COMMENTARY

Developing cross-cultural healthcare workers: content, process and mentoring

Mark A Strand[a], Alice I Chen[b], Lauren M Pinkston[c]

[a] PhD, Professor, School of Pharmacy and Department of Public Health, College of Health Professions, North Dakota State University, Fargo, ND, USA
[b] MD, MAR, Medical Department, Shanxi Evergreen Service, Taiyuan, Shanxi, China
[c] Doctoral candidate, Institute of Family and Neighborhood Life, Clemson University, Clemson, SC, USA

Abstract

Career service in cross-cultural healthcare mission work is the ambition of many people around the world. However, premature termination of this expected long-term service mitigates against achieving the goals of the individual and the organization. The lingering challenge of high rates of missionary attrition impacts the long-term effectiveness of the work and the health and well-being of the workers. One of the keys to reducing premature attrition is cross-cultural training for these individuals, provided it offers the right content, through the best medium, at the time of greatest perceived need by the missionary. This paper applies the Dreyfus Model of skills acquisition to the process of mentoring career healthcare missionaries in a progressive manner, utilizing a mentoring method. These missionaries can flourish in their work and more effectively achieve their individual and organizational goals through strategic mentorship that clearly defines a pathway for growing their cross-cultural skills.

Background

It is estimated that there are 400,000 cross-cultural Christian missionaries serving around the world, 127,000 of them from the United States and 42,000 of them serving four or more years.[1,2] Healthcare professionals are a part of this workforce. Every year, hundreds of healthcare professionals relocate to a new country to begin language learning in preparation for a career in missionary service.[3,4] At the CMDA Medical Missions Summit in Atlanta in 2012, it was determined that 6.4% of the missionaries in the eight organizations attending were involved in healthcare.[5] Of the 66 organizations studied in the Global Healthcare Workers Needs Assessment (GHWNA) study in 2013, 24% of new missionary candidates were healthcare workers.[6]

However, even as these new recruits are moving out, an approximately equal number of missionaries are relocating back to their home countries and ending their healthcare careers abroad.[7] Some of these departures are due to retirement, others are planned upon completion of a contracted term of service, but many are premature, with workers never fulfilling the full vision and expectations once held of a long and

productive career. Premature return from cross-cultural service is considered preventable in many circumstances.[7,8] This paper seeks to discuss the current state of missionary attrition, as well as to make recommendations for a cross-cultural training model that promotes longevity and success in overseas healthcare work.

Duration of intended healthcare missionary service is evolving. Younger generations of cross-cultural healthcare missionaries are shifting toward shorter terms of service.[9] This includes short-term missions (10-14 days duration), extended short-term missions (1-2 years), and one-term long-term missions (four years). The focus of this paper is service longer than four years, but it takes seriously the importance of each of the shorter durations of service as preparation for potential long-term service. This is based on evidence that short-term service has a significant impact on those going and, thus, can serve as an exploration into longer term service and an opportunity to grow in one's cross-cultural competence.[12] In contrast, most short-term service has limited impact on the intended beneficiaries.[10,11] For one, neither individuals nor communities change quickly; furthermore, conversion occurs through strong and culturally embedded relationships, not short-term encounters.[12-14] Therefore, the proposal of this paper for in-country training through a mentoring process can be implemented even for short-term mission experiences and, thus, begin an individual on the road to career missionary service.[15] This mentoring model, even for individuals initially reluctant to make a long-term commitment, is particularly important for the Millennial generation, as is described below.

The Millennial generation (those born between 1980-2000) represents 77.9 million Americans, the largest generational cohort in American history.[16] As the mission leaders of tomorrow, they bring many assets to this challenge. The Millennial generation represents the most culturally diverse American generation to date, with 38% of 18-24 year olds coming from minority ethnic backgrounds.[17] This has the potential to make cross-cultural acclimation smoother and faster for them. Millennials also gravitate toward holistic approaches to mission, which is an essential element of healthcare missions.[18] Millennials expect to maintain a close relationship with their parents and to seek their advice.[19] Therefore, they expect mentoring from someone when they assume a new role, but from an egalitarian perspective, not a hierarchical one.[18] They also respond favorably to small tasks, with clear expectations and of limited duration, as a way of testing out their interest in, or ability to perform that task.[18] Each of these attributes prepares the Millennial generation to thrive in the kind of healthcare missionary development process introduced in this paper and to be up to the challenge of leading in healthcare missions in the future.[20]

Challenges Facing Healthcare Missionaries

It has been reported that religious expatriates in general are highly resilient, with a uniquely high capacity for coping with stress and trauma.[21] Healthcare missionaries have completed challenging undergraduate coursework, undergone stringent graduate-level training, endured rigorous workloads, and sacrificed high salaries to serve under difficult circumstances. This selects individuals with a high capacity for facing challenging circumstances.

