

Medical Education for a Changing World: Moving Beyond Cultural Competence into Transnational Competence

Peter H. Koehn, PhD, and Herbert M. Swick, MD

Abstract

Given rapidly changing global demographic dynamics and the unimpressive evidence regarding health outcomes attributable to cultural competence (CC) education, it is time to consider a fresh and unencumbered approach to preparing physicians to reduce health disparities and care for ethnoculturally and socially diverse patients, including migrants. Transnational competence (TC) education offers a comprehensive set of core skills derived from international relations, cross-cultural psychology, and intercultural communication that are also applicable for medical education. The authors discuss five limitations

(conceptual, vision, action, alliance, and pedagogical) of current CC approaches and explain how an educational model based on TC would address each problem area.

The authors then identify and discuss the skill domains, core principles, and reinforcing pedagogy of TC education. The five skill domains of TC are analytic, emotional, creative, communicative, and functional; core principles include a comprehensive and consistent framework, patient-centered learning, and competency assessment. A central component of TC pedagogy is having students prepare a "miniethnography" for each patient that addresses not only

issues related to physical and mental health, but also experiences related to dislocation and adaptation to unfamiliar settings. The TC approach promotes advances in preparing medical students to reduce health disparities among patients with multiple and diverse backgrounds, health conditions, and health care beliefs and practices. Perhaps most important, TC consistently directs attention to the policy and social factors, as well as the individual considerations, that can alleviate suffering and enhance health and well-being in a globalizing world.

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By the start of the new millennium, some consideration of cultural diversity could be found in the curricula of virtually all U.S. medical schools, and most recognized the need to prepare "culturally competent" physicians.¹ In recent years, cultural competence (CC) has been linked to mainstream quality-assurance and cost-containment agendas² and, as a measure intended to help reduce disparities in health care, has been mandated for physicians practicing in New Jersey by the legislature of that state.³ The astonishingly rapid development of CC as a major curriculum element in medical education has occurred in response to gaps in

medical students' training and skills identified by educators, practicing physicians, major hospitals and managed-care providers, and influential bodies such as the Institute of Medicine and accrediting organizations.

In light of the rapid adoption of cultural competence as a formal curriculum goal, a growing number of observers concur on the need for critical assessment of the pedagogical construct and for consideration of future directions.^{4,5} One group of critics contends that CC is "soft science" and/or too onerous for already overloaded medical school curricula.⁶ Our position differs radically. In this article, we suggest that the frameworks for many CC curricula are constrained by a relatively narrow conceptual scope and insufficient depth of penetration and preparation. Although all CC programs are not equally deficient and some CC shortcomings can be remedied, the combination of inherent limitations in the CC framework and rapidly changing demographic patterns in the United States resulting from porous geopolitical boundaries is reason for moving beyond the current CC curricular approach. Transnational competence (TC) is a

model that involves a comprehensive set of skill domains, builds upon the gains initiated by CC, specifically addresses the connection between migration and health disparities, and, consequently, offers a timely, encompassing, and unencumbered approach to medical education that will better prepare physicians to practice in the coming decades.

Culturally Competent Clinicians and Persistent Health Disparities

In their recent systematic review of studies evaluating the impact of cultural competence interventions, Beach and colleagues⁷ found widespread evidence that CC training improves the knowledge, attitudes, and skills of health professionals, although they found no evidence that such training has improved health outcomes or diminished health disparities. Indeed, disparities in health and health care, both within and among nations, are increasing. The disturbing implication is that we live in a time of simultaneous and seemingly paradoxical increases in health inequities and in the number of culturally competent health professionals.

Dr. Koehn is professor of political science, The University of Montana, Missoula, Montana.

Dr. Swick is executive director, Institute of Medicine and Humanities, St. Patrick Hospital and Health Sciences Center, The University of Montana, Missoula, Montana.

Correspondence should be addressed to Dr. Swick, Executive Director, Institute of Medicine and Humanities, P.O. Box 4587, Missoula, MT 59806; telephone: (406) 327-3161; e-mail: (hswick@saintpatrick.org).

Although the reasons for the observed disconnect are multiple and complex, the failure of CC education to mitigate health disparities constitutes a challenge that should provoke serious concern among medical school administrators, faculty, and students. We suggest that five fundamental limitations of the CC framework help explain the current situation: conceptual, vision, action, alliance, and pedagogical limitations. Admittedly, a number of progressive CC curricula avoid some, perhaps even most, of the deficiencies we identify. The principal intention of our critique is to call attention to those educational approaches that have not succeeded in addressing all five limitations and, hence, have encountered difficulties implementing a CC curriculum that effectively addresses health inequities.

