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Cross-Cultural Competence in Transnational Medical Education Partnership

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Abstract
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Dedication

This work is dedicated to my loving and supportive husband, Bert; wonderful and cheer-leading daughter, Natasha; son-in-law Earl; adorable and delightful grandchildren, Chloe, Aidan, and Joshua; and the rest of my family, Elizabeth, Cheryl, Lennox, Ayanna, Richard, Rosita, and Yvette. Your love, humor, and support strengthened and cushioned me during this doctoral journey. Finally, this work is dedicated to the memory of my mother, Ellena; father, Kenneth; and godfather, Lionel who instilled in me a life-long love for learning. I embarked on this journey to be an exemplar for my grandchildren, that they too will aspire to leadership and experience the psychological completeness of education, for I firmly believe that leadership is the highest education.

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Biographical Sketch

Greta Rosalie Strong is presently employed as the Special Assistant to the Chairman of Neurology at Weill Cornell Medical College-New York Presbyterian Hospital. She is also an Adjunct Professor at a New York City college. She attended Metropolitan College of New York and graduated with a Master of Public Administration degree in 2003. She also obtained a Master of Mental Health degree from Touro College in 2008. She came to St. John Fisher College in the spring of 2011 and began doctoral studies in the Ed.D., Program in Executive Leadership. Mrs. Strong pursued her research in "Cross-Cultural Competence in Transnational Medical Education Partnership" under the direction of Dr. C. Michael Robinson and Dr. Brezetta Griffith-Bullock and earned the Ed.D., degree in 2013.

Mrs. Strong is the recipient of a number of honors and awards. She is a member of the National Scholars Honor Society; Pi Alpha Alpha, the Academic Honor Society of the National Society for Public Affairs and Administration; and Kappa Delta Pi, the International Honor Society in Education. For leadership, dedication, and service to the community, she is the recipient of the National Medal of Honor for Inspiring Initiative-September 12th Guild; the National Council of Negro Women, Executive Leadership Award (2012), two Certificates of Special Congressional Recognition from members of the U.S. House of Representatives, Congressman Joseph Crowley and Congressman Eliot L. Engel, and an Official Citation from the New York State Senate, Senator Ruth Hassell-Thompson. Mrs. Strong is the Vice President of Vitiligo Bond, Inc., a 501c (3) support

group for people living with Vitiligo and a Stroke Advocate for the National Stroke Association.

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To accomplish this, the research used a qualitative grounded theory approach to explore the experiences of twenty-five professionals involved in transnational medical education partnership. The research was conducted at Weill Cornell Medical College in New York and Weill Cornell Medical College in Qatar. Interviews served as the main source for the study. Narrative inquiry consisted of audio-recording, documentation, and analyses of the individual accounts and experiences of the participants.

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competencies necessary for maintaining successful partnership. It will also influence other researchers who design studies to test the theory in practice and provide theory for health care professionals requiring extensive cross-cultural competence to engage and collaborate successfully. Lastly, the study contributed to the literature on cross-cultural competence in transnational medical education partnership.

Table of Contents

List of Tables

Chapter 1: Introduction

Introduction

Globalization has become a transformational and powerful factor in the field of health care and education (Segouin, Hodges, & Brechat, 2005). It has increased economic competitiveness, forcing many countries to meet a global demand for education that is obtainable, pertinent, and non-discriminatory (Hodges, Maniate, Martimianakis, AlSuwaidan, & Segouin, 2009; Sahlberg, 2006; Tilak, 2011). Presently, many institutions of learning are involved in transnational activities such as partnerships and franchise agreements (Altbach, Reisberg, & Rumbley, 2009; Knight, 2006). In the field of medicine, transnational medical education is evolving into a growing and desirable field for students choosing to study under these forms of partnerships and agreements (Knight, 2006; McBurnie & Pollock, 1998; Stella & Granam, 2004). This has presented challenges and opportunities for health care professionals who navigate in cultures of difference both nationally and internationally (Bertucci & Alberti, 2004). For this reason, cross-cultural competence has become an important asset for health care professionals involved in transnational medical education partnerships and agreements (Harvey & Williams, 2010; Koehn & Rosenau, 2002).

The integration of cross-cultural competence can be problematic in transcending cultures (Blackmer, 2007; Gates & Bradley, 2009; Janus & Smythe, 2011/2012; The California Endowment, 2003) and failure to be aware of and acknowledge cross-cultural differences can present challenges and cause conflicts and problems across cultures

(Taylor & Gegios, 2010). Negligence in attending to appropriate cross-cultural behaviors can endanger partnerships or agreements of institutions involved in transnational education ventures (Gates & Bradley, 2009; Selmeski, 2007). Lack of cross-cultural expertise can also affect the "well-being" (Witsel, 2008, p. 5) of professionals who operate in the context of stark cultural differences. Medical professional must become proficient in demonstrating appropriate behaviors, understanding problems, and navigating intelligently (Adler, 1997; Harris, Moran, & Moran, 2004; Schein, 2004; Selmeski, 2007; Taylor & Gegios, 2010).

The purposes of this study were to discover the knowledge, behaviors, and skills that foster cross-cultural competence in transnational medical education partnership and to unite the research process with theory development using a qualitative grounded theory approach. This method was used to explore and identify the knowledge, behaviors, and skills that foster cross-cultural competence, which could be new or useful in the context of transnational medical education partnership.

The findings of this study provided empirical support of real-world guidance for medical professionals who navigate in environments where cultural differences are prevalent. The focus of chapter one was to articulate the problem statement, statement of purpose, and formulate the research question. This chapter also discussed the significance, purpose of study, provided definitions of terminology, and concluded in a summary.

Statement of the Problem

Transnational education is often considered as the franchising of institutions and programs (Adam, 2001). It also takes other forms of delivery such as may be found in

"branch campuses, off-shore institutions, corporate universities, international institutions, and distance learning" (Adam 2001; Council of Europe/UNESCO, 2000, p. 12) agreements, arrangements, and partnerships. The Global Alliance for Transnational Education [GATE], defined "transnational education as an export product" (GATE, 1997, p. 1). As such, the teaching and learning of "students are in a different country" usually referred to as the "host country" (GATE, 1997, p. 1). The provider of the educational product is referred to as the "home country" (Adam, 2001; GATE, 1997, p. 1).

GATE is an advocate for policy standards in the certification of transnational education programs (GATE, 1997). One of these standards is that professionals must have "an adequate levels of cross-cultural expertise, sensitivity, and awareness" (GATE, 1997, p. 1; Greenholtz, 2000). Bean (2006) cautioned, that institutions should not believe that only knowledge and skills are adequate for professionals to navigate successfully in these transcultural ventures. Transnational institutions of higher learning must, therefore, adopt and provide greater standardization of a code of skills, knowledge, and behaviors of what constitutes cross-cultural competence in the delivery of transnational medical education (Nicaise, 2008). This is central to ensuring that professionals who straddle cultures are culturally-aware, able to navigate effectively and appropriately, and balance the duties that are required by the institution and profession (Borduas et al., 2006; Witsel, 2008).

The impetus for this research arose from the increase in transnational medical education enterprises. Literature reviewed focused on workplace diversity and intercultural communication in the U.S. workforce and authors found a lack of agreement in defining what constitutes both appropriateness and effectiveness in cross-cultural

settings (Abbe, Gulick, & Herman, 2007; Nicaise, 2008; Johnson, Lenartowicz, & Apud, 2006; Selmeski, 2007). Many international business research articles did not classify models of knowledge, behaviors, and skills, and how they can be applied in the cross-cultural context (Abbe, Gulick, & Herman, 2007). Authors prominent in the field of cross-cultural competence defined it as specific knowledge, skills, and abilities that must be appropriately applied to function effectively in different national cultures, (Adler & Bartholomew, 1992; Hofstede, 1980, 2001; Leiba-O'Sullivan, 1999). Cross-cultural competence has also been described as abilities that allow us to increase awareness of how our beliefs, values, and attitudes influence the manner in which we perceive issues of mutuality, reciprocity, and interdependence (Barrera, 2000; Barrera & Corso, 2002; Barrera, Corso, & MacPherson, 2003). There were divergent views on the definition of cross-cultural competence and the absence of a universal definition compounded the confusion.

Cross-cultural competence has been studied in various contexts and overlooked in medical professionals involved in transnational medical education partnership. Studies examining cross-cultural competence revealed multiple factors that impact it. There is a dearth of studies where the applicability of these factors was examined in this particular environment. The literature on cross-cultural competence in the medical profession contained robust and engaging discussions on achieving cultural competency in health care, medical schools incorporating international experiences in the curriculum for future doctors, and health disparities in minority populations. These articles focused on culture and the patient-physician relationship, valuing ethnic diversity, and how culture affects illness and care.

There is limited literature on cross-cultural competence in transnational medical education (Greenholtz, 2000). A modicum of concepts pertinent to cross-cultural competence in transnational medical education limited the framing of this study from an existing theoretical framework. Such a framework would have been useful in providing the basis for training health care professionals involved in transnational encounters. There were few studies on the impact that culture plays on transnational education partnerships and research has been based on small studies (Helms, 2008; Walton & Guarisco, 2007).

Significance of the Study

Globalization has caused the world to be connected through the growth of transnational organizations and networks (Freitag, 2002; Lustig & Koester, 2010). Transnational medical education ventures and enterprises will contribute to the strength of global medicine and transforming learning societies into knowledge economies (Bloom, Canning, & Sevilla, 2004; Bloom & Cohen, 2002; Dodani & LaPorte, 2005; Skorton, 2010, 2012; World Bank, 2002). For the field of medicine and education, transnational medical education has important implications on how medical education is delivered (O'Brien, Alfano, & Magnusson, 2007).

If improperly managed, modeled, and codified, cross-cultural collaborations can adversely affect the quality of transnational partnerships and agreements (GATE, 1997; McBurnie & Pollock; Knight, 2006). In the process of identifying what trends most impacted the increased importance of cross-cultural competence in transnational medical education; there was reason to believe that there will be a greater global demand for transnational partnerships in the future (Drain et al., 2007). "Transnational education is

not a new phenomenon" (Adam, 2001, p. 4). Experts would agree that what is alarming is how the field of transnational education has grown (Adam 2001; Ramsaran, 2003). This pace has brought "challenges and opportunities for individual institutions" (Adam, 2001, Preface. para, 2) and organizations engaged in this process.

The importance of possessing skills, knowledge, and behaviors that define cross-cultural competence has emerged as a result of this expansion of partnerships across regions (Boyle & Sastrowardoyo, 2012; Knight, 2005). Cross-cultural competence has caught the attention of many organizations and must become a part of institutional policies and procedures for successful interactions, nationally and internationally (Bean, 2006; Sinicrope, Norris, & Watanabe, 2007). There must be a "process of integrating an international and intercultural dimension into teaching, research, and service functions of the institution" (Knight, 1994, p. 7)

The "scope and aspiration of Cornell University" (Skorton, 2012, p. 1) has been an international one and began with the vision of Ezra Cornell (Skorton, 2012), who felt that the Cornell University should be an institution where people could find instruction in a variety of programs (Cornell, 1868), and that education should be accessible globally and not limited to the U.S. (Skorton, 2012). At Weill Cornell Medical College-New York (WCMC-NY) a lot of emphasis is placed on global health. This constitutes "overseas healthcare, research, and educational activities" (Skorton, 2012, p. 2), which foster student and faculty exchange (Skorton, 2012), the improvement of health and equity worldwide, and "global public health success" (Global Health Action, 2010, p.13). WCMC-NY is partner to a growing number of health and education networks with institutions on many continents. There are also "joint study and exchange programs with

China, India, and Singapore and Cornell-administered programs in Europe and Japan, the Arecibo Observatory in Puerto Rico, and biodiversity field stations in the Dominican Republic and Peru" (WCMC-Q, 2013, para. 5).

The State of Qatar is one of the most economically and socially dynamic countries in the Middle East and the world and "is building capacity among its youth by investing heavily in education" (Hamod, 2011, p. 2) research and patient care in Qatar and the region (WCMC-Q, 2003). In recent years, Qatar has positioned itself as a country dedicated to the field of education "in its commitment to the dissemination of knowledge" (Sheikh, 2013, para. 4). In 2002, WCMC-Q established academic partnership operations between Qatar Foundation and Cornell University, offering a "unique six-year American curriculum, which includes premedical and medical education leading to the same medical degree awarded to graduates of WCMC-NY" (Skorton, 2012, p. 10; WCMC-Q, 2003). Supported by the Qatar Foundation, it is "participating in a project of extraordinary courage and promise for the region and the rest of the world" (Lehman, 2003, p. 2).

Many medical students will "become leaders and innovators in the planning and delivery of medical care in Qatar and the region" (Gotto, 2003, p.1) which will "lead to a generation of superb physicians, medical advances, and better healthcare" (Gotto, 2003, p. 4). The institutional strategic plan of WCMC-Q is to establish "distinguished centers of excellence in education, research and clinical training; unifying its tripartite mission of education, research, and patient care with Hamad Medical Corporation and Sidra Medical and Research Center in Qatar (Sheikh, 2011, p. 1)". These centers of learning will contribute "significantly to developing a Qatari biomedical work force" (Sheikh, 2011, p.

1) making Qatar a center for international collaborations (Hamod, 2011; Lehman, 2003; Skorton, 2012; WCMC-NY, 2013; WCMC-NY, 2013). To be economically successful in the global arena, institutions must train ambassadors linked to transnational medical education partnerships of this kind (Fantini, 2000).

Medical professionals who travel abroad yearly and engage in ongoing collaborations must adapt to different cultural environments, and reflect upon how their personal and professional experiences and preconceived ideas will influence their behaviors and attitudes (Yukl, 2006). A worldview and appreciation for understanding cross-cultural competence will foster satisfying partnerships in cross-cultural collaborations (Lustig & Koester, 2006; Slimbach, 2005).

A theory grounded in data was central to a foundation from which to develop meaningful attitudes, skills, behaviors, and knowledge. The audiences for this study are medical educators, curricula developers, lecturers, and trainers involved "in the social processes explained by the theory…to test the theory in practice" (Starks & Trinidad, 2007, p. 1377) and provide theory for medical professionals who require extensive cross-cultural competence to teach, exchange expertise, and collaborate successfully. The study will sharpen the skills, knowledge, and abilities of health care professionals who interact in cultures of difference across the globe (Kundu, 2001; Lustig & Koester, 2010). Academic programs, policy frameworks, and studies should also be designed with a view to strengthening cross-cultural training programs already in place within many institutions (Black & Mendenhall, 1990).

Purpose of the Study

The purposes of the study were to discover the knowledge, behaviors, and skills that foster cross-cultural competence in transnational medical education partnership and to unite the research process with theory development. The literature review uncovered unresolved issues of knowledge behaviors, and skills that must be applied in this context. Several studies contradicted each other, since there was no standard nomenclature. In many instances, the same terminology referred to different relationships. There were no generally accepted taxonomies about skills, attitudes, and behaviors that describe cross-cultural effectiveness in this context. Recognized was a diversity of definitions on cross-cultural competence with no universal definition.

In the development of this study, the goal was to investigate the knowledge, behaviors, and skills of a population of academicians involved in transnational medical education. The overarching goal of this study was to use the findings of a qualitative grounded theory approach to reflect the unique concepts of cross-cultural competence in transnational medical education. This theory is useful for professional development training, knowledge management, services related to cross-cultural competence, and future research.

Undertaking this study provided a rationale for seeking predictors for cross-cultural competence in transnational medical education partnership. The approach was to identify what medical professionals should know, be, and do. This study contributed to knowledge and practice in the field of cross-cultural competence. It filled a void since cross-cultural competence has been under-studied in this population, in the context of

transnational medical education partnership. It also extends research in the field of cross-cultural competence.

Research Question

This principal question of the research to explore important information was: What knowledge, behaviors, and skills foster cross-cultural competence in transnational medical education partnership?

Definitions of Terms

The study included a number of terms with various interpretations. To facilitate understanding of terminology, definitions are presented below:

1. **Conscious-conscientiousness**. The study generated this term to refer to: "Awareness and purposeful processing that drives understanding and genuine behaviors; vigilance in the communicative process for nuances of verbal and non-verbal interactions; immersion in interests and goals of interdependent parties to achieve shared mission and vision that value, protect, and promote partnerships" (Strong, 2013).
2. **Cross-cultural competence**. The study utilized this term to include individuals who function in international organizations and partnerships. This term refers to "the diverse array of beliefs, values, and attitudes that influence the building of trust, mutual respect, and shared goals to facilitate communication" (Cross, Bazron, Dennis, & Isaacs, 1989).
3. **Cultural competence**. "Specialized-knowledge about a distinct set of behaviors, attitudes, and skills that allows an individual to perform effectively in different cultural environments" (Slimbach, 2005).

4. **Culture general**. "Information that provides insight into the many ways that culture influences behavior" (Lustig & Koester, 2010).
5. **Culture specific**. "Information that provides understanding of a particular culture and the forces that maintain the culture's uniqueness" (Lustig & Koester, 2010).
6. **Knowing and doing**. "The possession of various attributes, knowledge, and skills, and the ability to use and adapt them in a cross-cultural environment" (Johnson, Lenartowicz, & Apud, 2006).
7. **Knowledge**. "The cognitive information you need to have about the people, context, and norms of appropriateness that operate in a specific culture" (Lustig & Koester, 2010).
8. **Mutual generativity**. This study generated this term to refer to: "Teamwork and interdependency that reinforces transnational relationship building, positive group behaviors, and skills competence that can affect knowledge generation. This competence is instrumental in project completion, goal achievement, and can carve footprints for present and future generations. It binds the efforts of synergistic respect and conscientiousness to harmonic relationships" (Strong, 2013).
9. **Perspective consciousness.** The ability to question constantly the source of one's cultural assumptions and ethical judgments, leading to the habit of seeing things through the minds and hearts of others" (Slimbach, 2005, p. 206).
10. **Transnational medical education.** "Formal partnership between two

agencies; often considered in relation to the franchising of institutions and programs. It also takes other forms of delivery such as branch campuses, off-shore institutions, corporate universities, international institutions, and distance learning arrangements" (Council of Europe/UNESCO, 2000).