Still, no matter how capable and resilient healthcare missionaries may be, cross-cultural service requires a set of skills and knowledge that is different from what can be learned in a classroom. McCrae and Costa claimed that

there are five major personality traits that can predict expatriate effectiveness: extroversion, agreeableness, conscientiousness, neuroticism, and openness.[22] Cultural intelligence, a multi-faceted individual attribute that assists a person in adapting effectively to a new cultural context, may also contribute to cross-cultural success. Adjustability,[22-27] cultural sensitivity,[28,29] self-efficacy,[30] previous international experience,[26,27,30] and family adjustment dynamics[31] also play major roles in contributing to the effective functioning of the cross-cultural professional. So, a number of factors have been identified which can help the healthcare missionary become successful; yet, many cross-cultural workers are surprised by the difficulties they face once established in their cross-cultural living situations.

Without proper cross-cultural training (CCT), healthcare missionaries are likely to struggle to understand cultural, relational, or systematic reasons for the apparent lack of efficiency, the slow pace of change, or the unique way in which people behave in a different country. Frustration with conflicts between the values of their home and host culture may be compounded by trouble with language learning, team conflict, or culture shock. After spending so many years preparing to be a professional in the field of medicine in their home country, healthcare missionaries may struggle with role deprivation or be discouraged or fatigued by having to face yet another season of training, cross-cultural training. Therefore, it is important that this critical process be encouraging and helpful to the missionaries, not onerous or perfunctory.

Missionary Attrition

Missionary attrition among organizations has been reported to be on average 5% per year.[32] The top reason for attrition is children's needs. Five of the next eight most frequently reported reasons for attrition were: change in role, physical and mental health, problems with peers, disagreements with their agencies, and poor cultural adaptation.[32] These reported reasons for attrition reflect the absence of some of the key factors reported above that predict cross-cultural success, such as cultural intelligence, adjustability, cultural sensitivity, previous international experience, and family adjustment dynamics. Ineffective attempts to help healthcare missionaries with the challenges they face contribute to missionary attrition. The progressive mentoring model proposed in this paper is well-suited to address these shortcomings.

One of the authors conducted a survey called the Global Health Workers Needs Assessment survey (GHWNA) of current and former healthcare missionaries associated with the organization MedSend.[6] The purpose was to determine some of the key factors contributing to missionaries remaining in service on the field. The GHWNA survey found that the average length of service for those who left the field was 4.77 years. Although the intended length of service of these missionaries was not reported, this attrition can exact a considerable toll on missions—financially, personally, and spiritually. The cost of supporting an American missionary family of five on the field varies by organization and field of service, but is estimated by the authors to be approximately $395,000 USD for a five-year term.[a]

The personal and spiritual toll of these premature departures is also significant. Respondents to the GHWNA survey reported that

a. This includes start-up costs of $20,000 for fundraising, overseas travel, and home set-up expenses on the field such as for furniture and appliances, and also includes $75,000 a year for living allowance, rent, children's education, mission administration fees, pension and Federal Insurance Contributions Act (FICA). This does not include the full cost of support services incurred by the sending organizations and churches through the entire application process and after the family has left for the field.

they experienced "great difficulty" in departing from the field and in resettling back in their home country. Parting ways with colleagues and national friends and co-workers can be very painful. The nature of mission work results in forming deep interpersonal relationships with mission colleagues and national coworkers, who all suffer when these bonds are severed, and even more so when the departure is premature. And, of course, seeing one's spiritual calling come to an end can be both painful and spiritually confusing. Furthermore, a cross-cultural health-care worker needs at least two years of dedicated language and culture learning, and usually only begins to have a significant impact during years three and four, so that many departing missionaries are just beginning to enter a time of cultural belongingness and ministry effectiveness at the time they leave the field.

