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Global Politics and Multinational Health-care Encounters: Assessing the Role of Transnational Competence

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Abstract: This planet's most likely political/population scenario for the 21st century anticipates more people, more spatial movement, and more transnational interactions. Global health increasingly will be shaped by encounters among clinicians and patients who meet in health-care settings where cultural, ethnic, and national-origin match is not an available option. In multinational clinical consultations, bicultural competence and lists of culture characteristics will not suffice. The article adapts the generic Koehn/Rosenau framework of transnational competence (TC), which encompasses analytic, emotional, creative, communicative, and functional skills, to the global challenge of providing migrant-health care. The focus is on the patient/clinician encounter, where interpersonal interactions carry the potential to reduce or reproduce existing inequities in health care. A structured literature review provides the basis for the adaptation to transnational health encounters presented for the first time here by incorporating recent research findings from more than 80 published studies regarding patient–provider consultations and cultural competence in the medical interview into the TC framework's empirical foundation in cross-cultural psychology, development studies, intercultural communication, and international management. The application elaborated in this article will enhance the ability of researchers to explore and to assess the role of encounter participants' TC capabilities and deficiencies in transnational health-care outcomes—including migrant satisfaction/dissatisfaction with provider care, the incorporation of complementary biomedical and ethnocultural health-promotion practices, effective/ineffective migrant-health-promotion behavior in the new environment, and agreement on mental-health needs. The results of conceptually grounded TC research promise to enhance practitioner training and patient education in both North and South.

Key words: migrants, health-care outcomes, transnational competence, global health, cultural competence

Introduction

Nearly 1 billion people move across national borders annually (Kovacs, 1999), and at least 170 million people (Bollini and Siem, 1995; Tuladhar, 1999) are known to reside outside their country of origin. People in spatial transition include professionals (Findlay, 1995), technically skilled specialists (Keely, 2001), unskilled and undocumented workers who serve as "serfs" of the global service economy (Raynor, 1999, p A31), people forced to move by environmental degradations (Castles, 2002), and

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internally displaced persons, refugees, exiles, and returnees (Koehn, 1991; Helton, 2002). Some participants in the global mobility upheaval, the transmigrants, are constantly or periodically in motion back and forth across contiguous or noncontiguous territorial boundaries (Schiller, 1999; Koehn and Rosenau, 2002; Eastmond, 1998).

The most likely population scenario for the 2lst century involves "more people, more population movements, more displacement—both internally and internationally—and more demands for effective responses by relevant authorities" (Helton, 2002, p 14). Social, economic, environmental, military, and policy contexts/events influence the health of people on the move (see, for instance, Martens, 2002; Martens and Hall, 2000; Kickbusch and Buse, 2001), and population movements generate new health risks and inequities. For instance, the health status of migrant families from the South frequently declines with deeper (intergenerational) incorporation in Northern host societies (Smedley et al., 2003; House and Williams, 2000). The interdependent challenges of global health that arise from the expanding volume and pace of cross-border population movements—including emergent, life-threatening, and economically and even politically destabilizing infectious diseases (see Martens, 2002; Kickbusch, 2003; Fidler, 2003; Grauwels, 2003; Porter et al., 2002), the accelerated transmission of noncommunicable population health threats such as drug addictions through trafficking across borders (Chen et al., 1999), the health effects of environmental degradations such as global climate change (Lee et al., 2002; Koehn, 2003), and unusual presentations of chronic illness, injury, and mental-health/health-promotion needs—increasingly are and will be played out in transnational health-care encounters.

In an era of expanding cross-border migration, it is not surprising that professional health-care providers must interact with recipients whose manifold national origins are different from their own. In light of the unprecedented "movement and mixing" of people who draw on diverse identities, global health is being shaped by interactions among healers and patients who meet in settings where cultural, ethnic, and national-origin match is not an available option (see Fox, 2000; Sue et al., 1991; Pachter, 2000; Smedley et al., 2003). In the North, care settings increasingly involve the patent's home—which is likely to introduce a third cultural system (see Janes and Hobson, 1998; Meleis, 1996). Although there is evidence that racial matching is associated with higher levels of satisfaction with health care, particularly among African Americans (Saha et al.,1999; Cooper-Patrick et al., 1999; Smedley et al., 2003), domestic U.S. population trends and medical-school enrollments foreshadow "decreased likelihood of race concordance for African Americans and Hispanics in the future" (LaVeist and Nuru-Jeter, 2002, p 304). Prospects for patient/clinician ethnic match are even more remote in other countries. Consequently, improving the "relationships that physicians have with patients of nonconcordant backgrounds" (Saha et al., 1999, p 1003) remains a global priority.

The local health challenges and complexities brought about by migration are apparent when one considers that, after decades of advocacy and consciousness raising, cultural competence is far from assured among the U.S. medical community and that racial, ethnic, nationality, class, gender, and age biases in health systems remain entrenched throughout the world (see Goode, 2001; 2002; King, 2002; World Health Organization and World Bank, 2002; Hall et al., 1988; Stewart et al., 1999; van Ryn and Burke, 2001; Maynard et al., 1986; Waitzkin, 1985; Schulman et al., 1999; Gifford et al., 2002; Smedley et al., 2003; House and Williams, 2000). In today's multinational clinical encounter, however, even the tools of cultural competence, which typically assume bicultural situations, will not suffice. One of the limitations of the culture-competence approach to health-care training is "its tendency to promote desperate attempts at superficial mastery of a seemingly endless list of concrete culture-specific characteristics" (Shapiro and Lenahan, 1996, p 249; also see Culhane-Pera et al., 1997). It is plainly neither possible nor necessary for health-care professionals to achieve "in-depth immersion in the multiplicity of cultures that comprise the patient populations of today" (Shapiro and Lenahan, 1996, p 250; Carrillo et al., 1999; Hunter, 1991; Borkan and Neher, 1991). However, it is possible to "master the knowledge and skills associated with cultural assessment and learn about *some* of the cultural dimensions of care for clients representing groups most frequently encountered" (Andrews, 1999, p 8; also see AMA, 1999; Smedley et al., 2003). For lists of culture-specific demographic, epidemiological, environmental, and cultural questions, see (Huff and Kline, 1999).