Chapter Summary

Based on the preceding sections of this chapter, the groundwork is provided to explain the following in Chapter 2: (a) globalization, (b) education, policy makers, and critical consciousness, (c) globalization and the transnational education commitment, (d) trends in the transnational medical education field, (e) globalization and medical partnerships in the Middle East, (f) culture and cultural competence, (g) cross-cultural competence and cross-cultural training, and, (h) grounded theory.

The research question for this study sought to discover the cross-cultural experiences of respondents in a transnational medical education partnership. Few studies have investigated the process in such a way that involved this approach. For the future of scholarship in the area of transnational medical education, it was important to develop a line of inquiry. The experiences of the health care professionals, students, and host country personnel at the center of the process, provided important information on cross-cultural competence. The purpose was to formulate these experiences as a foundation for a theoretical model. Grounded theory was useful for this project to offer a conceptual framework that can be applicable for this population.

Chapter 3 provides the research design methodology, which includes the research question, overall research design, context, participants, instruments, and procedures used in data collection and analysis. Chapter 4 provides the data analysis and findings with

significant responses generated from interviews. Chapter 5 includes study implications, and addresses the study's limitations and recommendations. The lessons learned sum up the data.

Chapter 2: Review of the Literature

Introduction and Purpose

Chapter 1 provided an overview of the research subject area and revealed the nature of the study and its primary question. Chapter 2 provides a review of relevant bodies of literature examining globalization, transnational medical education, culture and cultural-competence, cross-cultural competence and cross-cultural training, and grounded theory methodology. A summary of Chapter 2 follows.

Globalization

Most scholars suggest that globalization is not new (Ramsaran, 2003), and "best conceptualized as a long process of change" (Hardt & Negri, 2000, p. 15) linked to socio-economic forces and emerged through distinct historical periods (Jameson & Miyoshi, 1998; Mignolo, 1998; Sen, 2000). Other scholars have pointed out that many disciplines have their own definition of the term globalization (Bauman, 1998), and agree that the effects of globalization raise questions on policies that affect world affairs (Bauman, 1998; Ross-Holst, 2003; Smouts, 2001). They also believed that whenever events, decisions, and activities take place in one part of the world, opportunities and threats can significantly affect other nations, individuals, and communities (Groupe de Lisbonne, 1995). In order to combat fluctuations that take place in the global marketplace, they felt that a "well-educated, skilled, and adaptable workforce…able to embrace change" (Group de Lisbonne, 1995, p. 33) can lessen these uncertainties. In a white paper on the tensions that globalization can cause Rothenberg (2002-2003) questioned what

constitutes globalization. He examined whether it was the "integration of forces of economic, political, and cultural systems across the globe" (Rothenberg, p. 1). He questioned the "Americanization of world culture, and U.S. dominance on world affairs" (Rothenberg, p. 1). He wondered whether globalization was a "force for the growth of economic prosperity and democracy" (Rothenberg, p. 2). He was concerned about its potency to cause devastation to the environment, exploitation of the developing world, and suppression of human rights. He questioned the potential of globalization as a force for "good or bad" (Rothenberg, p. 3) and came to the realization that the answers will depend on which part of the world you are located. He subsequently recognized globalization as a process that "accelerates and augments interactions and integration among people, companies, and governments of different nations" (Rothenberg, p. 2). He believed that these forces brought about major effects on health and personal safety; "impacted the environment, culture, ideas, religion, political systems, economic development, and the prosperity of societies worldwide" (Rothenberg 2002-2003, p. 2). Similarly, Rodrigues-Diaz (2007) viewed globalization as a worldwide phenomenon of change, which redesigned the world's economy, an "inevitable developmental process" (Frankic & Hershner, 2003, p. 519).

Globalization demands well thought out plans, policies, strategies, procedures, and responses to the environment to promote sustainable economic growth and prosperity (Ramsaran, 2003). For this reason, globalization has caused individuals, governments, and institutions to focus their lenses on the improvement of human development and social capital and the education of its citizenry (Chan, Leung, & Flynn, 2002; Ruperez, 2003). The economics of globalization and its potential for the impoverishment of entire

societies and nations have demanded that governments strengthen their capacity for institutions of education that promote economic development and well-being (Bloom, Canning, & Sevilla, 2004) and "improved capacity to respond" (Ruperez, 2003, p. 258) to the global environment.

Education, Policy Makers, and Critical Consciousness

A world-class education system that is competitive is the conduit to economic opportunities (Ruperez, 2003; The World Bank's Group Education Strategy, 2011). Education is an engine for growth to support, sustain, and guarantee positive human growth and development (UNESCO, 2000). These factors are important in significantly reducing poverty, risks, and threats to long-term stability, improvement of health resources and outcomes, and equality for men and women in the global workforce (Bloom, 2002; Diaz-Bonilla, Babinard, Pinstrup-Andersen, & Thomas, 2002; The World Bank's Group Education Sector Strategy, 2011). In the global marketplace, education is central to transforming developing economies into learning nations, making knowledge and information the foundation for withstanding the demands of the negative or positive forces of globalization and the rigors of economic and social development (Carnoy & Rhoten, 2002; Gobbo, 2008).

The European Community Commission (1995) referred to knowledge societies as learning societies. Member nations of this commission believe that the demands of education and lifelong learning are connected to sustainable economic growth. Because of human development initiatives, China became a market-oriented economy, which was built on the "high literacy levels" (Sen 1999, pp. 42, 43) of its population. This growth began in 1979, when Deng Xiaoping's reformed his country through the use of (Zhang,

1996) “strong basic education policies” (Sen, 1999, pp. 42, 43). It was the belief of China’s governing institutions that in providing its citizenry with a solid education, they would broaden human and economic capital (Gries, 2004; Schultz, 1961; Sen, 1999).

Governments and policy makers responsible for formulating social and economic policies must develop educational models that will “meet global demands” (Cogburn, 1998, p. 1) and address the challenges and opportunities of globalization (Freire, 1997, 2001). They must utilize various educational models to promote the development of world-class education that is competitive and relevant (Freire, 1997, 2001). Freire viewed education as economic freedom and social advancement for the poor and illiterate (Mustakova-Possardt, 2004). For the building and development of world-education systems, least-industrialized nations must pay attention to the economic models of developing nations and the steps used in reforming their economic policies (Gries, 2004). Governments and institutions of education must seek out systems of quality educational borrowing and collaboration (Moutsios, 2009; Sahlberg, 2006).

The World Bank’s Education Sector (1999) in a policy report on education described what constitutes an effective, efficient, and accessible education system. Such a system provides access to quality education for all, is taught by transformative, competent, and motivated staff, with a relevant, reasoned, and systematic curriculum. Its delivery must be such that there are teaching and learning processes that afford students critical thinking skills. Governance, resources, and sound evaluations are important to sustain this process (The World Bank’s Education Sector Strategy, 1999).

The forces of globalization will strongly impact the footprints we set down for our children (Suarez-Orozco & Qin-Hillard, 2004b). It is, therefore, incumbent upon

governments and institutions to prepare students to be successful in a global society (Ross-Holst, 2003). Institutes of higher learning will need to ask questions about how education will help students make great contributions to community life, "both locally, and globally" (Green, 2002, p. 8). They must take a realistic approach to understanding interdependence (Suarez-Orozco & Hillard, 2004a, b) and how the "fate of nations and individuals…are inextricably linked" (Green, 2002, p. 8).

Globalization and the Transnational Education Commitment

Globalization has presented a "powerful challenge and an opportunity" (Harden, 2006, p. S22). This has caused institutions to examine special types of policies and guidelines of international quality standards that will turn missions and visions into beneficial results to improve the future for humanity in the lest-industrialized nations (Stella & Bhushan, 2011). Olsen (2005, p. 11) suggested a "brake and accelerator function" in applying transnational education policy. He believed that the brake function be used in the "protection of the home institution from financial and reputational ruin…best practice models for all proposed transnational education initiatives" (Olsen, 2005, p. 11). He posited that the accelerator function would "promote proposals for initiatives and ensure that checks and balances of quality assurance are adhered to for meeting good practice benchmarks" (Olsen, 2005, p. 11).

In an increasingly globalized and multicultural world, institutions of transnational education must make it a part of their operating policy and mission to develop cross-culturally competent practitioners who can transcend cultural differences (Braziel, 2011). They must possess the skills, behaviors, attitudes, and knowledge to address issues both nationally and internationally (Pedersen, 1989). In order to address these issues,

institutions must negotiate cultural challenges in the field by providing links for interface between, academicians, partners, and other stakeholders, since these linkages are "a key asset and powerhouse for economic development" (Chatterton & Goddard, 2000, Introduction, para. 1). Medical professionals must be aware of how their professional and personal cultures differ from that of their counterparts, and be mindful to understand the importance of effective cross-cultural practice (Harris, Moran, & Moran, 2004; Slimbach, 2005; Yukl, 2006).

Trends in the Transnational Medical Education Field

The health care industry in the U.S. has become a major player in the export of a "distinctively American commodity, U.S. health care" (Biviano & Makarehchi, 2002, p.16) and medical education (Leggett, 2009). Many developing countries are grappling with the brain drain and find themselves unable to employ or retain highly trained professionals because of their lack of development and industrialization (Wright, Fils, & Gupta, 2008). As a result, many immigrant physicians migrate from developing to developed nations with the hope of securing education and subsequent employment in the field of medicine (American Medical Association, 2010; Biviano & Makarehchi, 2002). In light of these issues, a number of foreign governments have engaged in affiliations, collaborations, partnerships, and alliances with prestigious medical schools or hospitals in developed nations for their expertise in building health and education infrastructure (Day, Herndon, & Fogel, 1998). These ventures have created an expanse of medical centers to enhance "global reputation, funding streams, and a patient base for service, education, and research" (Biviano & Makarehchi, 2002, p. 16; Day, Herndon, & Fogel, 1998; de Wit, 2010).

Weill Cornell Medical College of New York (WCMC-NY) has world-wide affiliations with several hospitals, medical centers, and corporations. These are the "American Hospital in Paris, France, American Hospital in Istanbul, Turkey, ASPETAR Qatar Orthopedic and Sports Medicine Hospital in Qatar, Weill Bugando Medical Centre in Tanzania, Group Florence Nightingale Hospitals, Turkey, Hallym University Medical Center, South Korea, Hamad Medical Corporation, Qatar, and Hospital das Forcas Armadas Brasilia, Brazil" (WCMC-NY, 2011, para. 10).

Duke University, Durham, North Carolina has a "global partnership in medical education with the National University of Singapore, which offers a post-baccalaureate medical education for students who complete the four-year Duke curriculum receive a doctor of medicine degree jointly awarded by Duke University and the University of Singapore" (Williams et al., 2008, p.122).

Harvard Medical International (HMI) was established in 1994 and has "official relationships with medical schools in Korea, Thailand, Brazil, and China… joint management of ventures with local investors developing hospitals in China, the Phillippines, and Thailand" (Biviano & Makarehchi, 2002, p.16). They plan, design, and enhance to assist countries in meeting international standards to advance their global missions (Partners Harvard Medical International, 2012).

The Baylor International Pediatrics AIDS Initiative (BIPAI) network supports projects in Eastern Europe and Africa. They manage complex programs and large staff and also provide their expertise for "the well-being of children and families worldwide" (BIPAI at Texas Children's Hospital, 2011, BIPAI Mission, para. 1).

"Texas Medical Center, a Baylor medical school-affiliate with established major international joint ventures. One of these ventures is with an allied health college in Peru training laboratory, radiology, and information technicians" (Biviano & Makarehchi, 2002, p.16).

The University of Pittsburgh Medical Center PMC (UPMC) "actively commercializes its care brand to global market, provides world-class health care, advanced technologies, and management skills with the goal to advance its mission to transform the provision of health care globally, building a global health care brand to attract the best and brightest medical professionals and staff for the benefit of all of its patients and business ventures" (para. 1). At present, "UPMC and Royal Berkshire National Health Service Foundation Trust, part of the United Kingdom's National Health Service partnership agreement to develop and expand cancer services offered by the Trust in Reading, England, and the surrounding region. "Satellite centers will offer patients cancer care closer to home…modeled after a hub-and-spoke system that UPMC first perfected in western Pennsylvania, where it now operates more than 40 cancer centers" (The University of Pittsburgh Medical Center, 2009, para. 2).

Globalization and Medical Partnerships in the Middle East

In building their nation, the government of Qatar made it a priority to establish education campuses in Doha, Qatar. Education City was developed as part of the "Qatar Foundation for Education, Science, and Community Development…dedicated to promoting holistic educational needs, fostering of community health and development, and nurturing research and entrepreneurship" (Education City, 2012, p. 1).

Presently, many prestigious western universities have established-partnerships with the government of Qatar and offer programs in medicine, international affairs, business administration, computer science, engineering, and design (Education City, 2012, p. 1). A number of the universities in Education City, Doha, Qatar are the "University Commonwealth University in Qatar School of the Arts; Texas A & M University at Qatar; Carnegie Mellon University in Qatar; Georgetown University School of Foreign Service in Qatar; Northwestern University in Qatar; HEC Paris; and UCL Qatar" (Education City, 2012, p. 1).

"Established in 2001 as a partnership between Cornell University and Qatar Foundation, Weill Cornell Medical College-Qatar (WCMC-Q) is part of Weill Cornell Medical College-New York and shares its mission of dedication to excellence in education, patient care, and research" (WCMC-Q, 2011, para. 1). WCMC-Q offers an integrated program of pre-medical and medical studies leading to the Cornell University Doctor of Medicine degree. "Teaching is by Cornell University and Weill Cornell Medical College faculty including physicians at Hamad Medical Corporation (HMC), there are exchanges of expertise with faculty-physicians from the New York Presbyterian Hospital/Weill Cornell Medical Center. Collaborative biomedical research projects are ongoing between Weill Cornell in the US and Qatar, and HMC" (WCMC-Q, 2003, p. 1). WCMC-Q students have "opportunities to take part in biomedical investigations. Summer research programs enable selected students to travel to the U.S. and work under the mentorship of leading investigators at Cornell and Weill Cornell, participate in projects in Qatar, guided by WCMC-Q faculty and funded by the Undergraduate

Research Experience Program of Qatar National Research Fund" (WCMC-Q, 2011, pp. 1, 2).

Since 2005, the Mayo Clinic has been in a joint project in Dubai, United Arab Emirates in Dubai Healthcare City. They provide "heart care services dedicated primarily to diagnostic and non-invasive therapy, heart research, and continuing education. This is part of their commitment to explore new models of care to meet the needs of patients in the Middle East…providing ongoing care supported by research and education to patients residing outside the United States" (Mayo Clinic International, 2012, para. 1).

The Cleveland Clinic Abu Dhabi is involved in partnership and the building of "a multi-specialty hospital. Currently under construction in Abu Dhabi, United Arab Emirates, it is scheduled at the end of 2013. A "range of tertiary and quaternary medical services will bring the highest international standards of healthcare to Abu Dhabi and the region...it is the result of a partnership…between Mubadala Development Company and Cleveland Clinic. Their shared vision is to bring the highest international standards of patient care to Abu Dhabi and the region. The Abu Dhabi Government Investment and Development Company owns the multi-specialty hospital. The Mubadala Development Company provides the capital and local business acumen, while Cleveland Clinic provides clinical expertise to manage and operate the teaching hospital" (The Cleveland Clinic, 2011, para. 1).

Culture and Cultural Competence

Culture is quite often referred to as "human behavior that includes language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups" (Cross, Bazron, Dennis, & Isaacs 1989, p. iv). Culture has also been described

as "values, norms, and traditions that affect a particular group's perception, thinking, interacting, behaving, and making judgments about their world" (Chamberlain 2005, p.197). It is also defined as "the collective programming of the mind, which distinguishes the members of one human group from another" (Hofstede, 1991, p. 21) and may present as ethnocentricity (Hofstede, 1991). Because most disciplines have their own definition of culture, concepts and models can vary among scholars (Abbe, Rentsch, & Mot, 2008). Understanding mental models that form as a result of intercultural experiences (Abbe, Rentsch, & Mot, 2008, para. 8) can be instrumental in cultural education, training, and learning (Selmeski, 2007).

The massive migrations of people have caused internal shifts in how we interpret and experience our national and cultural identities (Marsh, Bradley, Love, Alexander, & Norham, 2007) and sense of "cultural belonging" (Suarez-Orozco & Qin-Hilliard, 2004b, p. 3). Cited in Suarez-Orozco & Qin-Hillard (2004b, p. 173) "The ability to formulate an identity that allows comfortable movement between worlds will be at the very heart of achieving a truly *global soul*" (Iyer, 2000). Eldridge and Cranston's (2009) study on managing transnational education and whether culture really matters, advised that special attention must be paid to how people communicate and interact with each other.

Cultural competence was also referred to it as the integration of ability to transform knowledge through the use of models for better outcomes (Davis, 1997) . Cultural competence has also been defined as a "set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, and among professionals to work in a cross-cultural setting" (Pedersen 1989, p. iv).

Cross-Cultural Competence and Cross-Cultural Training

There are numerous definitions of the concept of cross-cultural competence. They range from those in the fields of business, education, health, and social issues. The ability to view cross-cultural competence from so many conceptual contexts and apparent lack of a single definition is problematic for scholars conducting research on cross-cultural competence. Researchers in the field of cross-cultural competence are concerned about how institutions train their teaching staff for overseas assignments (Bodycott & Walker, 2000; Dunn & Wallace, 2005; Gopal, 2011; Gribble & Ziguras, 2003) and the outcome of their cross-cultural interactions (Coleman, 2003; Wimshurst, Wortley, Bates, & Allard, 2006).

Brislin and Yoshida (1994) defined cross-cultural training as the process of preparing people to be effective and efficient in carrying out interpersonal and successful collaborations across cultures. Cross-cultural training was further defined as a process of improving "intercultural learning through the development of cognitive, affective, and behavioral competencies for successful interactions" (Littrell, Salas, Hess, Paley, & Riedel, 2006, p. 356) in cultures of stark differences. Cross-cultural training was designed to prepare people going abroad to carry out assignments and prepare them for return to their home base (Bhawuk & Brislin, 2000; Paige, 1986).

