ARTICLE

Transforming Cultural Competence into Cross-cultural Efficacy in Women's Health Education

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ABSTRACT

To prepare students to be effective practitioners in an increasingly diverse United States, medical educators must design cross-cultural curricula, including curricula in women's health. One goal of such education is cultural competence, defined as a set of skills that allow individuals to increase their understanding of cultural differences and similarities within, among, and between groups. In the context of addressing health care needs, including those of women, the author states that it is valid to define cultural groups as those whose members receive different and usually inadequate health care compared with that received by members of the majority culture. The author proposes, however, that cross-cultural efficacy is preferable to cultural competency as a goal of cross-cultural education because it implies that the caregiver is effective in interactions that involve individuals of different cultures and that neither the caregiver's nor the patient's culture offers the preferred view. She then explains why cross-cultural education needs to expand the objectives of women's health education to go beyond the traditional ones, and emphasizes that learners should be trained in the real-world situations they will face when aiding a variety of women patients.

There are several challenges involved in both cross-cultural education and women's health education (e.g., resistance to learning; fear of dealing openly with issues of discrimination; lack of teaching tools, knowledge, and time). There is also a need to assess the student's acquisition of cross-cultural efficacy at each milestone in medical education and women's health education. Components of such assessment (e.g., use of various evaluation strategies) and educational objectives and methods are outlined. The author closes with an overview of what must happen to effectively integrate cross-cultural efficacy teaching into the curriculum to produce physicians who can care effectively for all their patients, including their female patients.

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A real challenge that clinicians must face today is the increasing diversity of the U.S. population. The "Ozzie and Harriet" world of mother, father, and 2.5 children has transformed into a much broader and more inclusive definition of family and family constructs. Our patients' health perceptions are increasingly embracing alternative or complementary modalities. Clinicians must deal not only with such obvious cultural differences of their patients as language, dress, and diet, but also with more subtle cultural influences, such as the patient's perceptions of health, illness, and appropriate approaches to treatment. Health behavior can increasingly be best analyzed based upon a "differential diagnosis" of each patient's behavior based on the physician's understanding of those more subtle cultural influences. Understanding these culture-based possibilities and testing their relevance with the patient in one's office is at the heart of *cross-cultural efficacy*, a term that I discuss below. Furthermore, to prepare students to be effective practitioners, we must design curricula that enable them to lessen or eradicate the disparities of care for populations who come from divergent backgrounds, to effectively partner with them in health care decisions, and to function as their health care advocates.[1] One important area where these changes must be made is in women's health education. In the rest of this article, I define *cultural competence* and *cross-cultural efficacy*, explain why the latter approach is pref-

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erable, and discuss its application in women's health education.

CULTURAL COMPETENCE

To define cultural competence, we must first define culture. That in itself can be challenging. One study found 150 different definitions of culture.[2] But they all boil down to the following general concepts: Culture shapes how we explain and value our world. Culture is the lens through which we give our world meaning. Culture shapes our beliefs and influences our behaviors about what is appropriate. We are usually unaware that we see the world differently from how others do. It seems to us that we are seeing the world "exactly how it is." Yet each person's perceptions and focal points are the result of reality filtered through his or her cultural background. The skill of using multiple cultural lenses is called *cultural competence*, which has been defined in more detail in a number of different ways.[3,4]

One broad definition comes from the Office of Substance Abuse and Prevention, where cultural competence is described as "a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports." [5]

Which cultural groups should be included in any consideration of cultural competence and how these groups should be defined are the subjects of much controversy. Some feel that cultural groups should be divided exclusively along ethnic lines. Others define cultural groups as any that are discriminated against, such as racial or religious groups, sexual minorities, or the physically challenged. Since the goal of cultural competency discussed in this article is to address health care needs, I maintain that it is valid for health educators to define cultural groups as those whose members receive different and usually inadequate health care from that received by members of the majority culture. This strategy is supported by other health care initiatives such as Healthy People 2010, which highlights the need to address all disparities.[1]

Cross-cultural education, which aims to enhance students' personal insight and empathy with people from diverse cultures, will enable physicians to treat and communicate with their patients more effectively. Cross-cultural education, an interdisciplinary field of study, should also enhance physicians' awareness of differences between the provider and the patient regarding knowledge of health and healing practices, illness perception, and therapeutic options, and a greater understanding of population-specific disease prevalence and health outcomes. Students also learn the clinical skills necessary to improve their interactions with underserved groups and health care delivery to those groups.