As distance is compressed and cross-boundary movements accelerate, policy makers increasingly appreciate that health is a global public good. Moreover, "health is positive-sum: one person's good health does not detract from

another's. Indeed, better health usually has positive effects on entire populations'' (Chen et al., 1999, p 294). The distribution of this good remains vastly unequal, however. Dislocated people are particularly at risk of being bypassed by potentially beneficial interventions (Chen et al., 1999). Although the reasons for disparities in health-care screening, medical treatments, morbidity, and mortality among persons who lack ''voice'' in biomedical institutions are multiple and complex (see Roter and Hall, 1992), the clinician/patient relationship constitutes an important contributing—and potentially mitigating—factor. For a recent review of empirical evidence regarding the influence of aspects of the doctor/patient relationship, including physician bias, on health outcomes among limited-English speakers and other patients lacking voice in U.S. clinical contexts, see Ferguson and Candib, 2002; also see Elderkin-Thompson et al., 2001, Morales et al., 1999; Jacobs et al., 2001. On the barriers to effective mental-health services attributed to lack of cross-cultural understanding, see Goode, 2001. For refugees and other migrants at risk of health-care marginalization, ''the medical interview holds the potential to undermine inequalities or to reproduce them'' (Fox, 2000, p 27; also see Kaplan et al., 1995).

The response to transnational cases ''must be equally transnational'' (Farmer, 1999, p 244). *Transnational competence*, a specific set of skills derived from research findings in international relations, development studies, international business negotiations, cross-cultural psychology, and intercultural communication, promises to be particularly appropriate and useful as multinational cases and global transmissions multiply. In the May 2002 issue of *International Studies Perspectives*, Koehn and Rosenau (2002) elaborate the conceptual framework for transnational competence (TC) and contend that transnationally proficient actors will perform increasingly important roles in addressing a wide range of ''interdependence challenges.'' Can this framework provide the basis for development of a comprehensive measure of TC in health-care service delivery? Can transnationally competent clinicians and patients jointly overcome obstacles to effective health-care access and treatment associated with unprotected immigration and insurance status, time constraints, poverty, and racial/ethnic bias? Addressing these important questions (AMA, 1999) requires, first, that an effort be made to adapt the generic TC presentation to the interactions that occur in the multinational health-care context. The primary objective of this article is to refine the transnational competence framework in order that subsequent research projects can measure and explore the effects of individualized TC in the multinational health-care encounters that occur in both North and South.

In moving from interdependence challenges broadly conceived to the specific issue of migrant-health care, this adaptation of transnational competence is guided by research findings that deal with medical interviewing and cultural (especially intercultural-communication) competence. The interface of these resources with the theoretically derived and empirically grounded TC framework through a structured literature review provides the basis for identifying and operationalizing the key health-care dimensions of each skill domain.

Structured Literature Review as an Adaptation Tool

The method used to adapt the TC framework to the migrant-health-care context primarily employed the integration of research findings and insights from two bodies of literature—the patient–provider relationship and cultural competence in health care. The review initially focused on potentially relevant contributions included in five respected compendiums: *The Medical Interview* (1995), *Handbook of Health Behavior Research*, Volumes I and II (1997), *Child Health in the Multicultural Environment* (2000), and *Transcultural Concepts in Nursing Care* 1999; it also included patient–clinician-communication studies listed on the public-health-communication course syllabus (Biomed 564) prepared in March 2003 by Howard Waitzkin, Professor of Family and Community Medicine at the University of New Mexico and a recognized authority on the subject. From the references cited in these works, the author collected and examined a large number of additional sources—primarily peer-reviewed research findings published within the past decade. On the basis of this review, I incorporated relevant findings from more than 80 specifically health-care-related journal articles and book chapters in the adaptation process. References to these studies, along with generic TC-framework-building sources, are cited where they inform the adaptations set forth in the text of this article. The author recognizes that gaps in this literature review are inevitable and invites readers to forward references to important findings relevant to this adaptation exercise that might have been overlooked.

Adaptation of the Transnational Competence Framework to Clinical Interactions

The first adaptive insight from the structured literature review concerns the role and relevance of the principal participants in the multinational clinical encounter. The Koehn/Rosenau framework, 2002, p 120 is built on the premise that "the transnational competence/incompetence of *all* parties to the knowledge exchange will affect the outcome of... knowledge transactions." In the medical consultation, there is substantial evidence that influence "is a two-way street" (Roter and Hall, 1992, p 16; Street, 1991). Findings from numerous clinical studies consistently show that, when treated as an interactive, partnership-based process (see Salloway et al., 1997) (one approach is "integrated patient-doctor interviewing," which "combines patient-centered and doctor-centered interviewing processes to elicit both personal and symptom data" [Smith, 1996, p 4]), the medical consultation directly and indirectly improves the outcome of health-care interventions (Smith, 1996; Jezewski, 1990; Fox, 2000; Roter and Hall, 1992; Street, 1991). Nevertheless, measures of interpersonal interaction in medical contexts often fail to incorporate the perspectives of nonmainstream populations, "primarily because they were not developed with these groups in mind" (Stewart et al., 1990, p 307). When adapting transnational competence to migrant-health-care situations, therefore, researchers must investigate the skills possessed or not possessed by care receivers as well as by care providers (also see Walker, 1996; Katz, 2002; Street, 1991; Ngai and Koehn, 2002; Kline and Huff, 1999).