Many international businesses enter into cross-cultural ventures through partnerships, investments, and infrastructure and when faced with cross-cultural conflict and differences in the way business is conducted, cross-cultural training skills will make the difference in successful and effective resolution in cross-border transactions (Gegios

& Taylor, 2007). International legal professionals posited that companies such as General Motors consider cross-cultural competence an important characteristic for effective performance in the global arena. They stated that Microsoft and other industry leaders recognized the establishment and "broadening of cross-cultural skills as essential to international business success" (Gegios & Taylor, 2007, para. 3). Researchers in the field of cross-cultural competence also suggest the utilization of the critical incident approaches with simulation exercises, and the use of role play provide a better understanding of cross-cultural interactions and cross-cultural conflict (Bitner, Booms, & Mohr, 1994; Cushner & Brislin, 1996; Kotler, Bowen, & Makens, 2003; Shapero, 2007). Learning about cultures is a living skill and ongoing process that should be developed, whether in culture-general or culture-specific knowledge, learning, and experiences. However, one must remember that to be culturally proficient, there must be the willingness to learn about different cultures (Slimbach, 2005).

Grounded Theory

Glaser and Holton, (2004) cautioned about the critical importance in grounded theory methodology to "avoid influencing the pre-conceptualization of the research substantial reading of the topic under study, forcing of extant theoretical overlays on the collection and analysis of data" (Glaser & Holton, 2004, Use of literature, 3. 4, para. 1). Therefore, in this study a selective sampling of pertinent literature provided a cursory review of cross-cultural competence and cross-cultural training, to identify its importance in the context of transnational medical education (Charmaz, 1983, 1990). Strauss and Corbin (1990, 1998) suggested the use of grounded theory as a good design when no adequate theory has been identified to fit a research process (Glaser, 2001, 2002).

The literature reviewed had a few available models, which were developed and tested on different samples and populations. Theories were present but did not possess variables important to this study. For this reason, a grounded theory was utilized to examine the knowledge, behaviors, and skills of professionals who are involved in transnational partnership. The goal was to explain how participants were experiencing this phenomenon and identifying the steps in the process. Grounded theory provided such a framework.

Summary and Conclusions

Researchers will argue that people experience challenging cultural interactions in an international setting where their cultural perspectives and biases become more evident (Esbjorn-Hargen, 2009; Janus & Smythe, 2011, 2012). Therefore, in an increasingly globalized and multi-cultural world, it behooves institutions of education to develop culturally competent practitioners (Chisholm, 1994). Cross-cultural competence should not be avoided and professionals must be ready, willing, motivated, and sincere in addressing issues and "how cross-cultural competence might apply in" (Janus & Smythe, 2011, 2012, p. 446; Koehn, 2011) diverse settings.

Given these factors, this study set out to understand the nature of cross-cultural competence in transnational medical education partnership and to identify the knowledge, behaviors, and skills that support its success. Implications for the study included insights on cross-cultural practice in transnational settings. An expected benefit of this project was to inform practice in the training of health care professionals involved in cross-cultural ventures of this kind.

Chapter 3: Research Design Methodology

General Perspective

The state of literature from various disciplines around cross-cultural competence points to the critical importance of understanding knowledge, behaviors, and skills. Theories provided insight into the process but were based on differing methodologies, philosophies, and participant samples. The foundation for a substantive theory was useful for guiding research and practice with health care professionals involved in transnational medical education.

The cross-cultural experiences of health care professionals from Weill Cornell Medical College-New York (WCMC-NY) involved in active partnership with Weill Cornell Medical College-Qatar (WCMC-Q) were explored. Also interviewed were medical students who they teach and mentor, faculty with whom they teach, collaborate, and interact in exchanges of expertise, biomedical research projects, and mentorship.

Research question. This study sought to answer the question: What knowledge, behaviors, and skills foster cross-cultural competence in transnational medical education partnership?

Overall research design. Grounded theory was "suitable for studying individual processes, interpersonal relations, and reciprocal effects between individuals and larger social processes" (Charmaz, 2000, p. 510). Grounded theory was used as a strategy of inquiry induced from data, which included where the study took place, the population chosen, and the activities the participants were involved in (Charmaz, 1983; Lincoln &

Guba, 1985; Maxwell, 2005). The research utilized Charmaz' constructivist grounded theory methodology, and gathered rich-word data using concurrent data collection, comparative analysis, theoretical sampling, and early and advanced memoing to interrogate and explore the abilities, knowledge, and skills associated with cross-cultural competence (Charmaz, 2011). Research from the perspective of medical professionals provided rich word-data (Geertz, 1973), as well as real-world guidance in the process (Charmaz, 2000). This provided applicability and practicality for researchers, decision makers, and practitioners who seek explanatory models upon which to design professional development and services related to cross-cultural competence. The goal was to unite the research process with theoretical development (Charmaz, 2000; Creswell, 2002, 2007, 2009).

The research methodology was adapted from methodology used by Ross, (2008) in an internal report to the Department of Equal Opportunity Management Institute Directorate of Research. This report was "part of a project to support cultural readiness for the Department of Defense to derive a preliminary operational definition of cross-cultural competence and test and validate related measures in the military population" (Ross 2008, p.1). This researcher chose to "provide a voice for individuals not heard in the literature" (Creswell, 2007, p.102). For the purpose of this study, the researcher used Ross, (2008) methodology as a method of developing or generating theories during the research process (Strauss & Corbin, 1990).

Research Context

Adapting Ross' (2008) prescreening/recruitment instrument, project briefing, demographics form, informed consent form, and interview protocol, a proposal

requesting permission to conduct this research was sent to the Institutional Review Boards of WCMC-NY and St. John Fisher College (See Appendices C, D, & E). To ensure privacy, information gathered during the study was kept strictly confidential, stored in a locked cabinet at the researcher's office, and in such a manner that the data cannot be connected to the identity of the participants.

The study was conducted at WCMC-NY and at WCMC-Q. Participants were interviewed face-to-face at the academic institutions in which they work or attend classes and by telephone. At the beginning of each interview, the researcher gave an overview of the project to the research participants who were "given an opportunity to ask questions about the project and their role" (Bogdan & Biklen, 2003). An informed consent form was presented to each participant for signature. Permission to record the interview was obtained. All of the interviews except two were recorded. Participants were told that they could choose not to have the interview audio-recorded or stop the recording at any time.

Research Participants

Purposeful sampling was used as a strategy because the participants were able to "purposefully inform an understanding of the…central phenomenon in the study" (Creswell, 2007, p. 125). This sample of professionals working in the setting of transnational medical education was deliberately selected in order to gather information that could not be provided from other groups (Field & Morse, 1985; Lincoln & Guba, 1985; Morse, 1991). Twenty-five participants were interviewed. These groups were made up of six medical professionals and one medical administrator from WCMC-NY who were labeled Group A; three medical doctors who obtained their medical degrees from WCMC-Q, and three medical students who currently attend WCMC-Q were labeled

Group B; medical doctors at WCMC-Q who are native to the Gulf region at WCMC-Q labeled Group C; and six expatriate academicians (non-medical doctors) from WCMC-Q were labeled Group D. This allowed for a diversity of perspectives and rich word-data.

The researcher used a published list of medical practitioners who traveled to Doha, Qatar over the past three years. A letter was sent to these practitioners asking them "to consider participating in an interview, if …able to answer yes" to the following statements (Ross, 2008, A-5):

1. You have visited Doha, Qatar, where you interacted directly "with members of another culture" on a regular basis as part of a transnational medical partnership assignment (Ross, 2008, A-5).
2. You have visited Doha, Qatar within the last three years (Ross, 2008).
3. "You believe you have gained some level of competence in understanding how to achieve (partnership) goals that depend (on teaching, training, and collaborating) with members of another culture" (Ross, 2008, A-5).
4. "You have *first-hand experience* in making assessments and decisions about people from other cultures and in interacting with them as part" (Ross, 2008, A-5) of this transnational medical partnership.
5. "You are comfortable talking in detail…about your thoughts and attitudes as (I) ask you to tell me about any specific … experiences you have had" (Ross, 2008, A-5).

Instruments Used in Data Collection

Each participant signed a consent form, which described the nature, procedure, and implications of the research (Bogdan & Biklen, 2003). The first step was to conduct

face-to face interviewing with home country personnel at WCMC-NY who teach and collaborate with host nation personnel at WCMC-Q, in exchanges of expertise. Most of the interviews lasted between 35 minutes to about two hours using an open-ended and conversational style. The researcher was interested in a situation where the participants from WCMC-NY had to manage a challenging cross-cultural interaction with members of another culture (Ross, 2008). The goal was to seek knowledge, behaviors, and skills competence through the eyes of academicians involved in transnational medical education partnership (Ross, 2008). The following probing questions were adapted to fit this study from the methodology of Ross (2008) in an internal report to the Department of Equal Opportunity Management Institute Directorate of Research. This report was "part of a project to support cultural readiness for the Department of Defense to derive a preliminary operational definition of cross-cultural competence and test and validate related measures in the military population" (Ross, 2008, p.1). An example of a probing question that helped was: Can you think of a time when you were asked a question by a medical student or faculty member connected to your assignment which had "a strong cultural component" (Ross, 2008, A-13) and your cross-cultural ability really made a difference in navigating the answer skillfully (Ross, 2008)?

Participants were asked to tell of their experiences so that data based on their lived experiences could emerge (Charmaz, 2000, 2006; Ross, 2008). At the end of the storytelling, the researcher asked the "participants a wide range of clarification questions" to ensure understanding (Ross, 2008, A-13). The researcher formed a "general, abstract theory of the process, action, or interaction grounded in the views of the participants" (Charmaz 2000, p. 524). Line-by-line coding was used to break down information,

categorize findings, and form concepts (Bergkamp, 2010; Charmaz, 2000). Comparisons were done to categorize information (Charmaz, 2006; Strauss & Corbin, 1990, 1998) and determined what other groups and steps were necessary for theory development (Morse & Field, 1995). Elliott and Lazenbatt (2005) suggested the use of theoretical sampling to refine the emerging theory and the quality of the findings.

Refinement of the theory was done by gathering data from participants in groups B, C, and D (Charmaz, 2006; Elliott & Lazenbatt, 2005; Glaser & Strauss, 1967). Medical students and faculty members of the host nation based in WCMC-Q with "first-hand experience in making assessments and decisions about" home country personnel (Ross, 2008) who visit WCMC-Q for institutional collaboration and an exchange of expertise were interviewed. The medical students and faculty were encouraged to speak openly about their thoughts and feelings regarding situations and issues that impacted their cross-cultural knowledge, skills, and abilities. Questions were kept to a minimum to facilitate open dialogue and invite frank and honest narrative (Kvale & Brinkman, 2009). Expatriates at WCMC-Q who developed and used an understanding of another culture to develop cross-cultural competence were also interviewed. This diversity of participants brought richness to the data considered to be a valuable aspect and consistent with the interpretive research paradigm (Denzin & Lincoln, 2005; Geertz, 1973).

Early, advanced, and self-reflective memoing were engaged in during the research process for subjectivity and the production of accurate research findings (Elliott & Lazenbatt, 2005; Glaser, 1978). Memoing containing stories and ideas enhanced the data (Charmaz, 2000, 2006; Elliott & Lazenbatt, 2005), and influenced how codes and

properties related to each other (Glaser, 1978) in the emerging categories (Charmaz, 2011).

Procedures for Data Collection and Data Analysis

The raw data were "organized and prepared for analysis, interviews transcribed, field notes and memos typed, data were sorted and arranged into groups depending on which group was interviewed to obtain a "general sense of the data and to reflect meaning" (Charmaz, 2006, p. 5). Questions asked throughout the reading or memoing process were "(a) What is going on? (b) What are people doing? (c) What is the person saying? (d) What is the tone of the ideas? (e) What do research participants' actions and statements take for granted? (f) What is the impression of the overall depth, credibility, and use of the information? (g) Ho do structure and context serve to support, maintain, impede, or change their actions and statements?" (Charmaz, 2011, p. 80). Based on the answers to these questions, the researcher wrote notes recording her thoughts during and after the interview sessions (Charmaz, 2000, 2006). (See Table 3.1 for steps and actions in the data analysis process). These memos gave an account of the cross-cultural beliefs and experiences and were useful in interpreting the voices of these participants (Charmaz, 2006; Creswell, 2007; Lawrence-Lightfoot & Davis, 1997).

Collection of codes with similar content allowed the data to be grouped into advanced themes and sub-themes. Significant codes were sorted, synthesized, and organized and put into categories (Charmaz, 2006; Creswell, 2007). The theory was a collection of explanations about what constitutes cross-cultural competence in transnational medical education (Charmaz, 2006; Creswell, 2007).

Finally, the researcher consulted literature in the field to determine the fit for this

body of work. Literature was covered thoroughly and woven into this work. Analysis defined essential properties, assumptions, relationships, and processes provided data to demonstrate how this analysis was grounded in the lived experiences of the participants (Charmaz, 2000). Lessons learned summed up the data (Lincoln & Guba 1985).

Table 3.1

Steps and Actions in Data Analysis

Steps	Actions
Transcription of Interviews	Twenty-five recorded interviews were transcribed. A right-hand margin was used on each page to enter codes in the preliminary coding process.
Read through data	Transcribed interviews were read twice. Ideas were sorted, put into groups, and noted in a log-book.
Analyzed and coded data	Responses were sorted and grouped based on the research question. Data was coded using line-by-line coding. Codes were logged in code-book and noted for frequency. The coding list was then finalized.
Advanced themes, subthemes and categories represented in data	Themes began developing and were recorded for frequency. Sub-themes represented in the data were put into table format. Categories developed were based on groups of similar concept.
Density	The densest code drove the development of a theoretical framework.
Theory development	The development of a theoretical framework used a collection of explanations on the researched subject. A comparison of literature was made to determine which findings were supported or not supported.

Note. Adapted from Bouillon, B. M. (1996). *Socialization experiences of beginning elementary principals in selected California school districts*. Doctoral dissertation, University of La Verne.

Chapter 4: Results

Research Question

In this chapter, the results with significant responses generated from interviews are reported and derived from the guiding research question: What behaviors, knowledge, and skills foster cross-cultural competence in transnational medical education partnership?

"Grounded theory is qualitative theory rooted in the social sciences" (Strauss & Corbin, 1998, p. 11). Grounded theorists inquire about institutional and social structures, practices, and is one of the most influential models of theory construction used by qualitative researchers (Charmaz, 1993, 2006; Glaser & Strauss, 1967).

Data Analysis and Findings

Factors mentioned most frequently by the twenty-five participants across all four groups are described in detail. The findings of the study regarding cross-cultural competence in transnational medical education are reported. Interviews were audio-recorded and transcribed. Memos were instrumental in giving a portrait of the beliefs, accounts, and experiences and proved useful in interpreting the voices of the participants (Lawrence-Lightfoot & Davis, 1997). Reported in this chapter are the themes and sub-themes of knowledge, behaviors, and skills that contribute to cross-cultural competence. Quotations are used to lead to greater understanding and to capture the voices and experiences of the participants. Categories that developed from the themes and sub-themes are also presented.

Participants from Group A were six medical doctors and one academician (non-medical doctor); Group B was made up of three medical doctors who obtained medical degrees from Weill Cornell Medical College-Qatar (WCMC-Q) and three medical students who are currently attending medical school at WCMC-Q; Group C was made up of four medical doctors and two academicians (non-medical doctors) who are host country personnel and native to the Gulf region. Group D was made up of expatriates living in Qatar, two medical doctors, and four academicians (non-medical doctors). Table 4.1 illustrates the number of participants in the study.

Table 4.1

Number of Participants in Study

Institution/Group	Number of Participants	Gender
WCMC-NY/Group A	6 medical doctors	5 males/2 females
	1 non-medical academician	
WCMC-Q/Group B	3 medical doctors	2 males/4 females
	3 medical students	
WCMC-Q/Group C	4 medical doctors	4 males/ 2 females
	2 non-medical academicians	
WCMC-Q/Group D	2 medical doctors	4 males/2 females
	4 non-medical academicians	

Knowledge Competence

Two primary themes emerged from the transcripts with regard to knowledge competence. They are cross-cultural learning and global leadership. Knowledge competence has been defined by the participants as possessing international experience and global perspective about appropriate behaviors when navigating in a culture of vast differences. It connotes understanding shared institutional and cultural values, attitudes of the geographical region. There was reason to believe that exposure to international travel experiences facilitate open-mindedness, and flexibility. Participants across all

groups believed that world travel sharpened their personal and professional identity and how it affected their perceptions.

Cross-cultural learning. The theme cross-cultural learning referred to learning about the nuances of a society such as its conventional norms, mores, and the respect and values placed on personal and professional relationships.

> World travel impressed on me the value of learning about and experiencing other cultures and people. When I had the opportunity to do so in my career, I established an office of international activities and set up very active programs of student and research exchanges, and active interchanges. The establishment of active and ongoing communication networks between medical students here at the New York campus and in Ithaca with their counterparts in Qatar is crucial for their cultural development and learning
>
> (Participant A1).

> I think international experiences and knowing about the many cultures of the world is what makes you a better professional. You are growing and meeting people from different countries, different cultures. In my 4th year of medical school I got a chance to travel in Europe. I went to Prague for a conference and Tanzania for six weeks. For student electives, I got a chance to come to New York and Canada. These experiences taught me about different cultures
>
> (Participant B3).

Culture-specific knowledge. This sub-theme culture-specific knowledge connotes knowledge of the underlying values, norms, and mores of a particular culture. The majority of the participants across all four groups spoke about interests in and knowledge

of the host nation's practices, conventions, history, customs, and beliefs. Study participants were able to draw on culture-specific knowledge to assist them in navigating within this culture of strong difference.

> Home nation personnel should seek knowledge to further understand some of the differences in the lives of students in the east as opposed to students in the west. Professionals should attend to the relational and get to know about the students and their lifestyles. I think you do not just show up and expect to get an orientation. You should talk to people who were there in Qatar, before you start teaching. Ask, what does a person do when they get up in the morning? How do they get ready for work? Just by asking those questions, you find out that people get up and they pray before they go to work. They have to do ablution. It is a certain religious ritual for ceremonial cleansing. There are certain things they are not allowed to eat. They get to the school with their chauffeur or with their own car because of transport in Qatar. Taxis are expensive. It is too hot to walk. This knowledge offers insight on how people get to the classroom. They may live with their families if they are not married. They do not have studios where they live on their own. Just asking about people's lifestyles is a good way to prepare oneself. They must show the willingness to learn and engage when entering the culture
>
> (Participant B1).