Conceptual limitations

First and fundamentally, the CC model typically suffers from lack of conceptual consensus⁷ and comprehensiveness. In the published literature, the principal conceptual frame for a CC curriculum typically is left unspecified, although generally speaking the aim is to teach mastery of specific domestic two-culture interactions. In the absence of conceptual clarity, curriculum components are variable and fragmented—both across specialty disciplines and across medical schools. Rather than developing a comprehensive set of skills, some CC programs equate cultural competence with communicative competence.⁸

Vision limitations

Many CC curricula are designed to prepare medical students to address the health care issues of a single “other” ethnic population⁹ such as Hispanic patients. However, such an approach fails to address the increasingly diverse patient population physicians are likely to encounter. In this era of increasing mobility, human interactions across porous borders have intensified. Migration, both unidirectional (emigration/immigration) and circular (return and repeat migration), is a defining element of the current world order. The United Nations Population Division estimates that in 2005 there were nearly 200 million international migrants (one in every 35 people in the world) who had lived outside their country of origin for at least one year. About 110

million of these migrants resided in industrialized countries. The 2005 total was more than double the 1980 number.¹⁰ At the end of 2005, more than 35 million foreign-born persons lived in the United States (12.1% of the total population)—including about eight million who had relocated since 2000, in the highest recorded five-year immigration in U.S. history.¹¹ Current global demographic dynamics present new health care challenges. For instance, since 2000, six of every ten babies born in New York City have at least one foreign-born parent¹²; and U.S. hospitals increasingly are challenged to provide emergency care for undocumented migrants—most of whom now reside in suburban areas.^{13,14}

Increasing migration, transmigration, and global-local connectivity potentially limit the effectiveness of CC approaches to medical education. In a context of growing population mobility, many health outcomes are shaped by transnational interactions among care providers and recipients who meet in settings where there are few opportunities to match the nationality and ethnicity of patient and provider. In many parts of the United States, as well as in other industrialized nations, physicians encounter patients who are physically in transition from an unprecedented multitude of dissimilar nation states.¹² CC education, intended to teach mastery of specific domestic two-culture interactions, is of diminished utility in today’s dynamic, diverse, hybrid, and complex patient-care environment.^{15,16} In contemporary health care settings, where the effects on patients of war, dislocation, and multiple moves are as relevant to their physical and mental well-being as are their belief and value systems, to acquire mastery of the “multiplicity of cultures that comprise the patient populations of today”^{17,p.250} is not feasible; neither is it necessary for quality assurance and cost containment.

The vision shortfall is compounded when CC curricula emphasize reliance on lists of ethnocultural characteristics rather than patient-centered inquiry and on single-factor explanations such as health-belief systems instead of multidimensional analysis that is inclusive not only of ethnocultural determinants,⁶ but also of transitions in class, geographic location, and identity.

The CC movement in health professions education has devoted considerable effort to generating and reporting cultural information about specific ethnic groups. Some CC programs continue to rely on formulaic cultural approaches in patient treatment even though the work of Kleinman et al.¹⁸ Tervalon and Murray-Garcia,¹⁹ and others has encouraged a move beyond such a narrow approach. Clearly, the multidimensional nature of human experience generates considerable intragroup variation.^{20,21} Among more recent migrants, for instance, we encounter important attitudinal and behavioral differences from previous cohorts, and nearly every migrant reports unique experiences in his or her course of migration.²² In individual medical encounters, therefore, physicians need to be cognizant of the dynamic interplay between patients’ culture and their gender, socioeconomic status, and power position, as well as the degree of discrimination or persecution they experienced, the degree of integration within the host society, and, at times, their ongoing connections to circumstances, persons, care providers, and health beliefs in distant places.

Patient variability means that the “standardized list” approach to diagnosis and treatment associated with some CC curricula is problematic. When physicians focus on a typically extensive list of presumably universal and static culture-specific characteristics such as reliance on herbal remedies, “groups of people are often essentialized, lumped together, all of their members [presumably] possessing traits unilaterally.”^{25,pp.550–51} Among other limitations, lists of cultural characteristics miss the diversity of perspectives and behaviors that exists *within* ethnic groups due to mixed origins, socioeconomic differences, multiple national identities, and sustained transnational participation. In an increasingly global world, therefore, one outcome of physician education must be skill in identifying and taking into account the special circumstances that surround and define the individual patient. Rather than referencing cultural lists, the most promising health care approaches focus on building interpersonal therapeutic alliances and on inductive inquiry regarding transnational as well as domestic influences, and socioeconomic and political status as well as individual

orientations that reflect cultural, subcultural, and mixed-culture experiences.