Critical Dimensions

The framework elaborated by Koehn and Rosenau (2002) sets forth five distinct but interrelated domains of TC that are at work in the interpersonal interactions that arise in transnational contexts. Transnational competence involves mastery of analytic, emotional, creative/imaginative, communicative, and functional skills. Coincidently, the intervention categories found in the therapeutic-strategies model elaborated by Novack, 1995 closely approximate three of the five skills that constitute the transnational competence framework. Novack's model does not distinguish creative/innovative and communicative considerations. In the Koehn and Rosenau TC framework, each skill domain encompasses multiple dimensions. While each dimension contributes to skill competency, it is reasonable to expect that certain dimensions assume greater importance in specific contexts. In applying the framework to the health-care context generally and to transnational clinical care in particular, therefore, it is necessary to identify the most relevant components of competence in each skill area and, then, to define each in ways that facilitate skill assessment.

As a complement to extensive personal scholarly investigations of refugee conditions and adaptation (Koehn, 1991; Nagi and Koehn, 2002), I relied on published findings on cultural competence and on best practices in dynamic-interaction medical interviews (see Fox, 2000; Lipkin et al., 1995) in identifying those dimensions of each transnational skill domain that are particularly relevant in migrant–clinician interactions. Based on the results of this exercise, Table 1 highlights the dimensions of transnational competence that are expected to be of paramount importance when addressing migrant-health care.

Distinguishing Migrant-health-care Skill Domains

The third adaptive task involves specifying the highlighted dimensions of each TC skill domain for clinical encounters involving migrants. In this effort, I selected and extracted relevant, peer-reviewed, and empirically supported findings from medical-encounter research. These findings provided the basis for refined, contextually appropriate constructs of the key dimensions identified within the five skill domains comprising TC. In each case, emphasis is placed on generic skills that facilitate flexible responses to diverse cultural encounters (see Kai et al., 1999). A generic focus is critical because transnational competence aims to develop adaptable cross-culture skills that will be useful in encounters involving persons from a multiplicity of national (and subcultural) origins. In contrast, the goal of cultural-competence advocates often involves achieving mastery of one other (often domestic-origin) culture (Zweifler and Gonzalez, 1998). The following sections present the health-care-specific constructs that emerged from the literature review, along with their supporting sources, in considerable detail in order that this step toward developing a fruitful research instrument for transnational clinical interactions can be critically reviewed and enriched.

Transnational Analytic Skills

Transnational analytic competence involves the ability to acquire understanding of culturally unfamiliar and dis-

Table 1. Most Relevant Dimensions of Transnational Competence for Migrant-health Care

Analytic competence
Understanding of the central beliefs, values, practices, and paradoxes of counterpart culture(s) and society(ies)—including political and ethnic awareness[a]
Ability to link counterpart-country conditions to one's own circumstances and vice versa[a]
Number and complexity of alternative cultural paths assessed
Ability to discern effective transnational transaction strategies and to learn from past successes and failures
Emotional competence
Motivation and ability to open oneself up continuously to divergent cultural influences and experiences
Ability to assume genuine interest in, and to maintain respect for, different (especially counterpart) values, traditions, experiences, and challenges (i.e., intercultural/transnational, empathy)[a]
Ability to manage multiple identities
Sense of transnational efficacy[a]
Creative/imaginative competence
Ability to foresee the synergistic potential of diverse cultural perspectives in problem solving
Collaborative ability to articulate novel and shared transnational synthesis[a]
Ability to envision viable mutually acceptable alternatives
Ability to tap into diverse cultural sources for inspiration[a]
Behavioral competence
Communicative facility
Proficiency in, and use of, counterparts' spoken/written language
Skill in interpretation and in using an interpreter[a]
Proficiency in, and relaxed use of, interculturally appropriate nonverbal cues and codes[a]
Ability to listen to, and discern, different cultural messages[a]
Ability to engage in meaningful dialogue; to facilitate mutual self-disclosure[a]
Ability to avoid and resolve communication misunderstandings across diverse communication styles
Functional (project/task) adroitness
Ability to relate to counterpart(s) and to develop and maintain positive interpersonal relationships[a]
Ability to apply/adapt understanding, sensitivity, and imagination in transnational interactions
Flexible ability to employ extensive and nuanced range of transnationally accommodative organizational strategies and interaction paths
Ability to overcome problems/conflicts and accomplish goals when dealing with transnational professional challenges and globalization/localization pressures[a]

[a]These dimensions of transnational competence are expected to be of paramount importance when addressing migrant-health care.

similar information. The proximate reverberations of distant political events require that we develop expanded receptors for discerning determinants of individual health (see Martens et al., 2000). In the absence of transnational insight in the medical consultation, physicians are less likely to make helpful diagnoses in migrant-health-care situations because both clinicians and health-care recipients are prone to misinterpret explanations regarding the origins and nature of symptoms (see Gupta and Yick, 2001; Van Wieringen et al., 2002; Johnson et al., 1995; Barnes et al.,2000; Fadiman, 1997; Walker, 1994) as well as the meaning of the other's messages (see Lustig and Koester, 1996).

In the multinational learning context, the "bottom-up" approach to information gathering in which primary emphasis is placed on insights derived from proximate and current sources—the patient himself/herself and family, friends, and community members—is most reliable (Shapiro and Lenahan, 1996; Smedley et al., 2003). In light of the existence of subnational cultures and the intracultural (and changing) variations that occur due to "age, gender, income, education, acculturation, individual differences, and multiple other factors," general information about the patient's country and its endemic diseases, ethnic groups, or religious affiliations needs to be "regarded as having some bearing but requires further validation to be considered immediately