> Visiting and other faculty must try to learn about the culture by talking with students after lectures, have students take them to the local market, a museum, mosque, or perhaps a wedding. Faculty coming east must keep antenna up for cultural differences and get to know students for relationship development. They

must know that to succeed they must have the full respect of their colleagues and students. This is an opportunity for visiting faculty to share advice, vision, partnership, participation, and cooperation, to train students to take leadership positions in the region. We must take advantage of every opportunity for the students. It is part of the success factor

(Participant C1).

An expatriate who had to learn about the culture to live in Qatar offered the following advice for readiness to enter a culture with strong cultural differences and suggested.

To understand other cultures, I read numerous books, academic papers, and media articles on the Middle East that would describe the history of countries especially Qatar, the political situation, the culture. For me it was most helpful to think about the values, the philosophy. This provided me additional perspective beginning with the commonalities. What we have in common anchored me personally, the challenges of seeing differences. I traveled extensively but not in the Middle East previous to this experience. It takes a kind of person who is willing to be non-judgmental about the culture as you enter it and to be receptive to all the varieties and all the differences and just observe and learn. It does not always mean that one needs to approve but I think in the initial stage one should be a student of the culture

(Participant D1).

You cannot separate medicine from life. To maintain healthy relationships, and healthy people you must learn about their culture, it helps you to bridge the gap.

> You must also know about values. For example, for people living in the desert, water represents value
>
> (Participant C1).

Understanding the limits of own cultural knowledge. This sub-theme connotes that there are nuances of culture that the professional will never understand and must be prepared to be humble enough to acknowledge differences. Many of the participants believed that being true to oneself on the personal and professional levels through reflection and the acknowledgment of their own limitations, provided the conduit to new knowledge and ideas.

> We look for someone coming into this culture whether as visiting faculty or otherwise to be a person who is actively listening, someone who is not looking down at the host. We want someone who really shows that they care by interacting without showing concern that they are doing a wrong thing. What I am saying is that you don't want to appear as a guest doctor, lacking confidence or ignorant about the culture and at all times being over-protective and asking if you are doing a good job. Is that appropriate? Having been exposed to both cultures for a while not only with my presence in Qatar but also being brought up in the Middle East I know the culture very well. In addition, I lived in the U.S. Now with me, I invite the guest doctors when they come and visit to ask me questions. That makes me feel better if they did not have the chance to do their homework before they came to Qatar or if they just wanted to confirm with me. I'd be happy to inform them about it before they go to see patients or talk to students or to interact with doctors who have not had that experience with the

western world. So I will see the guest doctors and advise them to be humble and again be observant…meaning have a high very sensitive observing eye for what goes on so they can learn on the job very quickly. You do not want to be condescending; you don't want to be patronizing to the people. I acknowledge the fact that the guest doctors are coming wanting to spend time and giving the benefits of their expertise

(Participant C3).

This participant admitted to making a number of mistakes in the early months of moving to Qatar. This happened because of limited knowledge about the culture. Visiting faculty must know about the basic rules of appropriate behavior in public and the appropriate behavior in conversation. That is a basic fact about the culture, facts about the ways of life that are quite crucial. There is a book, which is called, *Don't they know it's Friday*. We oftentimes give it to new employees. It contains basic facts about the country, basic rules of behavior that is an important first step. Basic simple greeting forms in the local language that also show an implicit readiness to accept you are not coming just with who you are and expecting everybody else to conform to you. Arabic is a dauntingly difficult language. No native speaker of Arabic ever expects from a foreigner, a command of the language. They are proud of the language, know how difficult it is but they are incredibly appreciative of you trying to learn ten words. Simple gestures that show goodwill, basic understanding of the religion, I think those are very important

(Participant D2).

Global leadership. The second theme, global leadership, connotes ability to manage, understand, and lead across cultures. They suggested that true leaders must engage with others with a clear set of values and expectations that legitimize the partnership. Many of these participants acted within their personal and professional values systems to clarify expectations and to master culturally challenging situations. They believed that in the global environment, professionals must approach situations with a strong sense of moral agency to improve the visions and aspirations of others. They felt that having a strong self-concept and demonstration of leadership behaviors were signals of personal and professional commitment to the partnership.

Perspective-consciousness. This sub-theme is an example of regulating behavior and coping with ambiguity. A number of participants had moments when the roots of their subjective thinking were challenged. In moments of confusion, they admitted to stepping back and engaging in deep and quiet reflection on differences and commonalities in culture.

> I recognized very early on that many of the issues are similar, such as the doctor-patient dynamic. What I find compelling is how I can take a patient interaction that I have had here in New York and draw lessons from that. How often these come into play! They are helpful in dealing with analogous situations in Qatar. You know, patients who feel we are not communicating enough with them or their family about what is going on, and that happens in Qatar, New York, Baltimore, Boston, I mean, you see that everywhere. If you learned to be a better listener in New York because of certain scenarios with patients and their families, chances are that you can use those strategies as a starting point in Qatar.

Don't be shocked if those strategies turn out to be quite helpful in Qatar even though there are differences in the cultural, ethnic, and religious

(Participant A4).

I looked at the philosophy of the culture in the best sense of the term. I realized that it was not just commonalities but at the highest levels it was identical. We all want wonderful things for our children. We all want the best things for our future generations. We all want good things for nature. We do not want to abuse natural facilities. This is one of the things that I learned. I had to admit that I came away smiling a little bit at some of the naïveté of my own culture, in particular, marriage rituals and marriage traditions. We know there are many, many problems with arranged marriages in the Middle-East and in many countries around the world. If we can put aside that issue, we could think about the marriage tradition of having your family help select the partner, I believe that there is wisdom behind it. You know in the U.S. sometimes an 18-year-old selects a partner sometimes on a whim and then they get married. In some cases they live happily ever after but then in others they don't. I thought that if the parent and extended family would have a little more opportunity to voice the selection of a partner in the U.S.…this made sense to me. I learned that some of the cultural elements had more wisdom but the highest thing I learned was the commonalities

(Participant D1).

Superimposed mission, values, and expectations. This sub-theme portrays how important it is to see oneself as part of a team and for cross-cultural collaborations to

work, there must be mission- and vision-centered integrity of the partnership agreement. It must be superimposed and accompanied by mindfulness and diligence during all interactions. The participants believed that cross-cultural partnership was about building teams around common purpose, cooperative goals, and mutual respect. Most importantly it was about knowing what, why, and who they were doing it for. In other words, keeping the agreed upon goal in sight.

> The important thing is to have respect and an understanding of another person's individual beliefs, culture, and what they are trying to accomplish. In the case of establishing an educational presence in Qatar, it was very important that we had an understanding of minds and common purpose in collaboration. What we went over to do was to set up a type of education that Ezra Cornell proposed would be free of sectarianism, open to any person, any study. This particular program is aimed at training students to be physicians but ultimately to improve both the education level as well as a level of health care in Qatar, and by doing so to have a positive impact on that part of the world. Shared vision is very important. Partnership is very important, but also in the Middle Eastern Muslim culture, personal relationships and friendships in developing trust over a period of time are extremely valuable
>
> (Participant A1).

Many of the participants spoke about having knowledge of filial piety and the importance of family members when dealing with issues of health care.

> I think it was during my rotation that I had a family meeting together with one of the attending physicians from WCMC-NY who came to visit. There is a stigma

in the east where psychiatry is viewed differently. In the U.S., a very sick person can present to the hospital and the patient might be part of the decision and able to exercise that right. It is not the same way in Qatar. It works differently. The family is more involved and I really liked how the Attending coming from WCMC-NY realized that. He did not just look at the patient. He included the entire family. He called them into the meeting and involved them in the decision making process. He realized immediately that the process is different in Qatar. He handled the situation professionally in every way. That really got my attention and respect

(Participant B3).

I remind the students, medicine has its own universal language. Physicians practice under the four basic tenets of bioethics, and medical ethics. Respect for autonomy. The patient has the right to refuse or choose their treatment. For example, beneficence, a practitioner should act in the best interest of the patient. Non-malfeasance, first, do no harm. I think the most helpful that I will consider to be the undergirding of all of these is justice. Being fair, treating everyone with respect, and providing a standard of care for patients is a helpful guiding principle. The justice principle helps you cut through that by ensuring that you learn as much as you can to deliver the most personalized type of care for that patient

(Participant A4).

In reflecting on time control and having a personal/professional values system one participant believed that as a leader, there should not be a fear to speak up for what would

be of professional benefit to the students in their career as global leaders. This participant took a leadership role to control a situation that could prove embarrassing to the students in another place and time, and in their training to be world-class professionals. In this situation it was about respecting the value of time, and how critical the element of time is to the medical profession

> One of the cultural norms in the Middle East is tardiness. It is expected…I think for me I have had a hard time with that because I am a very on-time person. So when I went there…let me give you an example…a few years ago when I went to do medical rounds, four of the students did not show up on time. They came in 20 minutes later and strolled in nonchalantly. I chastised them. They said, "Nobody ever told us that we can't be late. We did not understand that." And I told them "You do not do this in New York"…and so there are examples like that where a behavior might be considered sort of standard in Doha will be considered egregious in the U.S. There are certainly some of those examples where you do have to set limits in certain situations and I think that was one of them
>
> (Participant A5).

In making professional decisions, this participant urged students to be mindful and vigilant during cross-cultural interactions, and in order to improve quality of care, ask for clarification on what is not understood.

> I tell students to think about what is in front of you. You need to just take a deep breath and ask the question - What am I delivering? Is it the same quality of care as what I deliver in a similar situation with a different person? Have I really done the basic standard of care for this patient? And that often includes tailoring your

intervention to their life circumstance, think ahead, try to anticipate issues you may encounter. If you do not know what the issues are, ask a few more questions

(Participant A4).

I know that depending on which culture the patient comes from that could affect the treatment in a major way. That's why I think it is very difficult for any medical doctor to be aware of all the cultures, I can tell you that from being a student at WCMC-Q and as a native of the Middle-East. I met a lot of American professionals working in the hospital in Qatar. So I got to integrate all of this cultural-knowledge and I can tell you that in Qatar the patients were not just Middle Easterners. Just to name a few, we had patients from India, Bosnia, the U.S. and Egypt. The patients come from different cultures. I got the opportunity to learn about all kinds of different cultures. I found what really helped me with that was to be really open and to ask the patients if I did not know something. It also benefitted me that there were doctors from the U.S. visiting and expatriate doctors, because I knew that I wanted to come and do my training in the U.S. So they shared their knowledge coming from the U.S. Basically, they shared with us their experiences in the U.S. and compared these experiences to Qatar

(Participant B3).

I worked on a poster about medical education in Qatar and I used faculty members here as well as in Qatar. These projects helped me to keep these links up in medical school residency fellowship. You try to have projects that link the two campuses and keep people involved so that we do not become two separate campuses. We are learning with one another learning from each other. It is really

enriching. It is good to live in different parts of the world. I think it is important to have your education at different institutions whether they are within the same country or internationally

(Participant B1).

The glue that allows these cross-cultural interactions to succeed is a common goal, a common denominator for people aspiring to be clinicians. This is strongly felt regardless of where you are, who you are, or what your ethnic background is. This cuts across any of those barriers I think we all share as physicians or physicians-to-be. It is a desire to serve people with our knowledge. I know the student-perspective, I know what their expectations are, what types of careers they want for themselves, and the cultural constraints that they have to deal with. When I went to Qatar, it helped me to gain a better sense of who the students were and to subsequently evaluate them here as clinical clerks

(Participant A4).

The students in Qatar are no different from any medical student here because they are students working towards not only learning the curricula but also working in a very diverse setting

(Participant A7).

These participants recognized the interplay of cultural, social, and personal identities in this culture of difference. When going to Qatar, medical professionals must know that the students in the east have the same aspirations as students in the west, and the religious, cultural, and ethnic influences of their lives. All of the students who were interviewed expressed an interest and excitement in doing their residency in the United

States. They recognized the importance of international learning experiences and also expressed a curiosity about new cultures.

Behaviors Competence

Behaviors competence has been defined as engaging in behaviors appropriate to the culture of difference. It connotes awareness of how behaviors reflect on others in the local context.

Authenticity. The theme authenticity illustrates the behaviors that allow one to maintain moral integrity in partnership interaction. Many of the participants reflected that their behaviors must be in balance with their personal and professional identities. They believed that to establish a climate of trust, their communicative behaviors must provide clarity, openness, and demonstrate a deep and abiding respect for partnership.

Transparency, relationship, and mutuality in partnership. For relational transparency and mutuality to be evident many of the participants felt that they had to be conscious of their personal and professional motivations, feelings, and how their sense of moral agency interacted with the outward environment.

> You want to let the host know what your role is and that you are not there to threaten anyone, you want to avoid these things. You just want to accept and invite to excellence rather than criticize and negatively critique.
>
> (Participant D3).

> Most people are usually open and intrigued by difference, especially when it is in a comfortable and welcoming situation. If it is in a student-teacher relationship by definition people have entered into partnership. If it is a physician-patient relationship, people have entered into partnership and so the differences are

> acknowledged but they are not necessarily seen as a threat. Do not be overly defensive about yourself and who you are and what your tradition or culture is. Obviously be sensitive. Try not to change your behavior because you will come across as artificial and insincere. I think part of this is to be truly aware, be conscious but relax at the same time
>
> (Participant D2).

Generosity of spirit. This sub-theme connotes that a person should respect his or her own and another person's moral worth. Many of the participants across all four groups suggested that it is about possessing a generosity of spirit, valuing commonality with, and the importance of other people. Generosity was reflected as empathy, being intuitive, understanding the minds and hearts of others, and the willingness to put oneself in another's situation. It was about exercising a holistic approach in developing education instruction that was mutually beneficial; facilitating mutual interaction, ownership in decision-making, non-imposition of agendas, and avoiding paternalistic behaviors at all cost.

> It starts off on a personal level. One has to personally accept the importance of other people who do honest work. My parents taught me this and instilled this in me that somebody who is out in the street digging a ditch, somebody who is working hard at doing that, making it possible for you to get water, or have your sewage taken away deserves your respect. What that person is doing is just as important to him as what you are doing is to you. So it is important to understand that people at all levels in society who are making an honest effort to contribute deserve respect, and this applies regardless of ethnicity, or color of skin, or

nationality. Part of what we believe will influence future generations of doctors and trainees is the implicit education that is learned by observing others, making rounds, by going to conferences, meetings, seeing how our peers and our mentors behave, how they treat others, and the respect that they show for medical education. These are important ways in which we achieve cultural education

(Participant A1).

Humility is key. You have to recognize this in interacting with your colleagues, that they have as much value as you do. In instructing students from different cultural backgrounds, they must know that there is a common purpose that everyone is working towards. It must be clear, that they are being trained to help the sick and populations of patients who are very diverse. We have to impress upon students acknowledgement of patients from different backgrounds and what is important in the health of the patients and that beneficence has a lot to do with humility and non-dominance

(Participant A7).

What I have learned from going and being abroad is that the world is so multiple and plural and cosmopolitan, that it even defies the categories that we lay down in relation to nation and religion. When you get up in the morning and this passes through your head, you get on with the business of believing that everybody has this authentic deep integrity that you need to bring out through education

(Participant D6).

There is one thing that took me a long time to realize. For students here, the family is very, very important. When we look at a life choice, medicine, or any

other career, from a western perspective, we tend to emphasize the individuality of the choice. We choose medicine because we want to serve our patients because we feel that that is our calling. In the east, it is based on the value; I really want to make my parents proud. Is that not a noble cause? So it is a fundamental cultural difference. Part of the individual calling towards a path for your life, while at the same time the value of a sense of truly belonging to your family, your clan, your nation. You have to make a choice and so being aware that values can conflict. There is no perfect solution to the idea of behavior, the idea of choice, the path of life. We have to respect that. If I had grown in that culture I could live by those values. I can understand why people would and that is an important frame of mind in seeing issues through the minds and hearts of others

(Participant D2).

I have never had one of our students or one of our doctors go to visit Qatar or our program in Tanzania, which is in one of the poorest parts of the world, and come back and not feel that they have been enriched by the experience. When the students or the residents who have been to Tanzania come back, they say, I really feel now…I know why I really went into medicine

(Participant A1).

The cultural differences were huge to me. It was important for me to be continuously self-aware and engage in perspective-taking to understand how religion and tradition were central to the society and how people integrate these into behaviors of how they work, how they act. I suddenly became aware of hierarchical nature of the society. I recognized the immensely respectful

> interactions of the students. They were initially afraid to approach but through relationship they soon grew vocal and willing to share their points of view
>
> (Participant A3).

> Home country professionals must have a curiosity for new ideas and environments and exhibit a personal kindness, graciousness, and generosity of spirit. They must have a willingness to engage. They must be open and receptive to different ideas and situations whether or not they raise questions in the mind of that person when entering this new environment. There were a lot of surprises to me about how I too was socially constructed in my culture just as all of us are socially constructed in our culture. But what I learned was to separate the culture from the value system and to study their high value system. I realized that harmony is high on the list and one can have a voice but one has to do it in a way in which you don't disrupt the harmony of the culture
>
> (Participant D3).

Conscientiousness. Conscientiousness in partnership connotes working diligently to build strong relationships and engagement to drive excellence. Conscientiousness creates sustainable organizations, understanding, and participation in the education process, and strengthens decision-making. The participants believed that conscientious partners lead through example and help others to set and achieve goals through an invitation to excellence. This is not only important to the organization, but to personal development and the exercise of personal leadership. This type of behavior supports people who are better able to perform tasks and align personal ambitions with the organization's mission and goals.