David Frazier suggests that the attrition seen today may be caused in part by an old mission system trying to challenge, guide, and equip a new generation of missionaries who have different expectations.[9] He reports that the top issues leading to preventable attrition have to do with character and relationships. Other major causes are a misunderstanding of calling, incorrect fit with one's skills, poor relational skills, and insufficient language progress. This paper fits the expectation of the Millennial generation to seek mentors, who partially fill the role they had previously valued in their parents.[18]

Underlying these myriad issues is a frequently encountered uncertainty about who is responsible for training the healthcare missionary. Mission boards rely on churches to refer and fund missionaries, and churches then rely on mission boards to train and screen missionaries for cross-cultural readiness. But once missionaries are on the field, they can be neglected and forgotten in their most difficult and crucial days of adjusting to a new culture and lifestyle. Sixty percent of mission organization leaders reported no specific training for healthcare missionaries, other than the training provided to all missionaries.[6] It is the purpose of this paper to introduce a model for healthcare missionary training that is progressive and mentor-driven, but first, the general concept of cross-cultural training will be explained.

The Role of Cross-cultural Training

Cross-cultural training (CCT) is defined as educational processes that improve intercultural learning via the development of cognitive, affective, and behavioral competencies needed for successful interactions in diverse cultures.[33,34] CCT is traditionally designed for preparing international trainees by targeting cultural issues.[33]

CCT aims to develop the skills and knowledge needed to interact appropriately and effectively with host-country nationals (HCNs)[34,35] and with members of multicultural teams.[35] Researchers have identified three goals for CCT. The first is to assist expatriates in determining acceptable cultural behaviors and appropriate ways to complete tasks in a new environment. A second goal is to equip field staff with coping strategies to deal with unexpected situations in the host country. The third goal of CCT is to help the expatriate define realistic expectations for life and work in a new country.[33,35] Ultimately, CCT aims to predispose members of one culture to rapid adjustment in their host culture.[26]

However, some studies have found that cross-cultural training may not provide significant benefit for expatriate adjustment.[24] Morris and Robie conducted a meta-analysis of 16 studies (total n=2,270) and found that the overall effectiveness of CCTs was weaker than expected in light of the wide use of training.[24] Chang was also skeptical about the impact of CCT, arguing that living in a foreign culture impacted people differently, so measuring expatriate adjustment based on CCT was too

difficult.[29]

Other research has reported the benefit of CCT. Brewster and Suutari reported that cross-cultural training was linked to an improvement in the relationships between expatriates and local people.[36] Likewise, Littrell et al. reported that CCT was positively related to the development of self-confidence and overall feelings of well-being, interpersonal skills, and cognitive skill development.[35] They wrote that CCT was positively correlated with adjustability and cross cultural adjustment, while negatively correlated with early return rates.[33]

Recommendation: On-field CCT and Mentoring

While CCT likely plays a role in helping a missionary adjust to his or her new life, the increase in CCT in recent years has not decreased missionary attrition appreciably. It is not that CCT is unable to help with the key predictors of success such as cultural intelligence, adjustability, cultural sensitivity, and family adjustment dynamics, but it is the concern of the current authors that CCT is being delivered in a didactic method and prior to the time of perceived need and, thus, is less effective than it could be. Extensive pre-field training can mediate against worker effectiveness on two planes. First, it postpones language learning and culture adaptation. Second, it inadvertently mis-prepares a person because the needs of the field or team and the needs of the country will seldom be a perfect match with the pre-field training they received and may not be optimally addressed in the CCT. The GHWNA study respondents reported preferring on-field to pre-field training.[6] Age is also a factor; seldom do healthcare workers arrive on the field before the age of 32, so adding more years of pre-field training can further delay their arrival.