useful'' (Shapiro and Lenahan, 1996, pp 251–252, 254–255; see also Goldman et al., 1996; Kavanagh, 1999; Garcia, 2003). In this analytic process, the patient's narrative of lived experience is particularly revealing (see Hunter, 1991; Kavanagh, 1999). As Tervalon and Murray-Garcia, 1998, p 121 point out, ''only the patient is uniquely qualified to help the physician understand the intersection of race, ethnicity, religion, class, and so on in forming his (the patient's) identity and to clarify the relevance and impact of this intersection on the present illness or wellness experience''; that is, ''how little or how much culture has to do with that particular clinical encounter.'' Although developing appreciation for the patient's unique life-shaping experiences is time-consuming, information about life circumstances and illness meanings can be filled in over time in continuity-care situations (Shapiro and Lenahan, 1996; Hunter, 1991). For questions that help providers avoid undue reliance on generalizations, see Smedley et al. (2003). For a specific set of questions for use in identifying the social context of patients in spatial transition, see Carrillo et al. (1999). For a specific set of suggested direct questions aimed at eliciting the patient's explanatory framework and therapeutic goals, see Kleinman et al. (1978). For clinicians, transnational analytic skill in developing accurate and reasonably comprehensive understanding of potentially stressful global/local social and environmental factors—a ''mini ethnography'' of health, illness, and migration/adaptation experiences (Johnson et al., 1995; Cassell, 1985b; Lecca et al., 1998)—reduces prospects for costly and dangerous mistakes due to stereotypic oversimplifications and/or insufficient information (Andrews, 1999; Carrillo et al., 1999; Chassin et al., 1998; Nunez, 2000; AMA, 1999; Kai et al., 1999; Smedley et al., 2003), reveals unaddressed needs and uncovers opportunities in the meaningful context of the migration ''lifeworld'' (Barry et al., 2001; Roter and Hall, 1992), minimizes unrealistic expectations (Maynard, 1999; Bell et al., 2002), and avoids the overgeneralized tendency to perceive and treat migrants as traumatized victims (Eastmond, 1998). For patients, the parallel dimension of transnational analytic skill is the ability to understand clinician outlooks in personal rather than stereotypical terms (see Smedley et al., 2003).

An especially valuable transnational analytic skill involves the ability to ascertain the basis for indigenous and other nonstandard health-related beliefs, values, practices, and paradoxes (Jezewski, 1990; Nudelman,1994; Anderson, 1994; Downs et al., 1997; Harwood, 1981) and to assess the role of these factors in the pre- and post-migration explanatory model and decision-making processes of specific patients and/or families (Pachter, 2000; Kleinman, 1980; Skaer et al., 1996; DeSantis, 1997; Flores, 2000; AMA, 1999; Ma, 1999). Harwood (1981, pp 486–488) suggests that ethnocultural beliefs about illness are most likely to be influential in four circumstances: ''(1) in treating chronic disease ...; (2) in diagnosing and treating diseases that relate specifically to known folk etiological notions; (3) in treating conditions whose symptoms overlap in whole or in part with a culture-specific syndrome; and (4) in life-threatening situations ...'' and that ''certain general etiological ideas turn up quite consistently across groups. ''Harwood also cautions that ''it is important for the clinician to learn what the pharmacological properties are of the most popular preparations used by members of an ethnic group'' (p 494; also see Flores, 2000).

As Bostock et al. (1999), p 250 point out, ''experiences of psychological suffering may often be meaningfully linked with situations of powerlessness.'') Transnational analytic skill further involves abilities to comprehend critically the internal and external forces behind migration (Koehn, 1991; Kickbusch and Buse, 2001) by expanding the ''scope of medical discourse'' to include the linked macro-structural and micro ''social origins of personal suffering'' (Waitzkin,1991, p 276)—such as ''the effect of war and torture on certain refugee populations and how this shapes their interaction with the health care system'' (Smedley et al., 2003, p 205)—to perceive linkages between migrant health and local reception problems (Eastmond, 1998; Kavanagh, 1999), and to identify/reveal relevant health-care capabilities/community resources (Zweifler and Gonzalez, 1998; Patel and Fatimilehin, 1999) and post-migration constraints and stressors among specific migrant populations. For instance, a patient's ''capacity for self-care may be limited by the effects of guilt, shame and anxiety'' (Stanton et al., 1999/2000, p 27) as well as by ongoing ''cultural and linguistic isolation, fragmentation of the family, deformation of social relationships, chronic absence of adequate support systems, poverty, prejudice, and unemployment'' (Allden, 1998, p 32; also see Fox, 2000; Waitzkin, 1991; Anderson et al., 2001; Boyle, 1999; Meleis, 1996; House and Williams, 2000)—all rooted in migration and post-migration experiences.

Transnational Emotional Skills

Whereas analytic skills center on cognitive processes, emotional skills rely on perceptual capacities. Transnational emotional competence is facilitated by two other-directed

dispositions (sensitivity and support) and two self-directed orientations (efficacy and reflection).

The motivation to develop interest in new cultural patterns—language, family life, dietary practices (see Sharma et al., 1999), customs, etc.—and the ability to gain and maintain sensitivity and genuine respect for a multiplicity of values, beliefs, pleasant and unpleasant feelings (including sensitivity to emotional distress stemming from social circumstances such as "economic insecurity, racial or sexual discrimination, occupational stress, and difficulties in family life" [Waitzkin, 1991, p 123; House and Williams, 2000]), traditions, experiences, challenges, and preferred communication styles comprise emotional skills that enhance transnational competence by building affective connections and trust (see Hannigan, 1990; Taft, 1981; Smith, 1996). Thus, TC includes the ability to empathize, or vicariously experience for oneself and emotionally connect, with the perceptions, encounters, perspectives, concerns, and interaction styles (Pachter, 2000; Novack, 1995; Lazare et al., 1995; Smith, 1996; Dinges, 1983; Hannigan, 1990; Salovey et al., 2001) of the other participants in the medical consultation (Andrews and Herberg, 1999). Among care providers who engage in multinational encounters, such skills are developed through "willingness to try to understand the patient's perspective... no matter how little the physician knows of the patient's [specific] culture" (Zweifler and Gonzalez, 1998, p 1058).