Action limitations

Prevailing disparities in health status largely reflect patients' lifestyle practices that are mediated by their socioeconomic position and differential ability to access and use health care opportunities. Displaced individuals and families frequently confront inequities in health care access and medical treatment alongside new health risks associated with living and working conditions that compromise their health.^{23,24} For migrants and other patients at risk of health care marginalization, "the medical interview holds the potential to undermine inequalities or to reproduce them."^{25,p.27} Nevertheless, responding to the voice of the least advantaged through social action has not been integral to the typical CC curriculum.⁵ Indeed, the opportunity for physicians to address contextual sources of distress generally has not been included in CC approaches.^{5,26} Issues of intraprofessional status and power as well as social and political barriers to greater equity in access to medical care and other health-promoting resources fall outside the scope of most CC curricula.⁵ Lacking a compelling theoretical foundation for its inclusion in their training, many medical students emerge from CC education believing that it is unnecessary, optional, or impossible for physicians to mitigate social, economic, and political barriers to equity in health care and health status.²⁷ Culturally competent clinicians who cannot or do not advocate for health care system (and other) changes on behalf of their patients are of limited effectiveness, especially when they are responsible for vulnerable and disadvantaged patients from diverse backgrounds.

Alliance limitations

While they have a key role to play, physicians alone cannot be expected to reduce prevailing disparities in health. Bringing about change in existing conditions also requires attention to power and policy. However, the CC curriculum typically fails to prepare medical students for building alliances across professions and with patients, for networking across national borders—especially in the developing world where one finds the greatest health disparities—

and for effective participation in policy-making processes.

Pedagogical limitations

In general, CC curricula lack pedagogical cohesiveness. For many programs, longitudinal integration across the curriculum remains an unattained goal. Insufficient attention is devoted to parallel needs for patient education. The development and assessment of strategic social-action plans is not an integral part of most students' CC clinical experiences. Finally, teaching methods are not related in convincing fashion to the development and reinforcement of a desired set of skills. Beach and colleagues⁷ found that all studies that evaluated the impact of CC education on provider skills demonstrated some beneficial effect. However, the interventions they studied differed in approach and timing, the skills measured varied in type and relevance to health care, and the acquisition of a particular skill was not attributable to a particular intervention(s).

Moving Beyond Cultural Competence: The Transnational Competence Framework

The conceptual framework of transnational competence differs from the cultural competence framework in several important respects. Building on research in international relations, development studies, international business, cross-cultural psychology, and intercultural communication, recent work suggests that TC is applicable in health care education settings as well.^{28–30} TC encompasses interpersonal skills that are valuable in encounters with patients from diverse cultural and social backgrounds who are recent arrivals in, as well as long-term residents of, a particular country. These skills also are helpful in addressing other groups of patients who differ from mainstream populations, including, for example, nonhearing or gay, lesbian, or transgendered patients. In the following sections, we outline the five domains of TC, set forth its core principles for medical education, and identify appropriate and promising pedagogical approaches.

The five domains of TC

The comprehensive TC framework explicitly encompasses five discrete, but

mutually reinforcing, skill domains: analytic, emotional, creative, communicative, and functional. Each domain encompasses multiple dimensions. Here, we cite skill examples specifically related to medical education and to health care settings (see Koehn³¹ for additional details).

Transnational analytic skills. Medical education and practice rely upon a large base of specialized knowledge. The analytic domain of TC emphasizes developing the ability to gather health-related information and analyze it critically instead of memorizing previously reported sociocultural findings. TC specifically points to the necessity to probe beyond ethnicity and culture as discrete factors. Both ethnocultural and sociopolitical analysis are required. In particular, it is important that medical students explore the longitudinal dimensions of spatial transition, as patients often are dealing with "unfinished endings" that preceded their arrival in the treatment setting.²² In their study of 187 refugee medical records in a large U.S. county, Weinstein and colleagues found a complete absence of notations regarding refugee experience in 93% of the cases and discovered that "the implications of refugee status were not considered in the diagnosis and care received by refugees."^{32,p.303} Transnational analytic skill involves the ability to identify factors that contribute to health variability, resilience, and vulnerability¹⁶—including such factors as the effects on patients of war, powerlessness, global manipulations of national and subnational economies,^{33,34} changing class profiles, persecution, and the type and frequency of trauma experiences. Transnational analytic skill further involves unraveling relevant links between patients' health and postmigration stressors associated with how they have been received locally—such as unemployment, discrimination, insecurity of immigration status, or family fragmentation.³¹ Moreover, events and conditions in the country of origin often continue to affect the mental and physical health of patients who possess transnational ties and identities. An especially valuable transnational analytic skill in migration health is a physician's ability to ascertain the role of ethnocultural and other nonstandard health-related beliefs, values, and practices, including return (physically or

virtually) to the country of origin for medical attention, advice, and/or treatment.