The concern of this paper is that a didactic, front-loaded CCT process does not fit with the needs of current healthcare missionaries. These needs can be characterized as being adult learner-focused, with great diversity by country and culture, a preference for real-time training, and a desire for personal on-site support and mentoring in the new culture. Therefore, while pre-field training is important, and in the absence of an on-site mentoring model as proposed in this paper, is essential, it has possibly been excessively relied upon and fallen short of expectations in the past. As will be explained below, training of healthcare missionaries through mentoring, coaching, and teaching after they begin their work on the field may better fit current needs. It will also allow for a guided, progressive process of finding a role for the missionary that has meaning and value and, thus, increases role satisfaction.[37-39] This means making the development of people an integral part of organizational culture, not an activity to be inserted into the organization.[40-41]

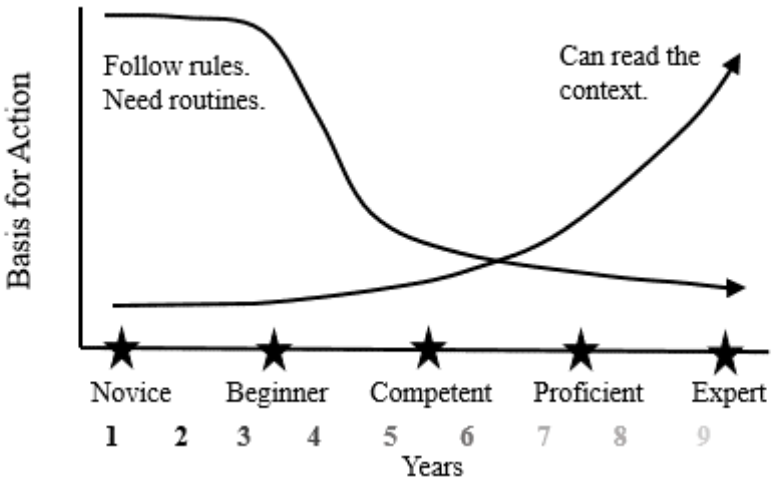
Finally, real-time training is a way to assist the expatriate through cultural adjustment. Real-time training can improve communication, leadership, and problem-solving skills. Common sources of real-time training are face-to-face or internet-based interactions with other expatriate workers, repatriates, or local nationals. Materials provided by their organization can also be helpful as an asynchronous learning tool.[24] Eschbach, Parker, and Stoeberl argue that high-rigor CCT, beginning during the pre-departure phase and continuing intermittently through-out the posting, is the most effective type of delivery.[42] Effective CCT teaches expatriates how to process the many new experiences they are having.[35]

Cross-cultural training should be provided over several years, according to the missionary's need, and through a mentoring relationship. The process of moving from

being a novice to expert is a long process, requiring at least eight years, and involves the mastery of specific subject areas, as shown in Table 1.

Just as healthcare professionals are expected to practice evidence-based medicine and to engage in lifelong learning through continuing education, so missionaries should practice evidence-based ministry and engage in lifelong learning commensurate with the enormity and importance of the task. Therefore, cross-cultural training for successful healthcare mission service should be delivered over a ministry life cycle through a diversity of educators and trainers. The Dreyfus Model shows the progression of an expatriate worker in five stages from novice to expert.[43] It has been well-utilized in other healthcare disciplines and can be aptly applied to cross-cultural healthcare workers.[44] The Dreyfus Model is shown in Figure 1 and explained below.[45]

Figure 1. Time and skill progression of healthcare missionary from novice to expert.



A Process of Progression into Effective Missionary Service

Stage 1: Novice

The novice stage involves formal learning and lasts approximately two years. The learner is given rules for determining actions much like data entry into a computer. The learner is guided and instructed within a narrow set of expectations that may be communicated through assigned reading or other academic formats. At this stage, the missionary seeks to learn basic concepts and establish routines. For the healthcare missionary, this includes learning basic language skills to communicate essential concepts with local people, such as ordering food and finding one's way around, and learning how to connect with and know one's neighbors by name. If the missionary is involved in patient care, he or she will be dependent on an interpreter to understand the patient's language and also to begin to recognize the cultural factors and nuances at play. It requires significant effort, and can be quite stressful as the learner seeks to grasp new information and new skills.

A young couple that arrived in an Asian country to study language in a university setting offers a real-life example of this stage of learning. Before arriving, they had completed assigned readings that described Asian etiquette and how to give face to their superiors. Upon arriving at their university, they were visited in their fifth-floor apartment by the head of the language department, their new supervisor.

After his short cordial visit, he got up to leave and the couple, recalling from their reading the importance of "sending off" their guest, then proceeded to follow this rule. Without the benefit of having seen it actually modeled, they accompanied the professor down each floor of their apartment building, despite the professor's vigorous protestations. The next day, the news on campus was that these newcomers were the most excellent and suitable of all foreigners that had ever come to this university, because they had gone to such lengths to send off their guest, despite the fact that they didn't fully understand the meaning of what they were doing.

