

**PREPARING TRANSNATIONALLY COMPETENT PHYSICIANS FOR
MIGRANT-FRIENDLY HEALTH CARE:
NEW DIRECTIONS IN U.S. MEDICAL EDUCATION**

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Introduction

In the 21st century, challenges to global health include an ever-changing mix of patients, providers, and medical narratives. Some 500 million people cross national borders annually and about 5 per cent of the individuals alive today reside outside their country of birth. Migrants differ from other patients because they rarely share the same personal experiences or social status.

In the past 10-20 years, physicians have been increasingly called upon to care for patients whose national, cultural, ethnic, class and experiential backgrounds are much different from their own. Many schools of medicine, both in the United States and in Europe, have implemented educational programs to ensure the “cultural competence” of their students and graduates. Curricula in cultural competence often focus on a single “other” culture, may rely on lists of specific characteristics or attitudes that are thought to characterize that culture (Shapiro and Lenahan, 1996; Wear, 2003), and underemphasize the structural foundations of constraining inequities (Green, Betancourt, and Carillo, 2002). Most such educational offerings have failed to prepare physicians adequately for practice in a multicultural, transnational healthcare environment, thus complicating efforts to improve health outcomes and reduce health inequities for migrant, dislocated, and otherwise disadvantaged populations.

To prepare physicians to care effectively for migrant populations, medical education must move beyond preparation for particular cultural and racial contexts, or “cultural competence.” Physicians must acquire a broad range of skills and perspectives that will

enable them to interact effectively and in a humanistic manner with patients from multiple and changing societies.

Transnational Competence

Transnational competence (TC) comprises a specific set of interpersonal skills derived from research findings in international relations, development studies, international business negotiations, cross-cultural psychology, and intercultural communication (Koehn and Rosenau, 2002; Koehn, 2004). In contrast to the “cultural competence” model, the TC model provides the skills that enable individuals to work effectively with others from multiple diverse cultures and nationalities without relying on commonly assumed (and often stereotypical) characteristics. The five domains of TC promise to offer a more comprehensive and useful framework than cultural competence for understanding and caring for patients from many diverse societies, cultures (and subcultures) (Tables 1 and 2). This project is the first effort to apply TC-domain skills in medical education.

Workshop

In early July 2004, an intensive five-day invitational workshop brought together teams of experienced medical educators from four U.S. medical schools to explore TC as a new conceptual model by which physicians could learn how better to care for patients from diverse and distinct cultural backgrounds. The participating medical schools were Mayo Medical School, Northeastern Ohio University College of Medicine, the University of Massachusetts, and the University of Texas – San Antonio. Faculty were drawn from the disciplines of anthropology, medicine, and political science at The University of Montana, Northwestern University, and the University of New Mexico.

The workshop included both plenary sessions and small group discussions. Plenary presentations were designed to convey the conceptual framework and various skill domains of TC, as well as to provide examples of how those domains could be implemented in medical practice. Much of the work of the workshop was carried out in a small-group format, which allowed the participants and faculty to focus on the issues in some depth. The composition of the small groups varied over the course of the workshop, in order to allow participants from different schools to share ideas about what the schools are now doing and “brainstorming” ideas for the new curriculum. The interactive nature of the workshop, in both plenary sessions and small groups, ensured a rich context for learning. The workshop clarified the educational issues involved, distinguished TC from cultural competence, elaborated the advantages of TC as a conceptual framework in undergraduate medical education, and led to the development of a model curriculum in TC.

Model Curriculum

One principal goal of the workshop was to develop a curriculum using the TC model (Table 3). The common features of the pilot curriculum agreed upon by the four schools include the following:

- Implementation of the pilot in 2005 in a major clinical clerkship: internal medicine, pediatrics, family medicine, and/or psychiatry;
- Introductory didactic components that address the conceptual framework of TC and the importance of culturally sensitive and appropriate care to help promote access and social justice in health care. Resources from the humanities (e.g., art and literature) will be utilized to convey concepts of humanism that are inherently important to patient care;

- A “mini-ethnography” exercise that will require students to work closely with patients, and often family members, from distinct and diverse cultural, ethnic, generational, and socioeconomic backgrounds. This learning experience will include observations in social context, opportunities for the patient to comment upon the student’s initial findings, and facilitated discussions with faculty in small-group settings of the students’ findings as well as possible hidden social and cultural forces;
- Group sharing of insights gained through the mini-ethnographies and of students’ social-context recommendations, with discussions centered on three or more patients of diverse backgrounds in a reflective seminar context;
- Integration of experiential or service learning into the curriculum. This will include feedback to the students about documented results that arise from their ethnographic work with patients;
- An opportunity for “reflective writing” that will encourage students to integrate what they have learned into a contextual framework for dealing with individual patients from diverse cultures;
- Rigorous evaluation, both of the students’ learning and of the pilot curriculum experience.

Conclusions

Transnational competence offers a promising approach for teaching medical students about how to care for patients with multiple and diverse backgrounds, health conditions, and health-care beliefs and practices. Further work is underway to create a longitudinal vertically integrated curriculum that spans all years of undergraduate medical education; create instruments to assess

student learning and evaluate program effectiveness; and expand the TC model into additional medical schools.

References

Green AR, Betancourt JR, Carillo JE: Integrating social factors into cross-cultural medical education. *Acad Med* 2002; 77:193-197.

Koehn PH: Global politics and multinational health-care encounters: assessing the role of transnational competence. *EcoHealth* 2004; 1:69-85.

Koehn PH, Rosenau JN: Transnational competence in an emergent epoch. *Internat Studies Perspec* 2002; 3:105-127.

Shapiro J, Lenahan P: Family medicine in a culturally diverse world: a solution-oriented approach to common cross-cultural problems in medical encounters." *Fam Med* 1996; 28:249-255.

Wear D: Insurgent multiculturalism: rethinking how and why we teach culture in medical education. *Acad Med* 2003; 78:549-554.

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Table 1

Domains of Transnational Competence in Medical Settings

<u>Domain</u>	<u>Principal Physician Skills</u>
Analytic	discern effects of migration and post-migration experiences on patient's physical and mental health status
Emotional	empathize with ethnoculturally discordant patients, and respect patient's beliefs and practices
Creative	articulate a biomedical, ethnocultural, and personal health-care plan that is neither clinically nor culturally contraindicated
Communicative	convey health-care recommendations across language and cultural divides
Functional	build trust by applying insights from other TC domains to recommended health-care approaches

Table 2

Transnational Competence vs. Cultural Competence

<u>Transnational competence</u>	<u>Cultural competence</u>
Skill-base: comprehensive	Skill-base: focused (typically, communication emphasis)
Flexible, fluid	Generalized, change-resistant
Addresses emotional component: shows empathy and respect for patients whose beliefs and practices are antithetical to one's own	Excludes the emotional component
Develops patient-specific skills	Relies on standardized lists of characteristics
Explicit social-context responsibility	Social-context responsibility missing or optional
Transferable to multiple ethnoculturally discordant settings	Prepares for single 'other' (often domestic) culture
Useful in multiple professional practice sites	Useful in limited practice sites

Table 3

Key Elements of a Transnational Competence Curriculum

- Longitudinal and vertically integrated
- Didactic and experiential components
- Applicable in preclinical and clinical settings
- Mini-ethnography core exercise
- Experiential, with patients from multiple cultures
- Reflective writing component
- Applied social-context recommendations with feedback
- Small group discussions
- Rigorous evaluation