A TC educational model would prepare students to assess the role of these multiple and complex pre- and postmigration factors in the decision making processes and health care practices of specific patients and/or families. In addition to the kinds of diversity training offered in conjunction with CC approaches, TC education would enhance opportunities for students to develop insight into how their own class backgrounds and unique experiences (or lack of experiences) affect their relations with dislocated patients who possess ethnocultural and socioeconomic backgrounds that are unfamiliar to their providers.

Transnational emotional skills. Many patients from non-Western cultures look for help in dealing with the emotional aspects of illness, whether acute or chronic, and are upset when clinicians treat their cases solely in terms of clinical efficiency.³⁵ TC explicitly acknowledges that the experiences of ethnoculturally and socioeconomically diverse patients have important emotional dimensions.¹⁵ In the migrant health care encounter, it is particularly important that care providers learn to respect rather than dismiss traditional practices that affect patients' acceptance of and compliance with treatment protocols. Transnational emotional competence is manifested by physicians' ability to gain and express genuine respect for a multiplicity of beliefs and values, and by their sensitivity to challenges related to migration, exploitation, and reception experiences,² to feelings of satisfaction or distress stemming from social circumstances, and to the false sense of division inherent in "othering." Emotionally skilled clinicians further appreciate that every medical encounter is a multidimensional interaction among the cultures of the mobile patient, the physician, the supporting professionals, and the health care systems that envelop them.^{24,36}

A TC educational model would prepare medical students to appreciate how a sense of personal, family, and/or group efficacy constitutes a powerful determinant of patients' adoption and maintenance of health-promoting actions and, therefore, is associated with

outcomes that enhance health and prevent illness. A TC approach would help students to recognize the role of patient resilience when faced with overwhelming obstacles. For migrants facing formidable language and adaptation challenges, and for all patients confronting discrimination, unemployment, and/or lack of social support, the clinician's respect for the individual patient's (and the family's) health care capabilities and the clinician's willingness to delegate manageable self-care responsibilities serve to strengthen patients' confidence in their efficacy and encourage perseverance to sustain new and/or demanding psychological and physiological behaviors that will restore or enhance health.

Transnational creative skills. Freeing up creative capacities among providers and patients alike is a powerful force for positive health outcomes in transnational medical encounters. A key TC creative skill is the ability to initiate fruitful connections among disparate parts of a patient's experience. Skillful transnational clinicians are able to inspire and collaborate with participants of diverse identities (patients as well as families and intercultural mediators) and complex problems (such as dislocated persons with severe disabilities coupled with few financial resources) in the design of innovative and contextually appropriate action plans. Especially in consultations with recent migrants, creative approaches to managing demands for medical treatment and health protection must include complementary integrations of biomedical and ethnocultural explanatory frameworks along with multilevel linkages of individual practices, sociopolitical considerations, and living conditions.

A TC medical education model would prepare students to recognize and incorporate the disparate and mobility-influenced elements of each patient's experience into a cohesive and effectively tailored approach to health care, which would often include other individuals and/or social agencies. The creative skill domain further enhances the ability of students to link physical- and mental-health interventions to societal reinforcement.

Transnational communicative skills.

While personal linguistic fluency in the patient's first language is an immense asset, achieving it is often impractical in contemporary health care situations involving participants with multiple first languages.¹⁵ In New York City, patients might communicate in one of 150 different languages. As a group, the 269,000 residents of Stockton, California, speak 100 languages. The communicative skill domain of TC emphasizes the effective use of an interpreter and the importance of employing skilled medical interpreters and intercultural negotiators. Transnationally skilled clinicians also develop proficiency in nonverbal communicative behavior.

The capacity to facilitate mutual self-disclosure via dialogue and questioning is particularly important in transnational health care situations characterized by vast social distance between patient and provider. Similarly, as a prerequisite for negotiating appropriate treatment plans and commitments, TC emphasizes the need to ensure that culturally and socially diverse patients are comfortable expressing to their physicians serious doubts about and constructive challenges to their health care.

Communicative skills are the most developed and emphasized components of many CC curricula, and TC draws heavily upon CC's contributions in this domain (for instance, Baker et al.,³⁷ Elderkin-Thompson et al.,³⁸ and Van Wieringen et al.³⁹). However, a TC educational model would move beyond approaches that are limited to learning a particular second language (most often medical Spanish in the United States) and learning about a specific set of cultural beliefs. TC aims to prepare medical students for healing encounters with patients from multiple cultures who speak many different primary languages rather than for encounters with patients from a single "other" linguistic group.