Gradually, the learner is able to understand the situations that had previously escaped, confused, or frustrated him or her. By following the rules and established routines, they begin to feel more comfortable and function more effectively. Thus, the healthcare missionary becomes a beginner.

Stage 2: Beginner

After seeing and experiencing a sufficient number of examples, the learner begins to recognize principles and patterns and identify further aspects and levels of meaning from what they have observed. This marks a movement beyond novice to beginner. It generally happens during years three and four (Figure 1). The beginner is able to compare personal experience with rules learned while a novice. Informed reflection allows the beginner to form principles and generalizations to further their understanding of their host country. Specifically, the beginner healthcare missionary will begin to develop cultural competence, including appropriate interpersonal physical contact, the use of greetings according to individuals' social status, and the recognition of the role of traditional world-views regarding well-being and illness. Thus the beginner starts to form mental models through practice and feedback.[46]

For example, in China, traditional Chinese medicine (TCM) continues to be widely used. For the new healthcare worker in China, gaining a basic understanding of the theoretical basis of TCM as well as commonly prescribed herbal medications is essential. Learning how to take a patient's history using TCM terms and familiarizing oneself with the side effects and interactions of TCM with Western medications will also become necessary skills for practicing medicine in China. Even more important, however, is grasping the cultural significance of TCM as a deeply-engrained worldview that embraces not only physical diagnosis and treatment but also the patient's overall well-being and interaction with one's environment.

Cultural learning and adjustment continues to be stressful, but as one's language and cultural competency improves, one feels increasing confidence in his or her knowledge and ability to access the information needed. Reliance on rules and routines begins to lessen, while reliance on the context becomes more important. This model explains why mission organizations previously treated the first three years of service as probationary, as it takes that long to become functional in that setting.

A career missionary named Emily, serving in South Asia, illustrated the model proposed here in her article, "Year 4," where she described the yearly progression she made in language, dress, food, shopping, and "normalcy" through her first four years of service. With regard to "normalcy," she described her progression as follows: Year one, "We're going to settle in here and find out what normal is like," progressing in year three to, "We're still trying to figure out what normal is like," and by year four concluding, "Well, I guess this is normal."[47] She had moved past searching for rules to beginning to accept the local context and seek to work within it. This is evidence that Emily had achieved substantial

cultural competence and was on her way to becoming highly effective as she moved toward proficient or expert missionary competence over time.

Stage 3: Competent missionary

By the end of their first four years, healthcare missionaries have struggled through cultural and ministry dissonance. If they have been properly mentored, they will have begun to organize their experiences into patterns and models which go beyond the simple, more unambiguous rules they learned as a novice or beginner. In diverse situations, they are increasingly able to decide for themselves what plan to choose and when to choose it and to identify and negotiate the nuances that distinguish different situations from each other. They are able to cope with uncertainty and maintain a degree of psychological balance in doing so. This occurs at about year five, as they prepare for and experience home assignment. (Note the fading color intensity of the years shown in Figure 1, intended to depict that the time at which healthcare missionaries achieve the levels of competency is harder to predict with time.)

In addition to knowing local terms for symptoms, the competent healthcare missionary will be aware of culturally embedded disease descriptions, the impact of various practices upon local medical practitioners, and be able to read non-verbal cues of patients. For the healthcare missionary to proceed to competence, he or she benefits from being independently immersed in work situations, with a mentor to debrief them afterwards.

The process of becoming a competent missionary is a long-term proposition. It has been observed that, frequently, it isn't until into their fifth year of service that missionaries are able to pursue tasks more in line with their skills and interests. With average term of service around five years, they frequently leave just as they are becoming competent. This is why it is so important for the missionary to be patient, knowing that they will be able to move toward more suitable roles with time, and for the organizational leadership to provide personal mentoring for the missionary.