CROSS-CULTURAL EFFICACY INSTEAD OF CULTURAL COMPETENCE

The term "cultural competence" implies a discrete knowledge set that focuses on the culture of the patient only as something "other" and therefore aberrant from the norm. Such an approach may actually perpetuate stereotypes. Students are taught, "This is how you deal with this ilk of patient." This approach is ethnocentric and has profoundly negative effects. (For information about ethnocentrism and why it is to be avoided in health care, see the Appendix.) I prefer the term *cross-cultural efficacy* because it implies that the caregiver is effective in interactions that involve individuals of different cultures and that neither the caregiver's nor the patient's culture is the preferred or more accurate view. In almost any medical encounter, there is a tricultural interaction: the culture of the physician, the culture of the patient (which is rarely exactly the same as that of the physician), and the medical culture that surrounds them. In this model, it is important that students learn how to see their own cultures and the impacts of their behaviors on others whose cultures differ—and the impacts of the patients' behaviors on them, the students. With this view, they can gain a broad appreciation of interactions among cultures, rather than just memorizing characteristics of certain broad groups.

In a nationally recognized curriculum, "Looking within to See the Outside Better: A Course on Enhancing Effectiveness in Cross-cultural Care," implemented at MCP Hahnemann University, *diverse* is defined as describing "anyone who is not you," and the focus is on the ubiquitous and positive role of culture in everyone's life.[6] This definition and focus incorporate the strengths that divergent backgrounds bring to any interaction and challenge learners to define their own cultural influences, thus shifting from a philosophy of ethnocentrism to one of ethno-relativism. A person who has an ethno-relative perspective understands that there are multiple valid interpretations of behavior based on diverse beliefs and values. In the MCP Hahnemann course just mentioned, we are able to address the dynamic of the doctor–patient interaction (negotiation, affirmation, and translation of communication) as well as, for instance, ethnic or religious differences. For example, we ask students to immerse themselves in the culture of medicine and examine how the culture of the clinic or the ward or the emergency room influences how they portray themselves, how the patient becomes a part of that culture, and how communication must be adjusted for the specific situation. This also allows stu-

dents to view a broader context of any interactions they have with patients and to incorporate culture as one key component of this context.

CROSS-CULTURAL EFFICACY IN WOMEN'S HEALTH EDUCATION

The *women* of women's health have common issues of gender but wide variance and perspectives regarding the priority of issues of ethnicity, culture, and class. With good reason, women of color have generally felt outside the women's health movement, since their issues and priorities have not uniformly been addressed. Women's health education needs to be about more than the health of that class of women who tend to be white and middle class. Progress is not made by replacing or augmenting the white male template for a white female template in medicine. For women's health to address the issues of *all* women, cross-cultural education to achieve cross-cultural efficacy needs to expand women's health objectives and present students with a more complete picture. The impacts of changing demographics, shifting health care markets, and consumerism necessitate this. More important, we need to train our learners in the new real-world experiences that they will face when aiding their female patients in an increasingly diverse world.

Fortunately, the inclusion of cross-cultural education shares common principles and challenges with those seen in women's health educational reform strategies. Both are best achieved by an integrative, interdisciplinary approach.[7] The *integration* of women's health implies intercalation of material using logical linkages rather than introduction of new information at the expense of existing material. True integration attends to the never-ending concern of the lack of available teaching time by adding cross-cultural objectives to existing women's health objectives (Table 1) that enrich the integrated material without expanding the time required to teach it. Multiple viewpoints are essential in cross-cultural education; thus an *interdisciplinary* approach is important, which is compatible with the inherently interdisciplinary nature of women's health education. Not only is faculty buy-in broadened, but various viewpoints—gained from primary care, medical anthropology, psychiatry, clinical skills educators, ethicists, health services researchers, and epidemiologists—all bring unique perspectives that enable learners to delineate the complex reality of the woman's world and of cross-culturally appropriate health care.

Cross-cultural education and women's health education also share similar challenges. These include resistance to learning and the lack of readily accessible teaching tools and knowledge. One source of resistance is in the invisibility of culture, a characteristic that seems unique to cross-cultural education. Women's health educators are, however, aware of learners who also are blind to the impact of their gender on their lives. In both types of education, educational methods to raise awareness and enable reflection help foster and deepen learner's personal insights.[8]

Another source of resistance is *fear of openly dealing with the hurt and anger associated with sex and racial discrimination.* Just as health care providers unintentionally discriminate, so do patients. Faculty and students must acquire the skill of addressing their own upsetness when they are misperceived by patients, and should learn to understand when patients' mistrust is validly based on the negative experiences minorities have had (e.g., the experimentation in Tuskegee).[9,10]