Transnational functional skills. The functional TC domain encompasses a physician's interpersonal as well as technical abilities to accomplish tasks and achieve objectives. Skill in establishing positive interpersonal relations is particularly valuable for the functional domain of transnational health care. Keys to success in building fruitful transnational relationships include demonstrating genuine and sustained

personal and professional interest in the patient as an individual, in the patient's cognitive and instrumental needs, and in social inclusion.

A TC educational approach would equip students for interventions that simultaneously are tailored to the patient's unique condition and account for the influence of socioeconomic and political factors on his or her health behavior. Valuable interventions by a transnationally competent provider might include, for instance, facilitating ties to traditional healers, medicines, and nutritional practices; help with transportation to appointments; and support for host-country language training, further education and (re-)certification, employment, and the maintenance of healthy practices learned in the patient's place of origin. Medical students also would be guided to develop proactive interventions that address context- and site-specific conditions that are conducive to elevated risk-taking behavior.²⁶ A TC approach would emphasize partnerships or therapeutic alliances between clinician and patient. Sustainable transnational agreements also often call for involvement by (extended) family and/or migrant-community support networks.

In the interest of equitable health opportunities and social justice, transnational functional skills necessitate competence and vigor in advocacy. Foremost within the advocacy skill subset is the ability to formulate recommendations and action plans that will generate changes in domestic and international economic, social, institutional, and legal/policy conditions that produce the systemic disparities that constrain individual health. Functional TC skills that focus advocacy attention on local "hot spots" where migrants tend to congregate are attainable by medical students and likely to be immediately rewarding.

Innovative aspects of the TC approach

Medical educators will recognize many of the specific skills that constitute the five TC domains since they draw upon published research regarding best practices in physician-patient encounters (for instance, Smedley,²⁴ Engel,⁴⁰ and Gracey et al.⁴¹). The innovative aspects of the TC approach for medical education are found primarily in its overall

framework and specific applications. First, TC training provides a comprehensive and consistent framework for organizing and delivering an important component of medical education. Because TC addresses the multiple skills required to deal with diverse populations, students will find TC applications more practical than CC applications when working with the rich variety of patients they are likely to encounter in contemporary medical practice. The TC framework also is especially inclusive in that it encompasses the contemporary challenges of migration health, as well as patients of diverse ethnicity and socioeconomic standing who possess a multigenerational heritage in a single country. In the long term, moreover, using a common framework that links the education of health care professionals to the education of other professionals (public health specialists, relief workers, businesspersons, diplomats, international development managers, engineers, and so forth) opens up special opportunities for resource sharing, alliance building, and collaborative cross-disciplinary research on TC approaches and outcomes for medical schools that adopt a TC framework. Finally, TC's applied emphasis on advocacy is distinctly advantageous. In terms of pedagogical applications, advocacy has not yet been effectively developed and integrated across most four-year medical school curricula.

Principles and pedagogical approaches for TC education

A basic principle is that the TC model for medical education must be comprehensive; that is, it must cover all five of the TC domains. In each domain, the TC model focuses on two primary and interconnected objectives: improved health outcomes for patients in social, cultural, and geographical transition, and reduced health inequities for dislocated and otherwise disadvantaged populations. Therefore, skill in advocacy is a conceptually integral component of TC education. In particular, medical students would learn to address the social and power contexts of patients undergoing transitions through making specific recommendations that would be discussed and evaluated by both their preceptors and their patients.

Another core principle of TC medical education, which is consonant with other educational models, is patient-centered learning. TC has a unique patient-centered emphasis, however. The health care encounter is approached as a partnership; the patient whose ethnocultural and social circumstances are unfamiliar to the student participates as teacher as well as learner; and the student values both the learning and mentoring dimensions of his or her role. The patient's voice is treated as an expert source of experiential insight. To avoid becoming stuck on how different the problems confronting "others" may be, TC education is designed to promote congruent patient/provider perspectives on health status and health promotion regardless of national origin, ethnicity, cultural identity(ies), or socioeconomic and political status. The TC model resolves the culture-centered conundrum that has entangled CC education by emphasizing flexible patient-centered responses that are transferable to diverse encounters involving persons from a multiplicity of national, cultural, and social origins.