An example experienced by one of the authors occurred in her fifth year of service in China. A 30-year-old man presented with a ruptured esophagus. His family requested financial assistance for his care through a charitable program for needy families. Assistance was not provided, as the patient did not meet the program's criteria. The patient was under the charge of a local senior internist who treated him extremely conservatively, choosing not to take him to surgery, but sought to reduce his pneumothorax with daily manual aspirations of air from his pleural cavity with a 30 cc syringe versus the insertion of a chest tube, a more conventional and effective therapy by Western standards. The pneumothorax did not resolve, the esophageal rupture was not treated surgically, and the patient deteriorated steadily and rapidly. Eventually the patient developed an abscess in the area of the rupture, descended into respiratory failure, and died of sepsis a week after admission.

For a foreign doctor working in this setting, acute distress was created by a number of factors in this case: the age and previous good health of the patient, the excessively conservative treatment provided, and the seniority of the attending physician who was generally respected and would not have been appropriate to contradict. It was tempting to circumvent the rules of the assistance program and to use personal funds to provide this patient with surgery, but this option too was problematic and conflicting when considered against how many other patients could be assisted with that significant sum of money.

What helped this young expatriate doctor in these ethically challenging situations was the

input of several veteran missionary doctors, one working in Nepal and two in Taiwan, who generously shared of their experience and wisdom from decades of caring for patients in under-resourced areas. Their thoughtful mentorship helped her to develop lasting and valuable principles for dealing with the inequities of medical care in needy areas, balancing conflicting values, and communicating compassion and care in seemingly hopeless situations. These events, and the role played by mentors, characterize the experience of the healthcare missionary gaining culturally appropriate competency.

Stage 4: Proficient missionary

Stage four in the Dreyfus Model represents proficiency. During this stage, the missionary is able to read the context and intuitively determine the right thing to do. The proficient healthcare missionary can discriminate a variety of situations and intuitively suggest plans from his or her experience toolbox. He or she understands the etiology of culturally embedded disease descriptions that patients report. He or she is able to care for patients independently, without a cultural or language interpreter. The proficient healthcare missionary understands the local healthcare system, so that he or she is able to confidently make referrals and fully understands the process the patient will experience in each setting. The proficient healthcare missionary will work for hours without being conscious that he or she is working cross-culturally. Work will be less of a struggle and cultural patterns will feel intuitive. He or she will be able to respond to unexpected changes, handle varieties of situations with varied groups of people, and provide healthcare confidently and safely.

Poor integration of the healthcare and church-planting aspects of the mission organization frequently cause stress and contribute to attrition. Sometimes the organizational leaders subconsciously communicate that healthcare work is less important than church-planting work. The proficient missionary can grasp the whole ministry context, appreciating both the medical and the church-planting components of the organization, and how their interaction is mutually beneficial. They can also communicate this integration to their organizational leaders as necessary, as a way of explaining the value of healthcare work for broader organizational goals.

Proficiency usually comes late in the second term, during years 7-8. Without persistence, humility, a stance of lifelong learning, and deep cross-cultural engagement, many healthcare missionaries will not achieve proficiency. It is important to remain persistent in the pursuit of language ability and cultural competence in order to prevent premature plateauing, which can compromise effectiveness and long-term personal flourishing.

The proficient missionary is likely prepared for cross-cultural leadership, including relating well with existing national leaders in medicine, politics, and religion. A skill that is essential in many of the cross-cultural healthcare settings that exist today is the skill of developing and maintaining relationships with local and national government leaders and officials. Keeping relationships with these individuals well-oiled is necessary to ensure future harmonious acceptance and cooperation. Certain knowledge and skills are involved in this process, such as appropriate seating at a formal banquet or where to position oneself while taking photographs with officials, but more important is an understanding of the dynamics of interactions with officials, such as when and how to make recommendations.

In many cultures, paying respect by visiting officials and leaders is a necessary, but

challenging part of the work of the healthcare missionary. Few Western missionaries are familiar with this practice, so it creates many questions for the expatriate missionary: What do we talk about with these officials? What gift should we bring? Will this gift be interpreted as a bribe? Over time, and with repeated exposures, individuals can begin to understand the underlying dynamics of such visits, and adjust their expectations. Gradually, the humanness of these officials becomes more evident, and the fact of their own personal challenges and limitations emerges. Eventually, these visits become not so much a make or break experience, but instead become an opportunity for shared understanding and shared blessing.

