none"> • <i>Articulate</i> a complementary biomedical, ethnocultural, personal, & structural health-care plan • <i>Participate in formulating</i> health-care recommendations that address contextual constraints 	<p><u>Creative/Innovative</u></p> <ul style="list-style-type: none"> • <i>Encourage exploration</i> of complementary care possibilities: biomedical, home remedies/self-management, traditional healers, occasional return to sending country (see Ma, 1999, pp. 429-430) • <i>Participate in formulating</i> health-care recommendations that address contextual constraints
<p><u>Communicative</u></p> <ul style="list-style-type: none"> • <i>Encourage</i> patients to <i>express</i> health-related experiences, questions, concerns, doubts • <i>Take</i> patient expressions/ideas <i>seriously</i> • <i>Convey</i> health-care <i>recommendations effectively</i> across language & cultural divides 	<p><u>Communicative</u></p> <ul style="list-style-type: none"> • <i>Provider-language instruction</i> • <i>Lessons in choice/use of interpreters</i> • <i>Information-seeking strategies</i> (Perry, 2001, pp. 48-52)
<p><u>Functional</u></p> <ul style="list-style-type: none"> • <i>Build trust</i> (e.g., by applying insights from other TC domains to recommended approaches) • <i>Take into account</i> influence of family – including younger generation – and community members • <i>Relinquish power</i> by discussing and allowing choice regarding individually tailored options • <i>Advocacy</i> skills: propose & secure institutional & community support for enabling approaches that address effects of social context, power, & policy on migrant health (Smedley, et al., 2003, p. 185; Waitzkin, 1991, p. 5) 	<p><u>Functional</u></p> <ul style="list-style-type: none"> • <i>Ways to show that one cares</i> about personal situation of doctor/nurse • <i>Personal/family participation in health-care decisions</i> – becoming more assertive about requesting choices before decisions are made • <i>Suggest desired changes</i> in treatment plan – especially ways to make it easier to carry out (Perry, 2001, p. 51) • <i>Active</i> involvement in health-care <i>self-management</i> (mainstay of therapy for many chronic diseases) • Skills in effective <i>negotiation with representatives</i> of receiving society institutions • <i>Ways to protect & reinforce</i> positive pre-arrival health practices (Barnes, 2004) and guard against chronic host-country diseases (Palinkas, et al., 2003, p. 20)