Information gathering that places primary emphasis on contextual insights derived directly from patients, families, friends, and community members is conducive to preparing students for contemporary medical practice.^{17,24} The patient is especially "qualified to help the physician understand the intersection of race, ethnicity, religion, class, and so on" in forming one's identity and to explicate the relevance and impact of these complex intersections on an individual's current experience of illness or wellness; that is, "how little or how much culture has to do with that particular clinical encounter."^{19,p.121} A central component of TC pedagogy, therefore, is having students prepare a "miniethnography" for each patient that addresses not only issues related to physical and mental health, but also experiences related to dislocation, migration, and adaptation to unfamiliar settings. The miniethnography approach reduces the possibility that decisions will be based on stereotypic oversimplifications and/or insufficient information. Others have suggested specific questions that help providers avoid undue reliance on generalizations,²⁴ that can be used to identify the social context of patients in transition,⁴² and that elicit the patient's

explanatory framework and therapeutic goals.¹⁸ In the TC educational approach, the miniethnography would explore the suggested core components of a patient's transnational social history presented in List 1 and students would document how these life circumstances and perspectives are addressed in the recommended health plan. The TC miniethnography is unique in that it takes into account transnational healing and social relationships and emphasizes the importance of considering the impact of host-country experience on a patient's physical and emotional health. To inspire medical students to consider critical issues that affect health and to ensure that the components set forth in List 1 become part of the physician's normal repertoire, students learning the techniques of history and physical examination before applying them in their clerkship experiences would be expected to integrate components of TC into their patient evaluations. In this manner, the TC miniethnography would become an integral and practical part of the student's

standard framework for later patient encounters, just as learning a detailed review of systems allows the experienced clinician later to pursue and use relevant aspects of a comprehensive systems review.

It is important that student competence be formally assessed according to explicit learning outcomes. Medical schools currently find the assessment of students' cultural competence problematic due to lack of consensus regarding the core attitudinal and knowledge objectives and skill competencies of CC education.⁶ Assessment of TC lends itself to standardization across schools and to applications that are directly relevant to practice because it is exclusively based on demonstrated skill levels. List 2 describes specific objectives that would provide a basis for assessing students' transnational competence during their clinical clerkships. By the end of a TC-focused clerkship, all students should be able to demonstrate the use of all five TC skills in their clinical interactions with patients

who possess multiple, distinct, and mixed ethnic and class identities. Multiple contacts with patients from different ethnic and cultural backgrounds are essential in order to avoid reinforcing stereotyping tendencies.⁴³ Demonstration of each skill (or skill deficits) can be assessed by independent patient and preceptor evaluations and through structured case presentations, objective structured clinical examinations, and/or randomly captured videotaped encounters.⁶ A valuable capstone project would call for students to formulate a set of recommendations aimed at building institutional and community support for approaches that acknowledge and address the effects of social context on the health of ethnically diverse patients¹⁷ and incorporate the multidimensional assets of patients. TC mastery can be further demonstrated by students' spontaneous proficiency in reaching intersubjectively verified congruent assessments regarding health care beliefs and practices, such as congruent patient, family, and provider perspectives on improvements in health status and satisfaction levels,^{6,44} in a variety of ethnocultural and social contexts.

List 1

Core Components of a Comprehensive Transnational Social History for Migrant Patients

- Place(s) of origin and ethnic-group identification(s)
- Premigration education level, occupation, social status
- Premigration state of health
- Personal reasons for departure (elective and/or involuntary)
- Structural contributors (political, economic, social, environmental)
- Presence/absence of persecution, physical/psychological trauma
- Who/what was lost in the place of origin or in the process of spatial transition; the extent of loss
- Step-migration circumstances and experiences
- State of health on arrival in receiving country
- Current immigration status (irregular migrants encounter additional barriers and need special assurances)
- Strength of current ethnocultural identity; extent of biculturalism
- Current local status (employment, insurance, access to health care system and treatments, support system, language abilities, discrimination, citizenship)
- Current spatial context (housing conditions, transportation opportunities, community climate)
- Gender roles, authority relations within the family, views about birth, dying, death, and spirituality
- Current state of health and unique health concerns
- Beliefs and practices regarding complementary healing, traditional healers, community-based support systems, and transnational healing
- Depth, breadth, type, and frequency of contacts and social relationships abroad
- Future migration/transmigration plans

Discussion

The recent focus on CC has constituted an important breakthrough in medical education. In particular, CC curricula have been associated with students' positive attitudinal changes and development of encounter skills. Presently, however, CC curricula are buffeted and constrained by multiple, complex cultural and socioeconomic variations among patients and by the challenges of encounters with patients who participate in transnational networks. The CC approach is increasingly deflected by the buying power of corporations that may seek to exploit CC for commercial gain,⁴⁵ and increasingly undermined by institutions' inability to demonstrate improved health outcomes and reduced health inequities.^{7,20} These issues suggest that the CC pedagogical model merits reconsideration at this critical stage in its development. Should CC curricula be modified and strengthened by incorporating elements of the TC model that they currently lack, thus addressing the limitations of many CC educational programs, or should TC replace CC as a