Stage 5 Expert missionary

The pinnacle of development in the Dreyfus model is the expert (Figure 1). The expert missionary no longer relies on routines, but functions intuitively and naturally, according to context and situation. The expert sees what needs to be achieved, and due to a vast repertoire of situational discriminations, he or she sees how to achieve the desired goal. The expert missionary is able to make an immediate, intuitive situational response that demonstrates expertise. He is able to take action without conscious analysis, and national coworkers respond to him or her comfortably and naturally.

The expert healthcare missionary is bilingual, and functions interchangeably and smoothly in one's passport and host cultural context. He or she will be able to link culturally embedded disease descriptions with their comparable bio-medical concept and will, thus, be able to provide evidence-based, but locally appropriate, care. The expert healthcare missionary will be expected to participate in local leadership decisions and does so in a culturally appropriate way. The expert missionary will frequently lose sense from what language or culture he or she is working, and those with which he or she is working will feel this naturalness and effectiveness. Granted, personal gifting, affinity for language and cultural learning, and individual personality predispose certain individuals for this proficiency, but generally, reaching this level can be achieved after nine or more years of cross-cultural service.

The expert missionary possesses an intuitive sense of what is appropriate in a given situation. The expert missionary will not get to that level without the help of many mentors along the way, formal and informal. Furthermore, the expert will be expected to likewise serve as a mentor to novice and beginner healthcare and other missionaries. As conceptualized in this paper, the process of moving from novice to expert involves specific content (Table 1), a gradual progression through the five stages (Figure 1), and guidance along the way by a series of mentors. Variations of the Dreyfus model have been used effectively in healthcare missions, but they have not been analyzed or reported in a formal way. Formal evaluation of a mentoring program should be considered by organizations that currently highly value mentoring, but have not implemented it in a formal way, and even less, have not evaluated its effectiveness. The role of mentoring will be described presently.

Mentoring

Cross-cultural training is essential for healthcare missionaries to be effective. This process should happen on the field and under the guidance of a trained mentor or coach. The content can be delivered through reading or viewing high-quality materials, but equally important is guided reflection on real experiences of the missionary with a mentor. Just-in-time training, under the guidance of an

experienced mentor, makes training in areas such as cultural sensitivity, adaptability, and even family adjustment dynamics, more practical and, thus, more highly valued by the healthcare missionary who is in the process of moving through the first three levels of the Dreyfus model. Although this paper proposes a ten-year process of development to become an expert healthcare missionary, it should be pointed out that the frequency and intensity of mentoring will lessen with time. The first four years through the beginner phase are especially critical and should be relatively formal. After that, the needs of the developing healthcare missionary will be most important in determining the content and nature of the mentoring process.

The mission organization is responsible to design a progressive mentoring program and create a culture where mentoring is normative. In the GHWNA study, organization leaders reported "mentoring ability" to be the most important area of leadership, but only 18% of them assigned mentors, and only 38% of the missionaries reported having any type of mentor.[6] The study also showed that those who left the field prematurely reported a lower quality of mentoring relationship than those who remained on the field. Therefore, mentoring success will require deeper organizational commitment to mentoring, setting clear expectations for the mentoring process, and training mentors and mentees.[48] It also involves providing specific feedback about their performance.

Mentors can be either expatriate or national coworkers, depending on the situation. Mentoring by national colleagues is an incredibly rich source of growth and direction to the learning missionary. It demonstrates respect for local individuals as the true arbiters of what is locally appropriate and shows true humility.

While offering advice and specific information about cultural issues is a valuable aspect of mentoring, coaching is an effective adjunct. Using a coaching approach, the mentor can offer thoughtful questions to stimulate the learner to reflect upon his or her experiences. Reflective listening, expressing empathy, and open-ended questioning can help the individual to process feelings, thoughts, and behaviors, thus, developing the skills necessary to function less rigidly and more according to context and situation in the future. Mentoring should be provided throughout the worker's progression from novice to expert and will contribute to improved interpersonal relationships, effectiveness, and cultural competence.

Table 1. Competencies and areas of training designed specifically for healthcare missionaries.