In migrant-health interfaces, moreover, transnationally sensitive participants "anticipate culturally based problems or barriers which might arise before, during, or after the health care encounter" (Jezewski,1990, p 506). Based on this connection, they manage emotions in ways that offer support and "compassion with equanimity," are tailored to individual needs, experiences, and decisions (DiMatteo, 1997, p 7; Salovey et al., 2001; Deber et al., 1996; King, 2002), prove successful in reducing anxiety levels and in motivating health improvements in a sociophysiologic mutual-feedback-loop process (Adler, 2002). Furthermore, they respect rather than dismiss nonstandard (ethnocultural and alternative) health beliefs (including beliefs regarding the mediating effect of "luck, chance, randomness and personal destiny" on healthy lifestyles [Davison et al., 1992, pp 679–684]) and practices that affect recommendation/acceptance of, and compliance with, treatment protocols and, therefore, influence outcomes (see Oster et al., 2000; Fishman et al., 1993; Salgado de Snyder et al., 1998; AMA, 1999; Goode, 2001). Indeed, skilled participants appreciate that every medical encounter is a multidimensional interaction among the cultures of the patient, the physician, the support professional(s), and the health-care contexts/systems that surround them (see Nunez, 2000; Pachter, 2000; Smedley et al., 2003; Barnes et al., 2000).

A sense of personal, family, and/or group efficacy has been demonstrated to constitute a powerful determinant of a host of health-enhancement and illness-prevention outcomes (Bandura, 1995). Health-care efficacy, or confidence that one is capable of exercising control over modifiable aspects of behavior and that the result is likely to be improved personal health, is positively associated with both the adoption and maintenance of health-promoting actions (Schwarzer and Fuchs, 1995; Roter and Hall, 1992). Under the vulnerable and stressful environmental conditions that migrants face as the result of formidable language and cultural constraints, discrimination, the threat of long-term unemployment, and/or lack of social support, clinician appreciation for resilience and delegation of manageable self-care responsibilities reinforces individual and collective perceptions of transnational efficacy and strengthens confidence and perseverance to sustain new and/or demanding psychological and physiological health-enhancing behaviors (Jerusalem and Mittag, 1995; Schwarzer and Fuchs, 1995; also see Van Selm et al., 1997; Roter and Hall, 1992; Cooper-Patrick et al., 1999). On resilience as social competence and functional adequacy in spite of losses and stressors, see Muecke (1992). Andrews and Herberg, 1999, pp 73 emphasize the importance of affirming the "achievements and successes" of care seekers. Many "refugee patients and their families bring to health consultation stories of incredible human resilience in the most extreme circumstances" (Stanton et al., 1999/2000, p27; DeSantis, 1997). At the same time, emotional competence involves self-monitoring and reflection, accuracy in expressing one's feelings, and humility; that is, life-long openness to critical self-appraisal, to learning in place of stereotyping (Tervalon and Murray-Garcia, 1998), and to promoting emotional growth and personal well-being (Salovey et al., 2001).

Transnational Creative/Imaginative Skills

The freeing up of imaginative capacities is a powerful force for collective action. While imagination is recognized as an important part of everyday life (Appadurai, 1996), its potential transnational applications remain undeveloped. A key creative/imaginative skill for professionals and patients involved with migrant-health care is the ability to articulate

a novel and shared transnational synthesis. Skillful transnational actors are "creative synthesizers" (Bochner, 1981, p 17; also see Van Selm et al., 1997) who are able to inspire and to collaborate with participants of diverse identities in the design and nurturing of innovative and culturally/contextually appropriate action plans (Novack, 1995; Kim, 2001).

A substantial proportion of all health care is provided "outside the perimeter of the formal health care system" (Kleinman et al., 1978, p 251; Kavanagh,1999). In the migrant-health arena, therefore, creative approaches to managing demands for medical treatment and health protection include complementary integrations of biomedical and nonstandard explanatory frameworks and health-related practices (Pachter, 2000; Oster et al., 2000; Nudelman, 1994; Skaer et al., 1996; Wilson et al., 2000; Downs et al., 1997; Kleinman, 1980; Harwood, 1981; Kavanagh, 1999) and multilevel linkages of individual, socio-political, and ecological considerations (see Johnson et al., 2001; Martens and Hall, 2000). In the case of potentially harmful ethnocultural practices, creativity would involve the ability to "replace the folk remedy with another that fits into the patient's belief system" (Flores, 2000, p 19; also see Kleinman et al., 1978). Creative skills also involve ability on the part of participants in the medical consultation to relate physical and emotional experiences that shaped the decision to leave the homeland, as well as those encountered during migration and resettlement processes, to approaches that effectively address the patient's current health-promotion needs (Downs et al., 1997; Johnson et al., 2001) and to promising social changes and policy alternatives (Waitzkin, 1991). The medical consultation provides the critical context for active and creative involvement in health care "because it is there that patients can have the greatest impact on medical decisions and the course of treatment" (Greenfield et al., 1985, p 520; also see Dye and DiMatteo, 1995)—as long as clinicians are capable of "some degree of imaginative participation in their plight" (Hunter, 1991, p 167).

Transnational Communicative Facility

Language and nonverbal-communication skills constitute the most extensively studied and reported dimensions in the extensive literature dealing with intercultural communication (see, for instance, Taft, 1981; Hardt, 1995) and with cultural competence. Moreover, effective provider–patient communication is widely perceived as "a core competency in the health care profession" (Fox, 2000, p 27; also see Roter and Hall, 1992; Smedley et al., 2003).

Verbal fluency in the counterpart's first language—coupled with the "willingness to use it"—opens otherwise closed doors along the road to achieving analytic, emotional, and creative competence (Brislin, 1993, p 215; Lustig and Koester, 1996). In the clinical setting, provider inability to communicate in the migrant's native language is associated with difficulty in eliciting relevant information, interpreting nonverbal cues, building rapport, conveying respect and concern, planning treatments, counseling, and, consequently, with problems in assessment and providing adequate and satisfying health care (Padgett and Barrus, 1992; Silverman, 2000; Ferguson and Candib, 2002; Carrasquillo et al., 1999; Baker et al., 1998; David and Rhee, 1998; Smedley et al., 2003). At the same time, migrant difficulties communicating in the healer's language can distort the explanation of symptoms and the presentation of health-related complaints and limit access to, and recall of, important health-promotion information (Uniken-Venema et al., 1995; Ferguson and Candib, 2002). There is evidence that language discordance is costly in U.S. settings, possibly because physicians "compensate for the diminished power of the medical interview by increasing the intensity of laboratory and radiographic investigations" (Hampers et al., 1999, p 1255; Woloshin et al., 1995).