List 2

Transnational Competence Learning Objectives

Analytic

- *Discern* effects of pre- & postmigration experiences, and distant & proximate health-shaping inequities, on patient's physical/mental health status
- *Recognize* variations in socioeconomic backgrounds, power relations, health care skills, health beliefs and behaviors, and transition experiences
- *Identify* patient's capabilities and resources amidst vulnerabilities and power deficits

Emotional

- *Empathize* with and respond to ethnoculturally discordant patient's expectations, vulnerability, and resilience
- *Respect* different beliefs/practices (lay expertise)

Creative

- *Articulate* a complementary biomedical, ethnocultural, personal, and structural health care plan
- *Participate* in formulating health care recommendations that address contextual constraints

Communicative

- *Encourage* patients to express their health-related experiences, questions, concerns, or doubts
- *Take* patient expressions/ideas seriously
- *Convey* health care recommendations effectively across language, social, and cultural divides

Functional

- *Build trust* (e.g., by applying insights from other transnational care domains to recommended approaches)
- *Take into account* influence of family—including younger generation—and community members
- *Relinquish power* by discussing and allowing choice regarding individually tailored options
- *Develop advocacy skills*: propose and secure institutional and community support for enabling approaches that address effects of social context, power, and policy on migrant health
- *Provide improved quality of care* to patient
- *Increase patient/provider satisfaction* with clinical encounter outcomes

core objective of and approach for medical education?

Incorporate TC elements into a modified CC curriculum

The “incorporate and modify” option is based on two powerful arguments. First, proponents contend that U.S. medical education is heavily “politically invested” in the CC approach and that the CC curriculum lends itself to adaptation. Given its hard-won acceptance, medical educators are understandably reluctant to initiate a complete break with the CC approach and to embark upon another initiative that addresses many of the same issues. Their objection is not to TC's principles, framework, or pedagogy. Indeed, they would argue that a progressive CC curriculum embodies most TC elements and that any pieces missing from CC curricula that can be found in the TC approach should be

embraced and incorporated in order to strengthen further the CC educational model. Second, others are concerned that supplanting CC with TC, instead of augmenting the former with the latter, would diminish attention to particular minorities within U.S. society.

Replace CC with a TC educational approach

While we acknowledge that some schools and professional associations would prefer to retain the CC rubric, we believe that the “replacement” option also merits serious consideration. To the extent that CC curricula are unable to prepare physicians for the breadth and diversity of clinical interactions and health challenges that characterize medical practice in a globalizing world, the value of current CC approaches will be diminished among current and future cohorts of medical students, and

commitment to CC education will decline among medical school faculty and administrators. Given the conceptual and evolutionary limitations of the CC approach and the unimpressive evidence attributing improved health outcomes to CC curricular innovations, it is time for a fresh, proactive, and more promising initiative.

By building on and extending the CC approach, TC is able to meet the educational need to define a comprehensive set of core medical and social competencies for work with diverse patients.²⁴ Because it encompasses the dynamic interactions of power, class, and social contexts, as well as cultural and subcultural identities, a “transnational” construct is broader and more useful than is a “cultural,” “transcultural,” or “multicultural” construct.⁴⁶ Currently, medical school graduates might be culturally competent without possessing the full range of multidimensional skills necessary to address the wide spectrum of patient diversity they will encounter in practice. The more encompassing TC approach is adaptable to a wide variety of service users and practice sites and is useful in addressing both the quality of patient care and the social constraints on health associated with an era distinguished by population mobility and transitional identities. Moreover, it is likely to be intrinsically motivating because it provides the skill base required for improved practice, quality assurance, and health gains in a complex, shifting, and multidimensional patient environment. For these reasons, medical schools that explicitly adopt the TC rubric and educational approach will be distinguished from those using less comprehensive CC approaches in terms of curriculum, transnational skill learning, vigorous advocacy, and the results of outcome assessments.

One clear benefit for medical schools that focus on teaching transnational health care skills will be avoiding identification with culture-exclusive or culture-centered approaches. Preparing students for transnational interactions more accurately reflects and responds to the complexity of contemporary and future medical encounters. By providing a set of practical and rewarding skills that obviate the need to rely on cultural “cookbooks,” the TC framework is likely to resonate powerfully with educators both within and

beyond the confines of the United States. For instance, those concerned with the health of African Americans appreciate that ongoing migration from Africa and the Caribbean (about 50,000 legal immigrants per year) is “redefining what it means to be African American.”^{47,p.A1} The emphasis of the TC approach on the socioeconomic dimensions of health and on reducing disparities in care and health outcomes provide additional reasons to consider moving beyond a culture-centered approach to U.S. medical education.