At whatever level you are at, your job essentially is to maximize productivity, so you have to understand what motivates people. You have to be sensitive to cultural issues. Let us use Qatar for example. One of the things I have learned from Qatar was that they do not want us from the west to come in and say, "well we are really smart and we have been doing this for years so this is how you do it. They understand that we have expertise and infrastructure that they do not have but they want to develop their own expertise. They feel very strongly, are very smart, and those who are motivated can really do well. You have to recognize that they want to develop their own capacity. And so our job is not just to tell them how to do it, our job is to work as partners and help them develop the capacity, so that they can do it, and get the credit for it that they so rightly deserve. You have to be motivational and understand other people's personal drivers. You have to be culturally sensitive to that and it's very similar in my view to marriage. Why does a marriage work? Marriages or relationships that work happen when the agenda is superimposed. If the agendas are different, inevitably, there will be conflict. And so this is true in marriages. It is true in collaborations. It is true in leadership. First, you have to try to be working with people who have a similar agenda. You want people to be best educated, to work hard, to learn, to be the best doctors they can be, the best researchers, so that is part of it but you also have to be tuned in to where the agendas do not merge

(Participant A5).

Professional commitment. Giving feedback and encouragement is important to motivating and building a stronger team, commitment, and development. They believed that if engaged holistically, there is increased personal and professional effectiveness.

> Obviously, there has to be strategic value and one must give strategic partnerships some time to endure. There must be people who have personal characteristics, which are desirable to make these partnerships successful. If not, that can hinder the progress and development of true partnership. You clearly must have strategic imperative underlying all of this. Both parties need to recognize the strategic interests in making this partnership successful, but yet without having the right personalities it will be delayed, and/or at times not succeed which has in fact happened during the lifetime of this partnership
>
> (Participant A2).

Skills Competence

Communication. Each discipline defines communications differently but most agree that it is exchange of meaning through verbal and non-verbal interactions, signaling respect and regard for the other person or people in the communicative process. In transnational partnership this level of communication fosters and improves relationships cross-culturally. For example, in Middle Eastern cultures, the harmony of the group is important so people tend to avoid saying anything that might be thought of as offensive.

> The first thing is to really be aware of the cultural differences, which do occur, not necessarily because the cultures are different, but also because of geography of thought. The physical distance makes a big difference and one needs to be aware of it. The second thing of course is the cultural difference. Everything that

> we may interpret in a different way in the Western culture might be interpreted somewhat differently in the Middle-Eastern and Eastern culture. Having grown up in the Eastern culture, having lived in the West and then going back, I have always been quite aware of cultural differences. So much so that sometimes I am on a conference call with colleagues in New York and Doha and the understanding, the interpretation, the gist of what they get out of it, might be very different from each other. So I think the first step is to be aware of this. This not only is a distinct possibility but this is a sure thing that people interpret events differently and communications are very different depending upon where they live and what their cultural background is
>
> (Participant A2).

Interpersonal engagement. Many of the participants viewed engagement as a vital skill that was important to planning and collaboration. They believed that diversity of thought brings to a partnership inclusion and sustainability. To be conscious of mission, vision, purpose, philosophy, goals, and what is happening in the environment brings sensitivity to partnership. They also stated that tolerance for complexity, improves verbal and non-verbal communication, and is tied to mission, vision, honor, reputation, integrity, and character.

> Most people go to foreign places and enter on their own terms. That will never work. You have to go with an attitude of constructive engagement…do not go with a rigid fixed agenda. We all have our own objectives, and want to have them fulfilled, but we must adjust them here and there. I have adjusted myself tothe people who come aboard. I went into Qatar and was acceptable to change and

listened very carefully. I knew what had to be accomplished and how I was going to fit into the fabric and for me it has worked very well, challenging, but worked well because I knew earlier on that I needed to constructively engage to get my work done and that has worked well

(Participant A6).

I have seen patients, families, and the whole team dynamic and saw it very differently in New York. I was able to have exposure to two different cultures and integrate them. Religion feeds into the cultural life of people from eastern cultures. You have to respect people's religious beliefs when relaying information and making certain recommendations. For example, in Islam men and women are not allowed to have physical contact unless they are married. Some patients still prefer to have a same-sex doctor and they will tell you that. I was not allowed to shake hands with the women or even look at them. When I came west I was totally used to that. This did not faze me but for a lot of the residents with a Western background, it fazed them. I had to explain to them that this is important in engaging with people from many of the Middle-Eastern cultures

(Participant B1).

I think the answer is to be very sensitive and to try to learn so that you can begin to pick up the different cultural cues that will help you in terms of guidance. Let's say for a young person who had to integrate himself …you cannot go in and say I am going to change this. The cultural things you cannot change. We are successful in certain things in the west for a whole complex number of reasons

and that may be harder for them. So my observations in Qatar compared to the U.S. is we tend in the U.S. to be more independent as individuals. We make decisions as individuals that in other societies the Middle East is one…where the hierarchies are much more dominant

(Participant A5).

In teaching moral codes and social values, and talking about how different societies might approach a social issue, there was international perspective because the student body is international. They have an Arabic culture, speak English, and are native to the region. I approached issues globally letting them explore differences and distinctions among all these topics acknowledging the opposition to any issue and then making their arguments. That was a way of teaching them without imposing any value system, or culture on them

(Participant D1).

Use conservative behavior that is always a positive starting point. Observe, have the capacity to be aware when everybody is staring at you, and realize that you are doing something wrong…that is very important…understanding the right way of engaging in a conversation, a professional conversation. Here you get there never without first having some very pleasant simple conversation. Just to get to know one another. That is a dramatic difference between the western way of doing business today. So I think that certainly tolerance and awareness for the difference but in a way to take the partnership to the long term. One of the things is to understand how people engage in the personal relationship. Do not just go straight to the truth. You just first get to know the person and make everybody

comfortable then you can go discussing even difference of views, difference in opinions. You get there first

(Participant D2).

You do not go to Qatar with the idea that you know immediately how to do things better. If you are going to take that step, you need to be smart enough to know that you are going to need to spend a lot of time before reaching any definitive conclusions about anything. That is true of any situation that I find myself in here in New York. It takes time to have a clear sense of motivations, incentives, the overall structure to figure out how people are interacting, what incentives are in place in a work environment, motivations that are encouraged or discouraged. It is a basic rule of thumb that you do not want to pretend to know something until you have spent time cataloguing your observations

(Participant A4).

As an educator, I think you should not just teach active listening. You should also teach active observations, and how students should present with humility and open-mindedness about the norms that are not their norms and get them to accept the idea that what might be my norm might not necessarily be the other's norm. They have got to be prepared with skills on how to communicate cross-culturally and bi-culturally, and know the effects of being judgmental and the dangers of engaging in stereotyping

(Participant C3).

If you are vigilant in New York you are going to be vigilant in Qatar. If you are a genuine listener in New York, you are going to be a genuine listener in Qatar and

it is only going to serve you well. I don't think you should completely re-invent yourself. As a physician dealing with patients in Qatar, you are going to be shocked at how similar the needs of the patients are even in a place as far away and in a cultural environment as different as Qatar. We are very plural here in New York and so it makes whatever we encounter over there less likely to be either problematic or foreign. So we go over there and immediately there are dynamics you can observe that are very similar to the dynamics that we already see here. I think our hospital here in the U.S. very accurately reflects the full spectrum of the socio economic and ethnic contexts in health-care

(Participant A4).

You come to the Middle East, let's say, Qatar, in the doctor-patient-family dynamic you need to know who is the person you need to talk to it could be the husband if it is about the wife. If a patient or family member in the hospital, it may be the uncle in the family who is the main man. Then how do you learn these things it comes from experience. You would be an inefficient doctor if you say I want to be very rigid about this. This is how I was taught and I will just talk to the patient. Well the question comes up you may in fact create an impediment or an obstacle in delivering good health care to the patient just because of your actions

(Participant C3).

If you make a *faux pas* it will be understood as well, you know obviously there is a difference and this often this gives rise to laughter. I can tell you about an episode. When you go here to a bakery or you buy a tray of fresh sweets, during

the preparation of the tray they always offer you one, and if you want to try one you are allowed to try one. I was invited to dinner, went to the bakery and they were getting the plates ready, it was 5:30pm, the sun was setting, and I was craving for a little cookie and I asked to try one and the gentleman kindly gave me one and he said, "You know its Ramadan, you are not supposed to eat in public." I said "OMG". He just laughed. Was it a *faux pas*? Yes, but you know my reaction was absolutely sincere. I realized that okay…it is not part of who I am to be aware of this right away

(Participant D6).

Be open-minded; accept difference in culture, personality, and orientation. There is always room for improvement and interaction. Just keep a positive manner. There is a lot of success using that approach

(Participant D2).

Yes, part of leadership is having everybody feel that they are part of the decision in terms of what you do. This is the way you educate medical students. The way you do it is by asking what do you think about this and it may be that the ideas are not good or they may be terrific but inevitably there will be overlap. You just have to be very open-minded

(Participant A6).

Dynamics consciousness. This sub-theme depicts the importance of reflecting on subjective and objective experiences, and communicating these experiences clearly and honestly.

Use as much as possible of all of your life experience to try and understand but at the same time do not think that you can come up with a theory of everything. Be prepared to be surprised which also means it is important at the same time to always be yourself, because most people are aware of the differences. It is not just you as the physician or educator that needs to be culturally sensitive. You are aware of the cultures of difference, so are the students

(Participant D2).

The doctors at WCMC-Q are terrific physicians and I do not think I brought anything unusual. I think the fact that I am there with an interest in patients, their way of practice, with an interest in spending time with them is important in cementing the relationship. I think the clearest motivation for having us interact with the folks in Qatar the way that we do comes from the needs of the students. So they are really the reason why we are there. We are there to cement their relationship with the parent/home country institution. We share the Cornell moniker, and by going there, we help the students feel that they are part of a larger community

(Participant A4).

In any partnership as it is true in marriage and true in any collaboration. The concept of partnership and collaboration is that you lose control. You do not have the same control you have if you are working alone but you gain because the pie gets bigger and if you understand that concept then you can enter into collaboration and be willing to give up something

(Participant A5).

> After a period of time, after five years, we sat down, we looked at what was happening, we saw the progress and said what we would accomplish in ten years and now as we go forward it is important to constantly review what is happening to challenges and successes. There will always be challenges to success but we need to look back and see where we need to fine tune and adjust. I think this is exactly what is being done and I think we are doing great. Partnership, strategic structure, and individual connections they form a trust factor in the big strategic mission. So most of us are going in with previous international exposure and exposure to Qatar. But with new people coming they are going to learn from our experience, it is the right thing to do, and makes our mission very unique
>
> (Participant A6).

The voices of these participants bear witness to the fact that in the student-teacher, doctor-patient, peer-to-peer relationship, people are listening and paying attention to behaviors. Individuals must be self-aware with values grounded in a strong sense of moral consciousness and integrity. They must be prepared to be vigilant and mindful in cross-cultural interactions. They must set standards for learning, values, and expectations and recognize how their individual behaviors interact with the behaviors of their counterparts.

Table 4.2

Themes and Sub-Themes from Research Question

Knowledge Competence		
Themes	Sub-Themes	
Cross-Cultural Learning	Culture-Specific Knowledge	Slimbach, R. (2005). The *Interdisciplinary Journal of Study Abroad, 11*, 205-230.
	Understanding the Limits of Own Cultural Knowledge	
Global Leadership	Perspective Consciousness	Morrison, A. J. (2000). *Human Resource Management, 39*, 117-131.
	Super-imposed Mission, Values, and Expectations	
Behaviors Competence		
Themes	Sub-Themes	References
Authenticity	Transparency, Relationship, and Mutuality	Avolio, B. J. & Gardner, W. L. (2005). *The Leadership Quarterly, 16*, 315-338.
	Generosity of Spirit	
Conscientiousness	Professional Commitment	Barrick, M. R. & Mount, M. K. (1991) *Personnel Psychology 44*, 1-26
Skills Competence		
Themes	Sub-Themes	
Communication	Interpersonal Engagement	Lustig, M. W. & Koester, J. (2006, 2010). *Intercultural competence: Interpersonal communication across cultures* 5th, 6th eds, New York: Pearson Education, Inc.,
	Dynamics Consciousness	

Conceptual categories of cross-cultural competence. In grounded theory categories are formed. These are the basis for the formation of a theory or hypotheses (Charmaz, 2000, 2006), which are presented in Chapter 5. The densest code most imbedded in the themes and sub-themes, and which occurred in relationship or property (Bergkamp, 2010) was *respect*. Respect described how the majority of the experiences were represented in the participants' reports on cross-cultural competence in transnational medical education partnership. In grounded theory, the results are judged by four criteria; "fit, relevance" (Charmaz, 2011, p. 54) workability, and modifiability (Glaser & Strauss, 1967; Glaser, 1978). Respect was refined into the following categories: (a) Recognition Respect, (b) Evaluative Respect, (c) Mutual Generativity, and (d) Conscious Conscientiousness. Brief definitions of these categories with theory implications are illustrated in Table 4.3 and will be discussed in Chapter 5.

Summary of Results

The practice of medicine is governed by conscience, respect, and dignity. Middle Eastern cultures place a high weight on respect in all interactions. The individual must begin the cross-cultural journey with the agency of common humanity, recognizing and celebrating individual and collective dignity and value. Navigation in cultures of difference must be approached with an open mind. Situations may not always work desirably so personal adjustments must be made. There must be flexibility and frustration-tolerance, accepting that there are other individuals with different cultural behaviors and attitudes. As a professional, the true mission must be superimposed. There must be engagement, and in engagement, there must be mutuality and common purpose. Leaders must be aware of how their behaviors relate to or influence the needs

of others. In the transnational arena, stakeholders must be committed to building an impressive global partnership where everyone is valued, creating an environment where the elements of respect, reciprocity, mutuality, generativity, transparency, consciousness, and conscientiousness are fostered and encouraged.

Table 4.3

Conceptual Categories of Theoretical Framework for Cross-Cultural Competence in Transnational Medical Education Partnership

Category	Definition	Theory Implication
Recognition Respect	Respecting and understanding the importance of other people and their individual beliefs, cultures, and ambitions. This is based on the fairness and equity principles of social justice.	It is the motivator for meeting and exceeding goals and the catalyst for self-actualization. It promotes efforts and behaviors that benefit the organization and performance.
Evaluative Respect	Honoring the host as competent partners, through positive appraisal, esteem, and admiration for standards of excellence.	It engenders empowerment, synergy, and trust, common, and collective agency and promotes efficacy.
Mutual Generativity	Reinforces relationship building, provides focus on purpose, gives meaning to interests and goals of interdependent parties working together to achieve a shared mission and vision. It is the willingness to continuously work at relationship building to benefit future generations.	Social justice becomes codified in behavior, through demonstration of equity and fairness in collaboration. It connotes shared purpose and never taking friendship or partnership for granted.
Conscious Conscientiousness	Awareness and mindfulness of moral agency and commitment to the ethical and moral application of knowledge, behaviors, and skills competence. It is doing what is right, effective, and efficient in partnership.	It promotes genuine listenership, reflective abilities, and motivation. It is the embodiment and integration of pro-socialness and adaptive agency in cross-cultural settings.

Chapter 5: Discussion

Introduction

The voices of the participants captured an account of the knowledge, behaviors, and skills competence that professionals must engage in for effective transnational partnership. Chapter 5 includes study implications, which are guided by the research question: What knowledge, behaviors, and skills foster cross-cultural competence in transnational medical education partnership? This question is important since cross-cultural competence has been under-researched among health care professionals in the context of transnational medical education partnership.

The researcher consulted literature in the field to determine the fit for this body of work. Related literature was thoroughly investigated and woven into this chapter (Charmaz, 2000). Additionally, this chapter will address the study's limitations and recommendations. The lessons learned sum up the data (Lincoln & Guba 1985).

Implications of Findings

The purpose of this study was to unite the research process with theory development. The study design used a qualitative grounded theory approach as a method to explore and create a lens through which to look at cross-cultural competence that could be new or useful in the context of transnational medical education partnerships. The findings provide rich qualitative data and an explanatory model upon which to design professional development training and services related to cross-cultural competence.

Lastly, the study contributes to the literature on cross-cultural competence in transnational medical education partnership.

The research used a qualitative grounded theory approach to explore the experiences of 25 professionals engaged in transnational medical education partnership. Interviews and memos served as the main sources for the study. The research was conducted at Weill Cornell Medical College in New York and Weill Cornell Medical College in Qatar. Narrative inquiry consisted of audio-recordings, documentation, and analyses of the participants' individual accounts and experiences.

Based on the diverse group of participants and observations, an inductive/deductive approach to identifying relationships in the data was used (Hood, 1983). Memos were constructed early and later on in the research process (Charmaz, 2011). In the coding stage, theoretical memos were used to explain how codes were related to the data (Glaser, 1978, 1998). Memoing was also utilized for any ideas based on personal prejudices and the individual experiences of the researcher (Glaser, 1998). In order to interrogate and minimize researcher bias, Charmaz, (2000, 2006) suggested reflective practice and that the "researcher represents them in written reports" (Charmaz, 2011, p.189).

The research used theoretical sensitivity to identify the objectives and actions of the participants and interrogated the studied experiences to establish connections in building the theory (Strauss, 1987). Coding was broken down into themes and sub-themes. Then, a conceptual framework was formed which provided the foundation of a theory.

"Theory is powerful and organizes what professionals pay attention to and how they pay attention. It shapes beliefs that in turn shape action" (Domahidy, 2003, p. 76). Several theories grounded this discussion. They are Kant's (1785) moral theory which recognizes the dignity of humanity in everyone; Roger's person-centered theory urging us to value others; Kelly's (1963) personal construct theory which postulates that it is our interpretation of experiences that can make life worthy or diminish the worthiness of the experience, Rawls' (1971) social justice theory which reminds us that for social justice to prevail, one must be vigilant and promote equity and fairness in decision-making; Bandura's (2001) social cognitive theory which describes moral agency as a signal of respect and pro-social behaviors; and emotional intelligence theory and its five components as developed by Goleman (1995) which encourages individuals to follow the heart through awareness and conscientiousness.

The code *respect* was the first and densest code to emerge from the data. It was positioned in each theme and sub-theme (Holton, 2007). Cited in Dillon, (2010) respect has cognitive, affective, and conative components (Bloom, 1956; Dillon, 2010; Downie & Telfer, 1969; Frankena, 1986).