While personal linguistic fluency is an immense behavioral asset, achieving it is impractical in transnational health-care situations involving multiple and fluid first languages (see Zweifler and Gonzalez, 1998). Thus, multiple-language interactions, as well as situations where one or more participants are only partially bilingual, typically call for skill in interpretation and in using an interpreter (Baxter, 1983; Struwe, 1994; Hardt, 1995; Elderkin-Thompson et al., 2001; Harwood, 1981; Baker et al., 1998; Flores, 2000). When not available locally, trained medical interpreters can be involved via remote telephonic contact or interactive video (Padgett and Barrus, 1992; Nudelman, 1994; Hardt, 1995; Kuo and Fagan, 1999; Smedley et al, 2003). Transnationally skillful actors also develop proficiency in nonverbal-communicative behavior and in interpreting facial expressions, gestures, posturing, use of space, body movement, pace, silences, intensity, and other cues (see Ngai and Koehn, 2001; Ngai, 2001; Fox, 2000; Roter and Hall, 1992; Hall, 1995). In medical encounters, "nonverbal communication skills ... are as important as verbal skills, if not more so" (Waitzkin, 1984, p 2445; Lazare et al., 1995; Robbins et al, 1994). An actor skilled in

intercultural nonverbal communication typically responds in a relaxed, spontaneous, and emotionally expressive manner that builds rapport by being sensitive to the cues and codes embedded in participant behavior (DiMatteo, 1997; Taft, 1981; Nudelman,1994; Elderkin-Thompson et al., 2001). In transnational interactions, interview pace, speech-simplification strategies, and the use of ''continuers'' are particularly important in order to ensure that participants are not rushed, prematurely interrupted, ignored, or incompletely understood (DiMatteo, 1997; Wooldridge, 2001; Hardt, 1995; Lazare et al., 1995; Lipkin et al., 1995; Purtilo and Haddad, 2002).

Effective transnational communication further requires skills in articulating relevant information and uncertainities in comprehensible (nontechnical) fashion, in listening, and in eliciting concerns and explanations (DiMatteo, 1997; Van Wieringen et al., 2002; Novack, 1995; Hannigan, 1990; Lipkin et al., 1995; Waitzkin, 1991; Frederikson, 1995; Lecca et al., 1998). Quality decision making rests on successful communication partnership that involves mutual teaching (Oster et al., 2000; Ohmans, 1996). Communicative competence requires the ability to discern messages by appreciating contextually specific cultural rules. In this connection, communication-recovery skills, such as humor, apology, and admission that one does not know everything, are valuable ways of indicating one's openness to learning from the other. Concomitantly, these skills ''reinforce confidence as well as competence because, when it is known that there is something to fall back on, one is less likely to avoid interactions that may prove difficult'' (Kavanagh,1999, p 245; also see Tervalon and Murray-Garcia, 1998).

The capacity to engage in meaningful dialogue and to facilitate mutual self-disclosure (Dinges, 1983) via questioning is particularly important in transnational health-care situations characterized by vast social distance (DiMatteo, 1997; Ohmans, 1996; Robbins et al., 1994; Perry, 2001; Bell et al., 2002). Similarly, a prerequisite for generating appropriate treatment plans and commitment to agreements through cross-national negotiations is that participants—especially migrant patients—are comfortable expressing serious doubts and constructive challenges (DiMatteo, 1997; Waitzkin, 1991; Roter and Hall, 1992; Bell et al., 2002).

Transnational Functional Adroitness

Analytic, emotional, creative, and communicative skills provide no guarantee of behavioral or operational competence (Ruben, 1976; Kim, 2001). Frequently, ''it is the gap between what people *know* and what people *do* that remains to be bridged'' (Johnson et al., 2001, p 253). Functional competence involves the interpersonal as well as technical ability to accomplish tasks and projects. Actions, reactions, and prescriptions must be perceived as *appropriate*—that is, regarded as ''proper and suitable given the expectations generated by a given culture, the constraints of the specific situation, and the nature of the relationship between the interactants'' (Lustig and Koester, 1996, p 59; from the cultural-competence perspective, see Flores, 2000). It is useful in this connection to apply a definition of culturally appropriate health interventions that encompasses ''those that are both tailored to people's perceptual and situational realities, and embrace the importance of social, economic, and political factors in determining health behavior'' (Johnson et al., 2001, p 252; also see Carrillo et al., 1999). Behavior also must be viewed as *useful* for ''achieving mutual goals or satisfying the requirements of particular tasks'' by participants with diverse cultural identities (Dinges, 1983, p 193; Bradford et al., 2000; in the health context, see Dye and DiMatteo, 1995). In migrant-health-care encounters, the transnational functional skills of both patients and clinicians affect illness management and wellness promotion (Greenfield et al., 1985; Brach and Fraser, 2000).

Successful transnational actors are adept at establishing and maintaining meaningful interpersonal relationships (Hannigan, 1990). The establishment of positive interpersonal relations is particularly valuable for migrant-health care because ''in intercultural encounters, overall goodwill, respect, and enthusiasm allow people to generate 'credit,' and their credit allows mistakes to be ignored and forgiven'' (Brislin, 1993, p 215). In migrant-health-care interactions, one key to success in building fruitful transnational relationships is demonstrating genuine (and persistent) interest in the recipient/clinician as an individual (DiMatteo, 1997; van Ryn and Burke, 2001). For instance, one can evidence personal interest by exploring the unique ways others understand the world and interpret events, experiences, and challenges (Lustig and Koester, 1996; also see Skaer et al., 1996; Harwood, 1981; Andrews and Herberg, 1999) and by expressed caring for the other person's cognitive and instrumental needs (Adler, 2002; Lipkin et al., 1995). In the case of migrants who lack voice in the socio-political context they find themselves in, concern for patient well-being can be demonstrated by actions that address the institutionalized sources of

their personal troubles (Waitzkin, 1991; Woloshin et al., 1995).