Conclusions

We believe that the TC approach—both its conceptual framework and its pedagogical principles—promises advances over the prevailing CC approach in preparing medical students to care for patients with multiple and diverse backgrounds, health conditions, and health care beliefs and practices. Specifically, TC education encompasses a comprehensive set of core competencies involving the ongoing acquisition of five specific skills and prepares medical students to use those skills in a diverse range of patient cases while avoiding stereotyping lists. TC emphasizes the physical and mental health consequences of economic disparities and the underlying global and local structural factors that contribute to those disparities, with the objective of empowering the multinational therapeutic alliance to deal with social-context challenges to patient health. In the future, clinicians increasingly will be challenged to work with ethnoculturally and socially disparate patients. By providing a common framework for medical education in an era of globalization and migration, the TC approach will be applicable in educating future clinicians in vastly different countries and health care contexts. Being transnationally competent will promote professional mobility by preparing medical students for multiple practice sites. Perhaps most important, transnational competence consistently directs attention to the policy and social circumstances as well as the individual considerations that can alleviate suffering and promote health and well-being.

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Teaching and Learning Moments

Michael Reese's Mission Commander

When Jordan J. Cohen strode through the front entrance of Michael Reese Hospital, then the major teaching affiliate of the University of Chicago, it seemed like a perfect match. He had accepted his first chief of medicine position and I had accepted a chief medical residency. "Both apprentices," I imagined. Little did I realize how well developed were his leadership skills or how deep and indelible an impression he would have on me.

As if a mission commander, Dr. Cohen presented a clear and detailed vision for our training program. Commitment to excellent education, renowned grand rounds speakers, and application of the current medical literature to clinical problem solving were priorities. Regardless of the venue, Dr. Cohen rose to every occasion. In teaching us, his chief residents, to be first-time administrators of a large and diverse housestaff, he was first to recognize battles worth avoiding. "Next slide," he would utter when facing an irresolvable conflict. We would move to the next dilemma and wait for his Solomonic decision. We appreciated his decisiveness. At his urging, no drug company luncheons or paraphernalia were permitted on his watch, as these sessions, however well-meaning, were unlikely to provide unbiased information to his housestaff.

At one remarkable Monday morning report meeting, Dr. Cohen, an acid-base maven for nearly 20 years, was presented an unusually complex case of anion gap metabolic acidosis. After pondering aloud the differential and eloquently expounding

on virtually every diagnostic possibility in order of likelihood, he crossed his arms and pronounced, "I don't know." With those three words he unleashed a key insight for all of us: clinical medicine is sometimes impenetrable and mysterious. Like Dr. Cohen, I too wanted to reason through cases with the same logic, tenacity, and insight that he so well elucidated.

During my renal fellowship only one year later, I sat in a small conference room, tightly packed with nephrology aficionados, where I was struggling with the concept of free water clearance. "I just can't calculate this," I confessed. The room suddenly became silent. "Yes, you can," Dr. Cohen insisted, as he logically probed this seemingly opaque concept. His belief in me (coupled with his ample prompts), enabled the concept of "clearance" to crystallize for me at last.

In addition to his clinical skills, he led us in interpreting reams of metabolic data obtained from elaborate dog models in the renal research laboratory. Enthused by watching him, I requested to train with him as a research fellow in nephrology. He refused, noting that science was rapidly moving away from his classic (and still oft quoted) animal experiments towards cell and molecular biology. Instead, he directed my future aspirations with two words: protein chemistry. As I now look backwards after 20 years in a basic science laboratory studying heat stress proteins, I appreciate his insightful advice. His influence on me was not limited to academics, however.

Outside the "Reese walls," we were once together on his sailing vessel, gliding across Lake Michigan. He quickly grasped the wind's direction and responded to its subtle changes as if "Master of His Destiny" (and ours). He was at ease in this world far different from alcohol and swabs. When his first grandchildren arrived, a new Dr. Cohen emerged, one with wallet-sized pictures and a conference room-sized smile. His enthusiasm for these new lives rivaled his enthusiasm for the most uncommon of metabolic derangements, the most revealing experimental data, or the most favorable wind. Dr. Cohen, a "Man for All Seasons," filled Michael Reese with his personality and invited each of us to make the most of our lives—as did he.

With his hallmark clarity, sense of purpose, and zest for life's pleasures, Jordan J. Cohen created a legacy of strength, humility, and excellence. As one of my consummate teachers, he could be both extraordinarily insightful and remarkably humble. As he departs this career for his next endeavors, I know he will continue to be driven by his undeniable energy. He has taught me unforgettable lessons about curiosity, self-discipline, and intellectual integrity that have rarely been matched.

Steven C. Borkan, MD

Dr. Borkan is an associate professor, Department of Medicine, Renal Section, Boston University School of Medicine, Boston, Massachusetts.