For this study, in the cognitive domain, respect was recognized as awareness of others, for example, their respect-warranting abilities. It also connotes that professionals must understand the meaning of partnership and accommodate respectful decision-making through inclusion. There must be consciousness to meaningfully appreciate and respect the magnitude of partnership and what it means to the strength and reputation of institutional practice. The individual must be capable of making judgments about the

importance of partnerships and demonstrate understanding of the norms, mores, and values of a different culture.

For this study, in the affective domain, respect was recognized in the motivation of the participants to be actively involved in the building of a knowledge and learning society. Many of the participants spoke about commitment and conscientiousness to the mission and values of the institution. They reminisced about the values of honor and nobility, which are imbedded in the practice of medicine, when as medical practitioners they consecrated their lives to the service of humanity. They demonstrated willingness to be humble, understand the perspective of others, suspend judgment, exercise emotional intelligence, and draw upon analogous experiences in resolving conflicts (Goleman, 2004; Tervalon & Murray-Garcia, 1998). In the conative domain, respect was recognized in motivation and disposition to accommodate and commit to appropriate and satisfying cross-cultural encounters (Slimbach, 2005).

Respect is the "single most powerful ingredient...in the creation of a just society (Lawrence-Lightfoot, 2000, p.13). Expressing respectful behaviors towards others signals regard for their personhood (Dillon, 2010). Respect is synonymous with positive regard, which is an attitude that enables us to value others (Rogers, 1959). Positive-regard is used in Person-Centered Theory and can be applied to individuals involved in growth-oriented enterprise (Rogers, 1959). Positive regard is also applicable in this setting as success in the global arena is dependent on individual and collective cross-cultural abilities, achieving common goals, and working toward common efficacy. Positive regard develops when professionals bring attributes that promote mutuality, generativity, and sustainability to the partnership. It is based on steering people in

positive directions accompanied by mutually agreed upon partnership goals and objectives with proper institutional and collegial support in place. When key decision makers are proactive, they engage and empower others. They also exhibit the proclivity for pro-socialness and signal that people are worthy of trust, capable of making decisions, that could affect their future and move them forward in accomplishing goals (Capuzzi & Gross, 2007). The literature review identified several manifestations of respect. *Recognition Respect* and *Evaluative Respect* were identified as suitable for categorizing many of the responses in these findings.

Recognition respect. *Recognition respect* has been described by Darwall, (1977) as a duty of virtue and moral obligation to recognize the dignity of humanity in other human beings (Kant, 1785). *Recognition respect* has also been referred to as respect for another person's moral personhood and is in action when we recognize someone else's rights and personal "value as equivalent to our own" (Calhoun, 2005, p. 88). This form of respect was also referred to as interpersonal recognition respect and connotes that all persons equally and morally deserve respect simply because they are human (Dillon 2007; Kant, 1785).

Studies based on social justice theory interrogated the process of fairness principles and investigated acting cooperatively with others. They revealed that interpersonal recognition respect among group members elicits extra effort and behaviors that benefit the performance of an organization (De Cremer, 2003; Miller, 2001; Rawls, 1971; Simon & Stürmer, 2003; Sleebos, Ellemers, & de Gilder, 2006; van Quaquebeke, Zenker, Eckloff, Tyler, & Blader, 2009). Smith (2007) believed that several values are fundamental to social justice in partnership. Smith believed that to complete the process

of fairness and justice, there must be "cooperation, collaboration, integrity, and compassion" (Smith, 2007). These values are illustrated in Table 5.1.

Table 5.1

Expansion of Concept of Social Justice in Partnership: Synergos Corporation

Value	Definition
Collaboration	Achieving better results through inclusion, participation, and partnership.
	Embracing diversity and connecting people across boundaries.
	Being open to new and differing opinions.
Integrity	Being honest and transparent.
	Consistently honoring values.
	Treating others fairly and with respect.
	Keeping commitments.
Compassion	Seeking to understand before being understood
	Demonstrating humility.
	Being of service to others.
	Expressing concern for others.

Note. Adapted from social justice and inclusive partnerships. A reflection by Barry Smith, 2007, for the Synergos Global Senior Fellows Meeting, New York.

The social justice principle in this study revealed that in this partnership, collaboration is fundamental to achieving shared goals and vision and producing

meaningful results for all stakeholders. It is signified in the building of human capital and allowing others to feel a sense of empowerment and equality in practice, and commitment to improving the quality of life through quality education. Embracing collaboration and diversity of thought is the harness for best business practices and knowledge-management. These are espoused to be essential drivers for building world-class organizations and working and learning environments. The justice principle when enacted in policy and procedure is synergistic and conveys understanding and appreciation of talents and skills, thereby, encouraging ownership and decision-making in partnership.

Compassion in the transnational partnership experience is the display of genuinely accepting another person from the space of their humanity. Mutual interactions involve caring and empathic understanding. These virtues lead the individual to expressions of confidence, which is especially important in communication as it transmits sensitivity, warmth, and collegiality. When people listen intently and are present in the moment, they ask questions for meaning, to solidify sharing, and engender trust.

Social cognitive theory describes agentic morality as a signal of respect and pro-socialness (Bandura, 2000) when navigating cross-culturally (Betancourt, Green, & Carillo, 2002). To respect others, one must be involved in positive actions and attitudes considered to be a component of agentic morality when demonstrated in behavior. The term agency is quite often referred to as making things happen through one's actions and behaviors (Bandura, 2001). Pro-social behavior begins with acknowledging another's personhood, making them the focus of attention, accompanied by cooperation and collaboration (Brief & Motowidlo, 1986). In this partnership, pro-socialness is

recognized as fairness, kindness, and civility with the worth and dignity of the individual as the overarching principle (Covey, 2006). *Recognition respect* is a cultivated skill, behavior, and state to be mindfully maintained and honed "for improved interactions" (Thomas, 2006, p. 80). Respectful behavior is valued in many Middle Eastern countries since great weight is placed on sensitivity and consideration in the process of quality communication, and is considered to be an indicator that the sender has excellent values and upbringing (Central Intelligence Agency World Fact Book, 2008; Foss, 2009).

The impact of *recognition respect* is acceptance, respect, and understanding the importance of both individual and collective beliefs and ambitions. A majority of the participants across all four groups spoke about the importance of behaviors and skills being regulated by recognition respect. It is central to putting others at ease with cultural differences and is unifying. It is the impetus to value and work collectively in partnership. *Recognition respect* must be a living, dynamic virtue in the personal and professional belief systems of practitioners. *Recognition respect* elicits extra effort and behaviors that improve professional interactions. It brings about the willingness to act cooperatively and engenders a strong value on working collectively with genuine demonstration of caring and concern about common goals.

Evaluative respect. The category *evaluative respect*, which is also referred to as appraisal respect, involves sensitivity and evaluative judgment on standards of excellence (Darwal, 1977; Dillon, 2010; Hudson, 1980; van Quaquebeke et al., 2009). In this study, it is connected to the positive appraisal of standards that are set for learning, mission, and vision and never taking the partnership or accomplishments for granted. Bhawuk and Brislin (1992) believed that the sensitivity that comes with awareness is a predictor of

success in navigating cross-cultural environments. In partnership, substantial planning and investments could be wasted if the acknowledgment of excellence is ignored or neglected. The impact of *evaluative respect* as a sensitivity in cross-cultural competence is empowerment. Empowerment creates a circle of trust where strength is amplified by collective agency, synergy, and engagement (Bandura, 2002b; Hudson, 1980; Lawrence-Lightfoot, 2000), and empowers others to achieve the full extent of their greatness.

Collective agency is the tie that binds shared beliefs, missions, values, and vision for partnership success. It is the driver for accomplishing goals and tasks in relation to the social need (Bandura, 1986, 2002a; Yolles, Fink, & Frieden, 2010) of equity and empowerment for all. The social needs in this partnership are the education of a medical workforce, a focused knowledge-driven organization, and the building of a world-class economy and learning society. *Evaluative respect* in transnational partnership is acknowledgement of the importance of the host/home teams as competent partners based on admirable qualities, skills, and accomplished achievements. This form of respect must be delivered appropriately and predicated upon respect-warranting capabilities (van Quaquebeke, et al., 2009). Kouzes and Posner's, (2007) *encouraging the heart* is espoused as the ability to move people forward into directions of greatness. Their minds, hearts, and spirits are uplifted which is a motivational tool in growth-centered partnerships and enterprises. This is synonymous with evaluative respect. *Encouraging the heart* must have the elements of motivation, passion, desire, trust, solidarity, inspiration, and selflessness (Cheese, Thomas, & Craig, 2008). When these elements are in action, the implications of evaluative respect are motivation to help others to self-actualize and commit to a just and worthy cause; passion, desire, and solidarity to work

toward causes through engagement and empowerment; abilities to motivate ambitions that are driven by lofty goals; trust born out of respect for human dignity; inspiration to realize a vision that will generate the health, wealth, and peace imperative. It is selflessness to act and work in ways where dominance is set aside and true partnership is reflected in doing what is right, just, and noble. Implications of evaluative respect for the individual, team, and organization are manifested in the realms of engagement and empowerment.

Synergy in this partnership is adding personal and professional values to services, with educational value at the center of the process. Synergy involves active cooperation for effective and efficient goals to be accomplished. It is important to productivity and responsibility for processes and systems that drive behavior, ownership of activities, leaders giving feedback, motivating partnership teams, and making everyone feel worthwhile. For synergy to be present and active, those in leadership must understand what their limitations are through the examination of the partnership process, how they work, and how people relate to each other. By objectifying the process, people work towards a purpose with an emphasis on building a solid infrastructure and listening to ideas. It must be about empowerment which is inclusive of people in the decision making process coupled with agreed upon goals for sustainable development.

Engagement is identified in business literature as a drive of quality performance and seamless delivery which then empowers stakeholders to commit to the process of partnership activities (Lawrence-Lightfoot, 2000; van Quaquebeke et al., 2009). Empowerment is putting the right conditions in place to allow people to make a difference, improve performance, and develop strong and successful cross-cultural

linkages and relationships. There are many reasons why empowerment must be viewed as a motivational tool. The main reason is involving people in making decisions to shape goals that serve their specific needs and the needs of the organization. It must be a good fit. When individuals and groups are not empowered they are less self-reliant and lack resilience (Improvement and Development Agency, [IDeA], 2011). Together, engagement and empowerment are important in building collective agency, unity, and connectivity and considered to be the building blocks of control, accountability, and responsibility (Bandura, 2000; Lawrence-Lightfoot, 2000). Evaluative respect is a responsive relation in empowerment and engagement. Lowndes and Pratchett's, (2009) categories of engagement and empowerment are illustrated in Table 5.2. They believed that people must be provided with forums where they can have their voices heard and participate in decisions that will affect their future and those of their children (Lowndes & Pratchett, 2009). They must be respectfully listened to, enabled, empowered, and share in decision-making to engender a sense of ownership and accountability.

Table 5.2

CLEAR: Engagement and Empowerment

C	When they *can* and have the resources necessary to make their argument.
L	When they feel part of something, they *like* to participate because of its centrality to their sense of identity.
E	When they are *enabled* to do so by an infrastructure of institutional support and collaboration.
A	When they are directly *asked* for their opinion.
R	When they experience the system they are seeking to influence as *responsive*.

Note. CLEAR: Understanding citizen participation in local government and how to make it work better. Adapted from, "*Local Governance Brief, Policy Journal of the Local Government and Public Service Reform" Initiative*, 9, by Vivien Lowndes and Lawrence Pratchett, 2009

The challenge for leaders who work in relationships "between nations, races, religions, cultures, organizations, groups or individuals is to…understand it and engage it and to groom selected other leaders" (DeLellis, 2000, p. 36) and invite others to do so. DeLellis (2000, p. 40) in his "integrated typology of respect" (identified several) elements of the subjective and objective aspects of respect, which were reported in the findings of this study. In the subjective sphere, DeLellis identified respect as

"appreciation, admiration, esteem, honor, and deference" (DeLellis, p. 40). In the objective sphere, he identified respect as "regard for nature, humans, civilization, and the metaphysical" (DeLellis, p. 40).

In this study respect was evident in the acknowledgment of patients and their families in the medical care experience. Esteem and value of self and others, was displayed in recognition and evaluative respect of value-warranting abilities and "for people who display one's own values of honesty, courage, and kindness" (DeLellis, p. 40). Respect was evident in how the participants viewed the social institutions of medicine and education, especially the Hippocratic oath, which guides the practice of medicine. Respect was evident in respect for "customs and rules, social etiquette and dress" (DeLellis, 2000, p. 40). Across all groups, there was sensitivity to laws, mores, and regulations. There was the deepest respect, regard, and honor for religion and its practice. The participants honored the influence and value of religion to those who believe in, are devoted to, and practice its tenets.

Mutual generativity. The category *mutual generativity* connotes the reinforcement of relationship building with a "long-term focus" (Johnson, 2012, p. 138) on positive benefits to humanity. It positions respect as a responsive relation. Mutuality is about connectivity and knowing where all parties are heading in order to meet the mission and vision, needs and goals of the partnership. Slimbach (2005) described mutuality as willingly removing the walls we place between ourselves to "enter the world of another to listen, hear, and receive" (Slimbach, p. 220). In the healing arts, this is referred to as attending, whereby one suspends judgment to stand in the shoe of another. This departure from one's identity should not be looked at as "geographical but as

cultural, psychological, and spiritual in its nature" (Slimbach, 2005, p. 220). Generativity is concern about the "consequences of actions" (Johnson, 2012, p. 137). These actions will affect the lives that present and future generations will lead and the world or footprints we will leave behind for our children (Johnson, 2012). Mutual generativity can also be considered as the appropriate sharing of feelings and informing the communicative process (Erikson, 1964; Kernis, 2003). This mutual interdependency is observed in commitment to building trust, encouraging synergy and empowerment, teamwork, and lasting cooperation (Lawrence-Lightfoot, 2000). It is reflective of clarity and transparency in relationship building (Gardner, Avolio, Luthans, May, & Walumbwa, 2005).

In an article on experiences in implementing a "medical ethics and humanities course for premedical students" (del Pozo & Fins, 2005, p. 135) offered in 2003 at Weill Cornell Medical College, Qatar, shared that the course was "designed to prepare students for the medical school curriculum to make global medical knowledge meaningful in the local context" (del Pozo & Fins, 2005, p.135) (pedagogical challenges included) "cross-cultural tensions that emerged when introducing themes from Western medical ethics and humanities into the Islamic context" (del Pozo & Fins, 2005, p. 135). The authors described how these unique challenges caused them to devise a course that would cultivate their students to "address ethical dilemmas from their own cultural perspective, as well as from a North American perspective" (del Pozo & Fins, 2005, p. 135).

Another article reported their "longitudinal experience in teaching a clerkship in clinical ethics and palliative care at the Weill Medical College campuses in New York and Qatar… using participant observation and reflective practice for this study…to

counteract the hidden curriculum when learning about clinical ethics and end of life care" (Fins & del Pozo, 2011, p. 321). Using the anthropological concept of Hofstede's (1980, 2001) high and low-context societies, the authors performed an experiment involving contrast in Doha's "high-context society, where much information is culturally embedded and appears to be hidden"… compared to low-context New York where information is overt" (Fins & del Pozo, 2011, p. 321). They concluded that contextual factors have an "influence on the importance of what is implicit and explicit in a student's educational experience…medical educators should be aware of local cultural context in order to provide effective pedagogy" (Fins & del Pozo, 2011, p. 321). These two papers are reflective of mutual generativity in transnational medical education. These professionals made decisions that recognized needs, with an understanding of the societal context of communication, and who and what were most important in this partnership.

Implications for the individual, team, and organization of mutual generativity include increased levels of trust and confidence in partnership to benefit the present and future needs of the society. It is micro-level agreed upon mutual dependency with implications for macro-level sustained harmonic relationships beneficial to the society-at-large. The impact of mutual generativity on cross-cultural competence is commonality of purpose in collaboration. It is acting on shared vision, partnership, and agreed on principles, in making effective, efficient, and impactful decisions (Thomas, 2008).

Study participants across all groups recognized cross-cultural collaboration as structure that promotes exchanges of expertise, join education and research projects, and interpersonal interactions. It is collective agency that binds cooperative efforts, facilitates quality relationships, and group interactions. Mutuality is respecting others and connotes

the ethic of reciprocity, a humanist principle, and the invocation of the Golden Rule; *Do unto others, as you would have them do unto you*. It incorporates the recognition of the need to uphold the value and dignity of others.

Conscious conscientiousness. Several of the participants spoke about the concern for critical awareness of dominant culture behaviors and suggested that humility is a responsive relation of self- and other-respect. They feared that lack of humility could threaten partnership stability. They encouraged meekness, unpretentiousness, and reflection upon assumptions that might otherwise endanger effective cross-cultural interactions (Arcuri & Ulrich, 2007).

The category *conscious conscientiousness* is reflective of awareness of personal moral agency (Bandura, 2002a, 2006). To be conscious is to be mindful, aware, and in the moment. When "functional consciousness" (Bandura, 2006, p. 167) is purpose-centered, it involves reflection and internal processing of information that informs actions based on the ability to regulate one's emotion (Bandura, 2001). Listening attentively with reflective abilities (Schon, 1983) can lessen tension, fear, and confusion in the communicative process. Slimbach (2005) believed that stepping out of a zone that is comfortable and walking in the boots of another can cultivate lenses with which to view the world of another (Appiah, 2006). Slimbach (2005) posited that this leads to greater self-understanding. Immersion as a form of mutuality provides focus on purpose and gives meaning to interests and goals of interdependent parties working together to achieve shared mission and vision (Genero, Miller, Surrey, & Baldwin, 1992). Conscious conscientiousness was also referred to in literature as *cultural humility* (Tervalon & Murray-Garcia, 1998) and described as "perspective consciousness"

(Slimbach, 2005, p. 206). Consciousness connotes being self-aware, disciplined, and open about current realities. It was also referred to as "balanced processing and the propensity to step back from a situation, suspend immediate judgment, and think" (Goleman, 2004, p. 3; Luthans & Avolio, 2003).