In addition, functional adroitness requires skill in overcoming problems, constraints, conflicts, and uncertainties along with the ability/power to achieve mutual goals when dealing with transnational challenges and global/local tensions. Skill in attaining desired outcomes builds on transnational analytic, emotional, creative, and communicative competence. It encompasses the capacities to manage conflicting patient/provider beliefs regarding appropriate treatment (Jezewski, 1990), to channel emotions in ways that facilitate creative problem solving (Salovey et al., 2001), and to exert influence in negotiations between healer and recipient over ''time, space, resources, and control'' (Pappas, 1990, p 201; Cooper-Patrick et al., 1999). This dimension of functional competence also is promoted by establishing clinician/patient partnerships (Makoul, 2001) or ''therapeutic alliances'' (Tervalon and Murray-Garcia, 1998, p 121). Then, participants in the clinical encounter are positioned to arrange acceptable compromises that result in satisfaction with, and adherence to, treatment protocols (DiMatteo, 1997) by requesting and advancing options subject to cross-cultural negotiation (see Schoenhaus, 2001; Lustig and Koester, 1996; Oster et al., 2000; Harwood, 1981). According to DiMatteo (1997, p 13), ''the process of negotiation between practitioner and patient involves developing courses of action that are consistent with the patient's values and goals and that also satisfy the physician's values and goals'' (also see Coulehan and Block, 1997). On the processes involved in reaching mutually acceptable agreements among patients and providers through cross-cultural negotiations, see Carrillo et al. (1999).

For many migrants, transculturally sustainable agreements necessitate involvement by (extended) family and/or (migrant)-community support networks (Silverman, 2000; Novack, 1995; Salgado de Snyder et al., 1998; Weine et al., 2001; Dye and DiMatteo, 1995; Downs et al., 1997; Makoul, 2001; Stewart et al., 1999; Flores, 2000; Kleinman et al., 1978; Andrews and Herberg, 1999; Boyle, 1999; House and Williams, 2000; Brach and Fraser, 2000). In addition, in the interest of equitable health care for migrant patients, transnational functional adroitness often necessitates advocacy competence; that is, recommendations/actions that advance changes in certain local and international economic, social, institutional, and policy conditions (Farmer, 1999; Pappas, 1990; Smedley et al., 2003; Smedley and Syme, 2000; Lee et al., 2002).

Research Applications

The next step toward applying the TC framework to challenges of migrant-health care is to define the adapted skill dimensions, or variables, in ways that are conducive to evidence gathering, assessing the impact of transnational strengths and deficiencies on health-care outcomes (also see Culhane-Pera et al., 2000), and targeting specific skills for practitioner training and/or patient education. In order to analyze the extent to which patients and healers of diverse racial, nationality, linguistic, religious, identity, and class backgrounds (also see Fox, 2000) possess the most relevant components of each transnational skill domain through qualitative or quantitative investigations, it is necessary to identify item stems, or descriptors, that are understandable and unambiguous to all participants in the health-care interaction. For skill-focused research, most item stems should measure perceptions of ''what actually occurred'' (Stewart et al., 1999, p 308). The sections that follow identify item stems adapted, slightly modified, or developed de novo by the author based on review of existing literature and respected surveys regarding physician–patient interactions and cultural competence. Although interview time constraints necessitated item selectivity, the author incorporated most of these item stems into the intersubjective survey instrument that guided his exploratory Fulbright New Century Scholar research project in Finland during the summer of 2002. Response choices were yes, partly, and no.

Analytic Skills

Research on patient-provider communication and on cultural competence in clinical consultations suggests that the extent to which participants possess transnational analytic skills in the migrant-health-care context can be investigated fruitfully by focusing on five discriminating analytic abilities (see Johnson et al., 2001; Kim, 2001). These analytic skills, which draw upon what might be considered ''critical epidemiology'' (see Farmer, 1999, p 5) and efforts to incorporate the perspectives and experiences of persons ''at greatest risk for loss of voice'' (Roter et al., 2001, p 81), involve clinician/patient *understanding* of:

- the conditions that led the migrant patient to leave his/her homeland (migrants understand why they left the homeland. For them, the parallel analytic challenge involves grasping the conditions that affect life in the host society);

- the *health-care* conditions that the migrant faces in the host society;
- the beliefs and practices of the migrant's culture and of the clinician's biomedical framework regarding the causes, treatment, and prevention of illness (Kleinman et al., 1978; Ma, 1999);
- the other's personal beliefs and practices regarding the causes, treatment, and prevention of illness (Pachter, 2000; Elderkin-Thompson et al., 2001; Perry, 2001); and
- connections between the migrant's life circumstances and his/her (family's) current health-care needs.

Emotional Skills

The extent to which migrants, physicians, and supporting health-care professionals possess the most relevant transnational emotional skills can be assessed intersubjectively with reference to six basic items. These are:

- openness to respecting the patient's/provider's health-related beliefs, practices, and agenda (see DiMatteo, 1997; Kline and Huff, 1999);
- valuing and reinforcing the other's ability/contributions to overcome challenges faced as a migrant or in helping migrants (see Smith, 1996; Kline and Huff, 1999);
- having an optimistic outlook on prospects that the care provider can make a difference in meeting the migrant's health-care needs (Novack, 1995; Stewart et al., 1999);
- acknowledging and validating the other's beliefs and practices (Western biomedical, ethnocultural, or nonstandard) regarding the causes, treatment, and prevention of illness even if one does not agree with them (Pachter, 2000; Oster et al., 2000; Johnson et al., 1995; Lazare et al., 1995; Smith, 1996; Barry et al., 2001; Stewart et al., 1999; AMA, 1999; Coulehan and Block, 1997);
- being personally interested in and concerned about the migrant's health (Roter and Hall, 1992; Stewart et al., 1999); and
- openness to being accepted in the other's (migrant or host) culture (Kim, 2001; Andrews, 1999; St. Clair and McKenry, 1999).