Medical Applications
• Up-to-date clinical skills
• A theology of health and medicine
• Community health
• Serving in situations of overwhelming need, death and dying issues, loss
• Whole health approach, integrating faith and medicine
• Developing specialty areas, such as HIV care, chronic disease management, mental health, rehabilitation medicine
• Patient care in a cross-cultural setting, traditional healing practices, culturally specific practices regarding health maintenance, time, stigma, face/shame, etc.
Politics/Policy
• Compliance with the national health system
• Working in a secular setting, such as a government hospital
• Ethics in medical missions
• Healthcare resource development
• Organizational/church leadership
Business/Finance
• Administration
• Fund-raising
• Guidelines for the use of finances for charitable care
• Consideration of donated equipment and supplies
Personnel
• Multi-cultural team building
• Management, especially related to human resource management in healthcare
• Integration healthcare into the mission strategy
• Professional and personal development of both expatriate and national colleagues
• Dealing with conflict and implementation of an effective grievance process
Education/Teaching/Training Skill
• Being an effective educator
• Adult learning theory
• Participatory training methods
• Problem-based learning
• Skills development and assessment
• Medical education, residencies
• Mentoring and training local (Christian medical) professionals
• Coaching and mentoring of students, residents, etc.
• Modeling self-care, professional excellence, lifelong learning
• Locally-appropriate educational technology

Note: Some baseline competencies required of all missionaries include language and cultural training, Bible and theological training, and basic spiritual health and vitality. These are not included in this table because they are already the focus of significant attention by mission organizations.

Assessment

It has been shown in many settings that people are successful in accomplishing those things for which they are being held accountable. Therefore, tracking and monitoring of progression in competency in missionary service should be provided.[49] Mission organizations should provide clear job descriptions, regular evaluation, and accountability to new workers, so that the missionaries are clear about what is expected. This process should be carried out in a constructive and supportive way, not in an onerous way. Healthcare missionaries need to be placed in settings where they have a greater chance of success. Furthermore, the mission organization should develop specific health care strategies that contribute to the overall mission, so that the healthcare missionaries do not feel marginalized.

As part of the annual evaluation process for healthcare missionaries, the missionary should be assessed for how they are mastering content areas and the degree to which they are

traversing the stages towards becoming an expert missionary. The assessment can be either process or summative. In order for the assessment to be fair and substantive, the expectations need to be stated clearly at the outset. Documentation of progress and barriers is also important so that the annual evaluation takes into account prior experience.

Limitations

This commentary has proposed an approach to the process of developing missionaries that has not previously been implemented in such a way that it could be formally assessed. However, it is based on good evidence from medical education models and from available literature on healthcare missionary development and retention. This is a call for mission organizations deeply committed to healthcare work to redesign their program for developing and training healthcare missionaries along the lines proposed here and then to perform rigorous assessment in order to determine strengths and weaknesses of the model.

It is also acknowledged that while the Dreyfus model is a good model to explain the acquisition of competencies that fit with intuition and more implicit decision-making required in ambiguous cross-cultural settings, it may not be the best model to explain the acquisition of more explicit skills, such as those listed under the domains of Medical Applications and Business/Finance (Table 1). For example, up-to-date clinical skills and administrative or finance skills might require more didactic approaches. Therefore, while the Dreyfus model is seen to be the best and most comprehensive approach to developing long-term healthcare missionaries, it must leave room for other elements of professional development that may not be as effectively delivered through this model.

Conclusion

Healthcare missionaries make a large personal and organizational investment in order to prepare for service. They are too valuable to lose to premature attrition. One of the causes of attrition is insufficient and inappropriately timed cross-cultural and professional training. An additional cause is the absence of mentors who are themselves competent or better. Yet another cause is the lack of organizational commitment to use mentoring as the core of the missionary development process. More support and accountability for healthcare missionaries from their organizational leaders and local team leaders is needed. One of the ways this can happen is to create a more clearly defined pathway for missionaries to move from novice to expert and then to guide that process with both essential content and a progressive mentoring approach.

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Peer Reviewed

Competing Interests: None declared.

Correspondence: Mark A. Strand, North Dakota State University, United States, MarkStrand3@gmail.com, Alice I Chen, Shanxi Evergreen Service, China, alice.chen@evergreenchina.net, Lauren M Pinkston, Clemson University, United States, lmpinkston@gmail.com

Cite this article as: Strand MA, Chen AI, Pinkston LM. Developing cross-cultural healthcare workers: content, process and mentoring. Christian Journal for Global Health (May 2016), 3(1):57-72.