The implications on the individual, team, and organization of conscious conscientiousness are mindfulness of behaviors, attitudes, and skills that are important in building and leading teams. Conscious conscientiousness drives understanding and consideration of differences and awareness that we come with our own culture and language, and how we view the world. It can be mastered through "self-monitoring and regulation" (Goleman, 2004, p. 3) to support dynamic transnational partnership (Ross & Thornton, 2008).

Goleman (2004) in his model of emotional intelligence described several competencies that mirror conscious conscientiousness. They are "self-awareness, self-regulation, motivation, empathy, and social skills" (Goleman, p. 3). Goleman defined "self-awareness as ability to recognize and understand moods, emotions, and drives and their effects on others" (Goleman, p. 3). He described on of the hallmarks of emotional intelligence as "self-confidence and realistic self-assessment" (Goleman, p. 3). For professionals in a cross-cultural environment, to be critically conscious is to exude a sense of presence that establishes trust and rapport. It is presenting with a global mindset, willingness, and ability to commit to partnership obligations.

Perspective consciousness is described by Goleman as "self-regulation…ability to control or redirect disruptive impulses and moods and to suspend judgment to think before acting" (Goleman, p. 3). The hallmarks of self-regulation are "trustworthiness and

integrity, comfort with ambiguity, and openness to change" (Goleman, p. 3). Perspective consciousness with objectivity is considering the views of others (Goleman, 2004).

Conscientiousness on the "Big Five Personality Dimensions" (Barrick & Mount, 1991; Digman, 1990; Norman, 1963) can be considered to be one of the strongest of dimensions in the realm of partnership in this transnational medical education setting. It governs "dependability, organizational, and hard-working abilities" (Barrick & Mount, 1991, p. 2). These qualities are important to transnational partnership performance. Goleman (2004) described conscientiousness as motivation to pursue goals that are driven by "passion and energy to work for reasons that go beyond money or status" (Goleman, p. 3). One of the hallmarks of conscientiousness and motivation is commitment to an organization thereby seeking opportunities to create and align values that are in tune with its mission and vision. In transnational partnership it is described as working toward mission, vision, and values with a strong desire for self and other achievement. Empathy mirrors cultural humility, which Goleman described as "understanding the emotional make up of other people" (Goleman, 2004, p. 3). One of its hallmarks is cross-cultural sensitivity. The final category was "social skill" described as the "ability to find common ground and build rapport for team building" (Goleman, 2004, p. 3). Collins (2001) suggested that motivating others into greatness is not about blind leadership and followership. The leader must be humble enough to trust the opinions of others.

Conscious awareness of others is conscientiousness in valuing, protecting, and promoting partnership and appreciating cultural values that are different from our own. This far-reaching aspect of respect neutralizes insecurities and pettiness which tend to

accompany those who have yet to put to bed unchecked pride. It is in the realm of Conscious Conscientiousness that respect becomes a virtue of high moral standard. Respect should not be seen only as a behavior, attitude, or feeling. It should also be understood as a universal basic human right.

Leadership dimensions of this study. Epistemology is the study of how we know, what we know (Steup, 1996). Epistemic virtues have been aligned with how we construct the way we view the world based on personal life experiences (Bishop & Trout, 2004). Kelly (1963) in personal construct theory believed that it is not what happens that makes a person experienced but our interpretation of these experiences. "Like all basic truths about what is best for human beings, when we catch a glimpse of that truth, we know that our lives and all that we touch will be better for the effort (Collins, 2001, p. 38)".

Table 5.3

The Five Components of Emotional Intelligence at Work

Components	Definition	Hallmarks
Self-Awareness	the ability to recognize and understand your moods, emotions, and drives, as well as their effect on others	• self-confidence • realistic self-assessment • self-deprecating sense of humor
Self-Regulation	the ability to control or redirect disruptive impulses and moods the propensity to suspend judgment- to think before acting	• trustworthiness and integrity • comfort with ambiguity • openness to change
Motivation	a passion to work for reasons that go beyond money or status, and a propensity to pursue goals with energy and persistence	• strong drive to achieve • optimism, even in the face of failure • organizational commitment
Empathy	the ability to understand the emotional makeup of other people, and skill in treating people according to their emotional reactions	• expertise in building and retaining talent • cross-cultural sensitivity • service to clients and customers
Social Skill	proficiency in managing relationships and building networks, and an ability to find common ground and build rapport	• effectiveness in leading change • persuasive • expertise in building and leading teams

Note. Adapted from "What makes a leader? By Goleman, D. (2004). *Harvard Business Review* November-December 1998.

Virtues are part of the canvas of an ethical portrait of leaders (Collins, 2001). These virtues are espoused as courage, prudence, optimism, integrity, humility, reverence, compassion, and justice (Johnson, 2012). Governing bodies and educators

who are courageous and care about education and its capacity to improve the human condition become passionately involved in enterprises that bridge the intellectual and cultural divide. They are committed to a vision of excellence and the exercise of prudence in selecting the best course of action, equipped with the right people for the partnership (Collins, 2001). They are optimistic about sustainability even in the face of unpredictability and volatility, able to transcend differences to build lifelong relationships that foster trust and cooperative effort. They are true and consistent and hold high ideals that are reflected in everything that they know, say, and do, walk the talk, and are fully aware of their stature and the responsibilities that accompany it. They possess humility and are willing to listen and act upon what other people can bring to the partnership. They are open to change and embrace it in the spirit of collaboration, exercising reverence and willingness to defer to others for ideas and direction and relinquish control if it is in the best interest of partnership. Compassionate leaders possess generosity of spirit and strive to maintain harmony and equity in their relationships with others. They believe in social justice and equity, human rights, and the dignity of the individual (Smith, 2007).

Cited in Johnson (2012), the Caux Round Table is a group of business executives from the U.S., Japan, and Europe. The group has been in existence for nearly three decades with clearly defined standards to guide business behavior. It is a platform for principled leadership based on seven principles based on harmony, dignity, better social conditions such as education, welfare, and human rights, respect for rules, social responsibility and the protection of the needs of future generations, and that businesses should not engage in unfair and corrupt practices (Caux Round Table, 2000, 2012;

Johnson, 2012). In a summary of the 2011 Caux Round Table Global Dialogue, one of their concluding statements read "We can take no consolation from the knowledge that since leadership ultimately rests on good values, a leadership crisis is really a failure of values and of the spirit. When there is no respect for others, ethics is at a very low point and the crisis comes through widespread promotion of what is best for the self" (Caux Round Table, 2012, para. 4, 5).

Reave (2005) in a review of over 150 studies found that leaders who saw their work as a calling demonstrated higher degrees of "integrity, honesty, and humility" (Reave, p. 655) which are considered to be key virtues in a leader. Reave identified behaviors, which are emphasized in spiritual practices, and are similar to behaviors mentioned by the study's participants and identified throughout this study. Among these behaviors are "demonstrating respect for the values of others; expression of caring and concern; appreciating the contribution of others; and engaging in reflective practice" (Reave, 2005, p. 657).

Described hereunder are some of the behaviors mentioned in Reave's study that mirror recognition and evaluative respect, mutual generativity, and conscious conscientiousness. A number of quotations from the study participants mentioned in chapter four are highlighted. These fit into the behavioral dimensions of spiritual leadership.

Demonstrating respect for the values of others. Ethical leaders characterized this behavior as the demonstration of respect for followers through inclusion in important decision-making, thereby empowering followers. It is a catalyst for bringing the values of the individual, group, and organization into alignment. Reave (2005) believed that

when values are in alignment with mission and vision, an organization is likely to enjoy long-term success.

Participants in this study believed that respect for values was equated with empowerment. With regard to empowering medical students, one participant stated, "Yes, part of leadership is having everybody feel that they are part of the decision…This is the way you educate medical students…by asking, "What do you think about this?" With regard to empowering host partners, another participant said, "There has to be strategic value and one must give strategic partnerships some time to endure. There must be people who have personal characteristics which are desirable to make these partnerships successful...both parties need to recognize the strategic interests in making this partnership successful."

Expression of caring and concern. Reave (2005) described this as taking the form of supportive behaviors that build positive relationships which are the key to personal success. In an atmosphere of care and concern followers tend to display satisfaction and productivity. One of the medical students from this study explained: "…I really liked how the Attending coming from WCMC-NY realized that. He did not just look at the patient. He included the entire family. He called them into the meeting and involved them in the decision-making process. He realized immediately that the process is different in Qatar. He handled the situation professionally in every way. That really got my attention and respect." Reave (2005) posited that people involved with this type of environment get a greater sense of achievement and take pride in the organization.

Listening responsively. This behavior portrays the leader as more effective when he listens and responds to what he hears by acting on feedback and suggestions (Reave,

2005). One of this study's participants recalled: "After five years, we sat down, we looked at what was happening, we saw the progress and said what we would accomplish in ten years and now as we go forward it is important to constantly review what is happening to challenges and successes. There will always be challenges to success but we need to look back and see where we need to fine-tune and adjust. I think this is exactly what is being done and I think we are doing great. Partnership, strategic structure, and individual connections they form a trust factor in the big strategic mission."

Appreciating the contributions of others. Reave (2005) advanced this behavior as generosity of spirit when one can recognize and praise the contributions of others as a method of generating community and commitment. One of the research participants emphasized this factor as an important contribution: "You have to recognize that they want to develop their own capacity. And so our job is not just to tell them how to do it, our job is to work as partners and help them develop the capacity, so that they can do it, and get the credit for it that they so rightly deserve. You have to be motivational and understand other people's personal drivers."

Engaging in reflective practice. Reave (2005) portrayed reflective practice as leaders engaged in self-reflection and -examination. One of the participants of this study shared the following: "I have never had one of our students or one of our doctors go to visit Qatar or our program in Tanzania, which is in one of the poorest parts of the world, and come back and not feel that they have been enriched by the experience. When the students or the residents who have been to Tanzania come back, they say, I really feel now…I know why I really went into medicine."

Table 5.4

Model of Cross-Cultural Competence in Transnational Medical Education Partnership

CCC Model	Individual	Team	Organization
Recognition Respect	Positive actions/attitudes, cooperation, fairness, kindness, civility, and understanding the importance of individual beliefs and ambitions.	Elicit extra effort and behaviors, willingness to act cooperatively with others, pro-socialness, genuine demonstration of caring and concern, and unity.	Benefit of performance, understanding the importance of collective beliefs and ambitions, and placing value on working collectively.
Evaluative Respect	Sensitivity to admirable qualities, skills and achievements. Non-dominance, self-control, accountability, and responsibility.	Empowerment, engagement, synergy and circle of trust, amplified by collective agency, encourages goodwill, uplifts the spirit, moves people forward in positive directions, and strengthens motivation, trust, solidarity, inspiration, and selflessness.	Recognition of standards of excellence, positive appraisal of standards set for learning, mission, and vision; never taking partnership or accomplishments for granted, strength is amplified by collective agency, unity, and connectivity.
Mutual Generativity	Concern for consequences of actions, appropriate sharing of feelings and motives, clarity and transparency in relationship building, and need to uphold the value and dignity of others.	Teamwork and interdependency, project completion and goal achievement, commitment to building trust, encouraging synergy, empowerment, lasting cooperation, positive group interactions, and reciprocity.	Reinforcement of relationship building for sustainability, consequences of actions for the present and future generations, project completion and goal achievement, binds cooperative efforts, and harmonic relationships.
Conscious Conscien-tiousness	Awareness, purposeful processing, self-regulation of emotions, evaluating courses of action, empathic attunement, sensing of another's perspective, vigilance for verbal and non-verbal cues, genuine speaking and listening, reflective abilities, dependability, greater self-understanding, emotional resilience, appreciating cultural differences that are different from our own.	Genuine speaking and listening, willingness to engage, dependability, hard-working abilities, suspend judgment, thinking abilities, tolerance for ambiguity, aligning values and agreements of collaborative team effort, non-pretentiousness, reflective about assumptions that might endanger effective cross-cultural interactions, appreciating cultural differences, and neutralizes insecurities and pettiness.	Positive partnership performance and stability, immersion in interest and goals of interdependent parties to achieve shared mission and vision, understanding and consideration of differences, valuing, protecting and promoting partnership, appreciating cultural differences that are different from our own.

Limitations

This study's research design used a convenience sample. A limitation to this study is that it was conducted at only one institution involved in transnational medical education partnership. The participants do not represent the larger population.

Pauleen and Murphy, (2005) suggested that an individual's cultural knowledge, behaviors, and values influence their world view. To enhance the interpretation of the research findings, and how my own *a priori* assumptions or cultural biases shaped my analysis, I, hereby, disclose my own cultural background.

I was born in the twin-island Republic of Trinidad and Tobago, which is a multi-cultural society. I am British- and American-educated. I have experienced the forces of colonialism, independence, nationalism, and globalization. I have done extensive international travel and been influenced by multiple-cultures, values, and norms within my country of birth and from international experiences. I have been influenced by the cultural competency movement, which began during my undergraduate and graduate school years. My fields of study during those years were global and public affairs (business) and mental health (counseling). I have also been influenced by the "Rogerian" approach to the individual, which is a person-centered way of listening non-judgmentally to the thoughts and feelings of others (Rogers, 1959).

Reflexivity is the process of taking a deep look within oneself as a researcher and your relationship with the research, constantly questioning observations, assumptions, and propositions during the research process (Ashmore, 1989). In order to avoid perpetuating bias, I engaged in the process of continuous reflection on the research. I

constantly examined myself for assumptions that could interfere with personal and professional judgment. I controlled for this by memoing and communicating my impressions with peers and professionals involved in the multi-cultural movement. This activity was influential in how I stated my problem, the data selected and studied, what was omitted, and the use of words with a positive or negative connotation.

I also examined my relationship to the respondents, since I work at Weill Cornell Medical College in New York. I was constantly aware of the situational dynamics in which I was involved with the respondents. I gave each respondent a summary of my background and assurance that all information gathered from the interview will be kept confidential.

Recommendations for Further Study

Future opportunities for research could extend this study to other institutions of learning involved in transnational education practices. This could increase the range of reported experiences. A diverse pool of professionals from various disciplines may provide additional opportunities to lend insight into the studied experience. This study on cross-cultural competence in transnational medical education united the research process with the development of a theoretical framework and adds to the existing body of research. More research is recommended to explore the four categories of recognition respect, evaluative respect, mutual generativity, and conscious conscientiousness, which occurred several times in the study. This study can be used and replicated with new participants and at new sites. This study can also be used for the training of healthcare professionals domestically to assist them in navigating competently in the field. It can be used to inform practice when working in diverse teams.

This study provides recommendations aimed at assisting medical professionals involved in transnational medical education partnership. The recommendations are suggestions for maintaining successful partnerships and will assist in the development of knowledge, behaviors, and skills for effective cross-cultural competence.

The study provides a foundational model of cross-cultural competence in transnational medical education partnership. The emergence of the core variable *respect* drove this model of cross-cultural competency. The model is generalizable to various professional levels of what health care professionals should know, be, and do. It is also applicable to professionals who seek models upon which to design professional development training and evaluation, and services related to cross-cultural competence.

The professional must seek common purpose in collaboration with clearly defined goals to build a world-class knowledge-based and learning society. It is the driver for setting and maintaining standards for learning, mission, values, and expectations. There must be recognition and evaluation respect for each individual in the partnership as competent partners based on respect-warranting abilities. These must be evident in a generosity of spirit to invite to excellence, facilitate mutual interaction, promote ownership in decision-making, and the non-imposition of agendas. There must be the facilitation of institutional and collegial support.

The professional must be respectful of religion and tradition and how they reify into the society. There must be intuition and openness to surprises; willingness to engage with immediate understanding of dynamics, embracing pluralism, and extracting virtues of different cultures, to shape universal character. These must promote mutuality,

respect, and reciprocity, build trust in collaborative partnership, and provide an atmosphere whereby everyone feels a sense of ease. There must be a moral obligation to justice and self-consistent moral behaviors with an established focus on what is important and how to get there. There must be the creation of collective direction and vision that resonates with others.

Conclusion

There is a shared morality for health care professionals involved in the delivery of transnational medical education. All four groups of participants agreed that their wider international experiences contributed to knowledge of cultural structures and understanding of how medical professionals should navigate in the field of partnership in transnational medical education. They believed that international experiences provided awareness and skills that were useful when serving multicultural populations and our interconnectedness in an increasingly cosmopolitan world. It is living by the conviction that we all belong to the world community based on a shared morality that is utilitarian in its nature and contributes to the common good.

The establishment of active and ongoing cross-cultural linkages is important in transnational medical education. The medical students welcome opportunities to do their electives abroad and build relationships with their overseas counterparts. Fostering these types of exchanges is important, supportive, and builds mutual generativity. Learning about culture occurs mostly through cultural encounters. It is the conduit to understanding how people see themselves in relationship to their culture and the culture of another, communication styles, behaviors, and spiritual values. It is essential in knowing how people consider health and illness. Most of the participants believed that in

partnership, stakeholders such as senior leaders of both institutions, department chairs, administrators, trustees, and students have an important role to play in effecting global citizenship education. Many professionals travel to other regions without training or education in cross-cultural skills. One of the biggest challenges to the future of transnational medical education partnership is cross-cultural competence and cross-cultural training, which must be incorporated into its standard operating procedure.

In describing culture as a "minefield" it must be treated with vigilance, "understanding, and respect" (Wunderle, 2007, p. 3). He believed that most cross-cultural training activities treat issues much simpler than they really are and base these on social skills/etiquette information such as not showing the bottom of one's feet in Middle-Eastern environments. He felt that there must be concrete models, frameworks, and behavioral guidelines for training based on critical incident approaches that will influence cross-culturally competent behaviors, knowledge, and skills.

In designing for project management, high-quality, effective development programs should be put into place for staff. These should include topics such as "cross-cultural understanding, environmental conditions", institutional profile, and information about dominant culture (Connelly & Garton, 2005, p. 7).

Acknowledging the limits of one's cultural knowledge is the beginning of humility. Given the pluralism of many of the major cities of the world, having a global mindset as opposed to an ethnocentric one is important to understanding the structures, beliefs, norms, values, and mores of cultures.