Creative/Imaginative Skills

Creative/imaginative skills can be assessed in the migrant-health-care context in terms of five items. First, does the migrant contribute ideas about his/her own health care and does the healer help establish and reinforce an atmosphere that is conducive to the contribution of problem-solving ideas (see Roter et al., 2001; Roter and Hall, 1992; Miller, 2001)? Second, are the participants able to apply the deciphered physical and emotional experiences of the migrant in addressing his/her current illness/health needs? Third, does the care provider suggest, and does the patient utilize, complementary combinations of Western medicine and the traditional health-care beliefs and practices of his/her culture (Pachter, 2000; Stewart et al., 1999)? Skaer et al., 1996, p 33 suggest that "health care practitioners need to make a standard practice of asking their patients about their use of folk remedies and/or nontraditional providers," while the AMA's *Guide to Talking to Your Doctor* recommends, "always tell your doctor about any alternative therapy you are using" (Perry, 2001, pp 99–100). Fourth, are participants able to recommend health-care practices or coping strategies that are suitable for the conditions that migrants similarly situated in the host society face (Hassinen-Ali-Azzani, 2002)? Fifth, does the migrant suggest ideas about his/her health-care goals/treatment and does the clinician include such suggestions in his/her recommendations (Street, 1991; Lecca et al., 1998)?

Communicative Skills

Seven items guide operationalization of communicative skills in the analysis of migrant–physician-support professional interactions. They are:

- ability to communicate in the other's first language (or in a mutually understood third language such as English) concerning health conditions and treatment (Flores, 2000);
- ability to communicate with the patient/clinician through an interpreter when necessary (Ferguson and Candib, 2002);
- use of culturally appropriate non-verbal communication (such as interview pace and gestures);
- the ability to express (encourage expression of) health-related worries and questions (Lazare et al., 1995; Dye and DiMatteo, 1995; Roter and Hall, 1992; Street, 1991; Putnam and Lipkin, 1995);
- the ability to listen attentively to the other in a genuine effort to comprehend and to take seriously what s/he is saying (Novack, 1995; Stewart et al., 1999; Morales et al., 1999; Cassell, 1985; Roter and Hall, 1992; Harwood, 1981; Saha et al., 1999);

- the ability to express (encourage expression of) uncertainties, doubts, and disagreements (Dye and DiMatteo, 1995; Waitzkin, 1991; Dressler and Oths, 1997; Street, 1991); and
- the ability to convey health/illness information (or health-care instructions) and to answer/raise questions in a way that the other can understand fully (Morales et al., 1999; Roter and Hall, 1992; Harwood, 1981; Perry,2001; Saha et al., 1999; David and Rhee, 1998; Stewart et al., 1999; Putnam and Lipkin, 1995).

Functional Skills

Functional skills can be assessed in the migrant-health-care context with reference to 10 items.

These items are:

- showing that one cares about the other individual's personal situation and troubles (Novack, 1995; Harwood, 1981; Stewart et al., 1999; Flores, 2000);
- not treating the patient/clinician in a way that makes him/her upset (Roter and Hall, 1992; Stewart et al., 1999);
- relating to the patient/provider in a way that builds mutual trust (see Pachter, 2000; Oster et al., 2000; Watters, 2001; Mollica et al., 1987; Mechanic, 1996);
- joint participation (involving the migrant) in making health/illness assessments (Lazare et al., 1995; Dye and DiMatteo, 1995; Roter and Hall, 1992; Stewart et al., 1999);
- offering (suggesting ways to make) health-care instructions that are easy to adhere to (Dye and DiMatteo, 1995);
- taking into consideration the influence of family and/or community members on the patient's illness/health situation (Lazare et al., 1995; Roter and Hall, 1992; Harwood, 1981);
- requesting/giving (and explaining expected risks and benefits associated with) alternatives and choices before decisions are reached regarding health-care measures (Roter et al., 2001; Deber et al., 1996; Cassell, 1985b; Golin et al., 2002; Braddock et al., 1999; Cooper-Patrick et al., 1999);
- making an effort(s) to activate societal resources that are likely to enhance the migrant's health situation; and
- perceived likelihood that the clinician would provide health care effectively in the migrant's homeland or that the migrant will exercise responsibility for thoughtful and effective health behavior in the receiving land (see Roter et al., 2001; Kaplan et al., 1995).

Conclusions

As more people in spatial transition compress the distance/time transmission of life-threatening infectious and chronic lifestyle-linked diseases, migrant-health protection and treatment will assume increasing consequence for individual patients and receiving societies/health-care systems. In a variety of ways, "all members of a community are affected by the poor health status of its least healthy members" (Smedley et al., 2003, p 37; also see Buse et al., 2002).

The health-care consultation provides the primary context within which migrants of multiple nationalities and culturally dissimilar clinicians engage in reactive and proactive interactions. The evidence compiled from a wide range of quantitative and qualitative studies of single-culture and bicultural patient–clinician interactions gives us ample reason to expect that these transnational medical encounters will profoundly shape critical global/local health-care outcomes—including the provision of treatment/preventive opportunities and migrant satisfaction/dissatisfaction with provider care, confidence/lack of confidence in Western biomedical and nonstandard treatments for personal health futures (DiMatteo, 1997), adherence/nonadherence to advice and instructions (Van Wieringen, et al., 2002; Dye and DiMatteo, 1995; Lau, 1997), and effective/ineffective health behavior in the new environment. In our efforts to identify "key elements of what would constitute a virtuous cycle of health governance" in today's interdependent world and to explore these components with "creative and rigorous research" (Kickbusch, 2003) the potential contribution of transnational competence in migrant-health-care encounters should not be overlooked by researchers and educators.

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