Downing (2013, p. 206) in referring to interdependence stated:

> By themselves, differences are not a problem. But add to them the human tendency to judge, fear, and…you have the perfect recipe for conflict between individuals, groups, and nations. The antidote is to replace judgments with respect. There are certainly moral arguments to be made for treating everyone with respect, but there is a very practical reason as well. Today, more than ever before, everyone's success is affected by their ability to interact effectively with people who are different from them. Judgments lead to fear, misunderstanding, conflict, discrimination, oppression and even war. By contrast, respect leads to cooperation, compassion, learning, empowerment, success, and peace. Your choice either to judge or show respect will have a profound effect on the outcomes and experiences of your life and those with whom you interact. (p. 206)

Goleman (2004) referred to the Delphic oracle – *Know Thyself* as a form of reflective practice (Schon, 1983) in explaining how knowledge, behavior, and skills competence can drive the virtues of "honesty, values, and goals" (p. 3). With self-knowledge and strong professional ethos, the professional is likely to be aware of and demonstrate commitment to the ethical and moral application of knowledge, behaviors, skills, and pro-socialness (Bandura, 2002b; Karim, 2003). According to Mezirow (1991) self-awareness and critical reflection can lead to learning and enhancement of who we are, how we transform ourselves and professional practice, and our place in the world (Schon, 1983).

Culture within a nation is pervasive and defined as "a set of values and beliefs shared by people" (Nahavandi, 2000, p. 8) living within a nation, influencing the behaviors, values, norms, and mores of everyday life and the organizations that operate

within that nation (Nahavandi, 2000). In organizations, culture is the "shared values, norms, and beliefs shared by members of and organization" (Nahavandi, 2002, p. 9) with members who look to the leadership for dictating policies and procedures, encouraging specific behaviors, and governing the culture (Schein, 1985; Nahavandi, 2002). It is expected that people of different cultural groups who live within nations must share in and respect that nation's values (Nahavandi, 2002). Massive migration has caused many societies to grow in diversity (Lustig & Koester, 2006). It is, therefore, imperative that cross-cultural competence is viewed as synergistic knowledge, behaviors, and skills that enable harmonic relationships, commitment to partnership, and interdependence (Adler, 1997). Cross-cultural competence is integral to the service culture of an organization, processes, and engagement in practice standards that will increase the quality of professionalism (Betancourt, Green, & Carrillo, 2002; Wu & Martinez, 2006).

Held and McGrew, (2002) believed that in managing international partnerships, growing interdependence promotes the need for rational thought and behaviors for increased cooperation. Perhaps the most important view they gave is that institutions contribute to the peace process and world order by creating international norms, incentives, and patterns that give life to improved human and global conditions.

Transnational medical education partnerships and franchise agreements are a facet of globalization presenting challenges and opportunities for governments and institutions of learning. Proficiency in cross-cultural competence is important to successful partnerships and agreements. International institutions of learning must be leading agents of change in revolutionizing cultural challenges to produce a framework for successful interactions between students, academicians, partners, and other stakeholders in the

transnational medical education field (Koehn, 2011). Institutions with transnational partnerships must be constantly aware of cultural differences and promote cross-cultural competence (Knight, 2005, 2006). The successful outcomes of transnational medical education partnerships will be the manifestation of the peace, health, and wealth imperative (Drew & Bensley, 2001).

Findings of this study were derived from the experiences of the participants. Several hypotheses can be generated to test the foundation of the theory, which include: (a) *Recognition respect* will emerge in studies involving cross-cultural competence. (b) *Evaluative respect* will strengthen sensitivity toward host and foster greater reciprocity. (c) *Mutual generativity* will increase common agency in transnational partnership. (d) *Conscious conscientiousness* will increase competence in the behaviors, knowledge, and skills of moral agents in transnational partnerships.

Health care professionals must be capable of demonstrating appropriate behaviors through cross-cultural expertise. They should not only view issues through the lens of science; for, people deserve the ultimate obligation of respect and to feel respected. Maslow's (1954) hierarchy of needs can serve as a universal lens to the holism of respect and dignity, for respect and dignity are present when we recognize the physiological, safety, social, esteem, and self-actualization needs of another.

Understanding of social realities may be one of the most critical issues in transnational partnership. Many of the medical students who are stakeholders in this partnership are poised to become leaders and innovators in the planning and delivery of medical care in the region. It is incumbent upon medical leadership to superimpose the peace, health, and wealth imperatives of transnational partnership.

Previously limited research on this population in transnational education provided the impetus for the study. The study materialized due to the researcher's interest in cross-cultural competence and cultures of difference. Upon completion of the research, it was recognized that respect, as a term, has been loosely used and as a consequence has been grossly undervalued; for respect is not so much an attitude as much as it is grace in action. The thread throughout the study was the overarching attitude of respect for self, others, and cultural communities. The underlying nature of respect holds important ramifications for the health, wealth, and peace of nations.

Since many societies are multi-cultural and it is impossible to acquire knowledge of specific cultures, there are several universal principles to which the professional may adhere. The principles are: (a) Know Thyself, (b) Be a Moral Agent, (c) Strive for Relational Transparency, (d) Possess Generosity of Spirit, (e) Practice Reflectivity, (f) Be Mindful and Adaptable, and (g) Promote Human Dignity. The pillars are: (a) Recognition Respect; (b) Evaluative Respect, (c) Mutual Generativity, and (d) Conscious Conscientiousness.

The lessons learned are that cross-cultural knowledge, behaviors, and skills are prerequisites for entering cultures of difference. Unless the undergirding approach is wrapped in respect, attempts to appear culturally sound can be short-lived and viewed with skepticism. Respect must be a living reality; it underlies behaviors, attitudes, and skills that promote and preserve human dignity in self and others. It encourages people to learn from, about, and with each other. Respect as the undergirding of consciousness promotes integrity, trust, mutuality, truthfulness, and generosity. To respect oneself and others is to be conscientious in every encounter. When an individual sets out on the path

to exercise self-respect and promote human dignity, there is expressed value for the importance of other people. Respect is important in partnership. In behaviors, clear signals must be sent. They must convey positive regard, mutuality, trustworthiness and a sense of goodwill. Knowledge and understanding of the potent influence of respect is essential to objectivity, discernment, wisdom, and healthy partnership.

Currently, research on cross-cultural competence in the field of medicine focuses heavily on achieving cultural competence in healthcare, the incorporation of international experiences in medical school curricula for future doctors and health care disparities in minority populations. Because of this epoch, practitioners involved in transnational medical education must be vigilant when recognizing and responding to cultural differences and the resultant actions they take in the process.

The audiences for the study are clinicians, practitioners, and researchers interested in designing lectures, interventions, and training, to assist others who will be engaged in the social processes explained by this framework. It will also influence other researchers who design studies to test the theory in practice and provide a framework for professionals who will require extensive cross-cultural competence to teach and collaborate successfully. The study contributes to knowledge and practice and fills a void of research in the field of cross-cultural competence in transnational medical education partnership. It also extends existing research in the field of cross-cultural competence.

The health care professional administering cross-cultural services in transnational contexts must be conscious of professional identity and how interpersonal communication style can encourage the heart, promote trust, or adversely affect perceptions. There should be the embodiment of personal and professional ethos to

model the way and to demonstrate a healthy respect for medical education. Professional interactions must be engaged in respectfully with a focus on commitment to the mission, core values, and ethical standards of the profession and institution. There must be clarity and transparency in communication that transmits a sense of personal authenticity to promote trust. Actions based on truth-seeking behaviors and genuine values must accompany cross-culturally appropriate verbal and non-verbal communication. The professional must possess culture-specific knowledge, flexibility, and be relational in communication. They should be professionally friendly and courteous. These are signals of respect, conscientiousness, and appreciation of partnership. There must be knowledge and understanding of dominant culture behaviors and how these are perceived. Demonstration of cultural humility, unpretentiousness, and professional commitment in an intentional and conscious manner builds positive relationships.

In envisioning an organization where everyone is equal and open to opportunities, leadership must navigate the field of transnational medical education with strong moral principles in handling internal and external issues and minimize challenges that are disruptive to practice. This can be done through the creation of shared and equitable governance policies, which are well-formulated and super-imposed to maintain the respect of shareholders and the education community. The leadership must be proactive and pro-social in helping others to empower themselves to build better lives, and to transform and strengthen the economic development of regions and communities in which they are allowed to form transnational medical education partnerships and fulfill these agreements.

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Appendix A

Permission from Weill Cornell Medical College

Weill Cornell Medical College

Rosemary Kraemer, Ph.D.
Director, Human Research Protections Programs
Division of Research Integrity
Research and Sponsored Programs
407 East 61st Street, First Floor
New York, New York 10065

Telephone: 646-962-8200
Email: rtkraeme@med.cornell.edu

December 13, 2012

Steven C. Karceski, M.D.
Assistant Professor

Submission Type:	Expedited New Response to Issues
Protocol Number:	1209012979
Protocol Title:	Cross-Cultural Competence in Transnational Medical Education
Risk Level:	Minimal Risk
Expedited Review Category:	7

Dear Dr. Karceski:

The Institutional Review Board (IRB) has conducted an expedited review and approved the abovementioned protocol via expedited review procedures as per 45CFR46.110, including the following documents:

- Consent Form
- Recruitment Flyer

The protocol and its relevant documents stand approved for the following period:

Approved: **December 13, 2012** Expires: **December 12, 2013**

Please do not hesitate to contact the IRB office staff if you have any questions or need assistance in complying with the terms of this approval.

Sincerely,

Rosemary Kraemer

Rosemary Kraemer, Ph.D.
Director, Human Research Protections Program

Please note the following important information about this approval:

- Billing Compliance: This approval is contingent upon continued adherence with institutional billing compliance policies.
- Immediate Reporting: Investigators must follow the Immediate Reporting Policy at http://weill.cornell.edu/research/research_integrity/institutional_review_board/irb_adv.html. Failure to comply with IRB directives within specified time frames may result in federally mandated penalties, up to and including suspension or termination of IRB approval and mandatory reporting to the Federal government.
- Human Gene Transfer: If this is a human gene transfer protocol, it is a term and condition of IRB approval that the principal investigator obtains Institutional Biosafety Committee (IBC) approval of all amendments prior to initiation, reportable adverse events as per WCMC policy, and annual reports as per M-I-C-3 of the NIH Guidelines for Research

Appendix B

Permission from St. John Fisher College, New York

ST JOHN FISHER COLLEGE

December 17, 2012

File No: 3149-122012-10

Greta Strong
100 Benchley Place #2211
Bronx, NY 10475

Dear Ms. Strong:

Thank you for submitting your research proposal to the Institutional Review Board.

I am pleased to inform you that the Board has approved your Expedited Review project, "Cross-Cultural Competence in Transnational Medical Education."

Following federal guidelines, research related records should be maintained in a secure area for three years following the completion of the project at which time they may be destroyed.

Should you have any questions about this process or your responsibilities, please contact me at 385-5262 or by e-mail to cmerges@sjfc.edu, or if unable to reach me, please contact the IRB Administrator, Jamie Mosca, at 385-8318, e-mail jmosca@sjfc.edu.

Sincerely,

Eileen M Merges, PhD

Eileen M, Merges, Ph.D.
Chair, Institutional Review Board

EM:jlm

Copy: OAA IRB
IRB: Approve expedited.doc

St. John Fisher College
IRB
Approval Date: 12-17-12
Approved: 12-17 Expired: To 12-13

3690 East Avenue • Rochester, NY 14618 • 585-385-8000 • www.sjfc.edu

Appendix C

Invitation Letter for Participation

Greta Strong
Doctoral Candidate
St. John Fisher College
Tel: 212-746-6575
Cell: 917-774-0132
gstrong@med.cornell.edu

Dear:

I am a doctoral candidate at St. John Fisher College, Rochester, New York and conducting research on cross-cultural competence in transnational medical education. I have been granted permission by the Institutional Review Boards of Weill Cornell Medical College-New York and St John Fisher College to do this study. For my dissertation, I have made the Weill Cornell Medical College-New York and Qatar partnership the focus of my study. The overall purpose of this study is to understand the nature of cross-cultural competence in transnational medical education. Of interest are the behaviors, knowledge, and skills that foster cross-cultural competence.

To support this project, selected participants with cross-cultural experience are being interviewed. You have been identified as someone with relevant cross-cultural experience. I will use the information you provide to support the development of a model of cross-cultural competence.

All of the information you provide will be used for research purposes only. Anything you discuss will not be revealed to your peers, subordinates, or superiors. I will combine interview data collected from you with data collected from other interviewees. The eventual products of this effort will support effective cross-cultural partnerships, training, and contribute to scholarship and practice in the field. Full confidentiality of all individuals will be maintained in data handling and reporting. With your permission, the interview will be audio-recorded and later transcribed for research purposes.

Thank you for your consideration to participate in this research process.

Sincerely yours,

Greta R. Strong, MPA, MSc, HS-BCP

Attached: Institutional Approval

Appendix D

Consent Letter

IRB Protocol Number: 1209012979

Informed Consent and Privacy Act Statement

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose of this research and how the findings will be used.

You are being asked to participate in an interview to understand the nature of cross-cultural competence in transnational medical education. Of interest are the behaviors, knowledge, and skills that foster cross-cultural competence in these partnerships. Participation in this study is voluntary. If you participate, you are free to withdraw and discontinue participation at any time without prejudice.

Anonymity

All individual information gathered during this study will be kept strictly confidential. Further, the information provided throughout participation in this study will be stored in such a way that the data cannot be connected to people's names, thus ensuring privacy. I will combine interview data collected from you with data collected from other interviewees to gain an understanding of how cross-cultural competence develops and how it can be assessed. The eventual products of this effort will support effective cross-cultural training and assessment of curricula design in cross-cultural settings. Full confidentiality of all individuals will be maintained in data handling and reporting. With your permission, the interview will be audio recorded and later transcribed for research purposes. You may choose to not have the interview audio recorded or to stop the recording at any time. When speaking of colleagues, please do not use any identifiers, as they are irrelevant to the interview's purpose.

What is being asked

Your participation will consist of providing demographic information and answering interview questions about your experiences during your visit to WCMC-Q. The interview will take approximately two hours to complete. Your response will be recorded via a digital audio recording device if you consent. The purpose of the recording is to ensure I do not miss any of the information. I will use the audio recordings only to verify what was written in interview notes. Your personal identifying information will not be maintained with the recording, and the recording will not be available to anyone.
The interviewer agrees to answer any questions that you may have at this time or at any time during the duration of the study. You do not have to answer any questions that you do not wish to answer. If at anytime during the study you feel uncomfortable in any way, you can and should inform the researcher and the study will be terminated immediately with no penalty or loss of benefit. If I feel that participation is emotionally stressful for

you, I will ask if you wish to stop the interview. There will be no compensation for your participation.

Information regarding your rights as a research volunteer may be obtained from either contact listed below:
If you have questions about your rights as a research participant, contact the WCMC IRB Office.
Direct your questions to:
Institutional Review Board at:
Address: 407 East 61st Street, First Floor
New York, New York 10065
Telephone: 646-962-8200

Principal Investigators' Contact Information:
Steven Karceski, M.D.
Weill Cornell Medical College
Department of Neurology
525 East 68th Street, K6
New York, NY 10065
212-746-5519

Greta Strong, MPA., MSc., HS-BCP
Weill Cornell Medical College
Department of Neurology
525 East 68th Street, K6
New York, NY 10065
212-746-6575

I have read the procedure described above. I understand all points and agree to participate in the interview process and I have received a copy of this description. I further state and certify that I am at least 18 years of age.

_____
Signature of Participant

_____
Date

_____
Signature of Researcher

_____
Date

Appendix E

Pre-Screen Flyer

IRB Protocol Number: 120912979

Protocol Title: Cross Cultural Competence in Transnational Medical Education

PRESCREEN SURVEY FOR CROSS-CULTURE COMPETENCE INTERVIEWS

Purpose of the project: The purpose of the project is to understand the nature of cross-cultural competence in transnational medical education. I am interested in the skills, knowledge, and attitudes that are involved in cross-cultural competence. This understanding will be used to develop a theoretical framework grounded in data. One part of the effort is to interview physicians who travel to WCMC-Q to teach and interface with faculty, students, and host country personnel. A second part of the effort is to interview medical faculty and students who have been taught by or interacted with these medical professionals. The third part will be to interview host country medical professionals and/or personnel who have had to develop and use an understanding of another culture. They must also have first-hand experiences in working with people from another culture. I would like you to consider participating in an interview if you can answer yes to the following questions:

(**First Group**) Medical practitioners who traveled to Doha, Qatar over the past three years. A letter will be sent out to these practitioners asking them to consider participating in an interview, if they could answer yes to the following statements:

1. You have visited WCMC-Q where you had to interact directly with members of another culture on a regular basis as part of a teaching partnership assignment.

2. You have visited Doha, Qatar within the last three years.

3. You believe you have gained some level of competence in understanding how to achieve partnership goals that depend on teaching and interfacing with members of another culture.

4. You have first-hand experience in making assessments and decisions about people from other cultures, and in interacting with them as part of your assignment.

5. You are comfortable talking in detail about your thoughts and attitudes as I ask you to tell me about specific experiences you have had.

If you meet these criteria and would consent to an interview, please provide the following information to help me select a group of interview participants. Your name is for contact information only and will not be used or retained in the data records of this project or used in reports.

(**Second Group**) Students and faculty who have interfaced with WCMC-NY faculty and have first-hand experience in making assessment about physicians.

1. You are a student at WCMC-Q and have experienced learning through a WCMC-NY physician.

2. You are comfortable talking in detail about your thoughts and experiences as I ask you to tell me about specific experiences you have had.

(**Third Group**) Faculty who have lived in Qatar for several years and had to develop and use an understanding of another culture. They have first-hand experiences in working with people from another culture.

1. You are a faculty member or administrator at WCMC-Q and have had to interface with physicians from WCMC-NY.

2. You are comfortable talking in detail about your thoughts and experiences as I ask you to tell me about specific experiences you have had.

Contact for questions about this research project:

PI: Steven Karceski, M.D.
Weill Cornell Medical College
Department of Neurology
525 East 68th Street, Room K6
New York, NY 10065
Tel: 212-746-5519

co-PI: Greta R. Strong, MPA., MSc., HS-BCP
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