The final two challenges are the lack of readily available teaching materials and the lack of knowledge about the cultural issues important for optimal women's health outcomes. Many textbooks provide insufficient, incorrect, or stereotypic information about cultural groups that, when used, only teach students how to stereotype. Such misleading information does a huge disservice to women patients. The challenge of stereotyping exists in women's health (e.g., all female athletes having eating disorders), although group traits regarding "all women" usually seem illogical. Unfortunately, group traits about women who are Latinas, Native Americans, or Asian Americans are far too often accepted as irrefutable facts. There are some materials available to enable students to see the variance within groups and begin to conceptualize the variance as a norm (rather than as a single example apart from the norm), but more materials are needed to assist educators in their goal of delivering cross-culturally effective care for women. In addition, just as we uncover unasked and unanswered questions in women's health, we need to ask and address issues for women of color. For example, we know that African American women get breast cancer less often than do white women. Why, then, is the death rate of African American women so much higher than that of white women? New knowledge and research are needed to answer questions regarding disparities in care for all women.

As these issues and challenges are addressed, the appropriate timing of the curriculum needs to be considered. Similar to advances in women's health educational reform, cross-cultural education needs to be delivered in a manner that is linked to the level of training. Students progress through four years of training by achieving educational milestones. For example, they are initially introduced to the normal, or healthy, human. They then learn of human illness and the pathophysiology of disease. Later they acquire specialty-specific knowledge, skills, and attitudes and, finally, advanced specialty-focused clinical skills. Table 1 provides examples of women's health and cross-cultural objectives linked to these typical milestones of medical students' education.

Table 1

Examples That Link Typical Educational Milestones to Women's Health and Cross-cultural Objectives Throughout the Four Years of Medical School

Typical Educational Milestone	Women's Health (WH) Objective	WH Cross-cultural Objective
Year one, the normal or healthy human		
Knowledge		
Biologic science		
Principles and processes in normal growth and development	Recognizes anatomic similarities and differences between sexes	Recognizes anatomic differences and similarities across ethnicities (average heights, facial morphology, etc.)
	Recognizes anatomic changes characteristics of domestic or partner violence	Identifies ecchymosis in dark-skinned women
Skills		
General principles of care		
Communication	Demonstrates inclusive language in history taking by asking the female patient how she would like to be addressed	Demonstrates the ability to ask the woman about her health beliefs
Ethics and professionalism	Obtains informed consent with gender sensitivity (e.g., including patient's concerns for day care when obtaining consent for chemotherapy sessions)	Obtains informed consent in a culturally appropriate manner (e.g., disclosure of end-of-life issues to inculturated Mexican American patients with terminal illnesses)
Research skills	Interprets the literature understanding the limitation of generalizability in research studies where female subjects are excluded or not analyzed	Evaluates validity of study results to various cultural groups
Year two, the human and illness—pathophysiology of disease		
Knowledge		
Biologic science		
Principles and processes of conditions and diseases	Understands that menstrual cycle influences insulin efficacy	Understands the increased risk of diabetes mellitus in Mexican Americans and hormonal-mediated effects of insulin in women
Pathophysiologic and clinical manifestations of disease	Understands the prevalence of eating disorders and differentiates them from dieting habits; can describe pathophysiologic hormonal changes	Recognizes the increasing incidence of eating disorders in minority girls/women
Skills		
Physician tasks		
Communication	Recognizes gender differences in communication (e.g., process-focused women versus product-focused men)	Recognizes and appropriately interprets cultural variation in communication styles (e.g., eye contact, affect, nonverbal communication)
Interviewing and physical diagnosis skill	Performs a sensitive breast examination	Educates patient in a culturally effective manner on self-breast examinations

Year three, specialty-specific knowledge, attitudes, and skills		
Knowledge		
Clinical knowledge		
Differential diagnoses, specialty-specific clinical manifestations of diseases	Understands gender disparities in cardiac care	Recognizes cultural disparities in accessing cardiac care for minority women
	Recognizes and screens women for cerebrovascular disease	Understands increased CVA risk and morbidity when evaluating African American women
Skills		
Clinical skills		
Psychosocial issues in care delivery	Recognizes and inquires into the role of relationships and emotional health	Recognizes the implied social status of attaining motherhood, as seen in some cultures, and the impact on contraceptive usage
Increased skill in interviewing and physical diagnosis	Demonstrates effective health education with women	Uses translators effectively when obtaining a history
Emergency management issues	Performs examinations in a patient-focused, sensitive fashion (e.g., pelvic)	Negotiates with a patient whose culture does not allow a male clinician to examine a female patient (e.g., some Islamic patients)
Specialty-specific skills (phlebotomy, obtaining ECG, immunizations, suturing, casting, laboratory analysis, etc.)	Recognizes the prevalence of depression in women and screens appropriately	Identifies community-based culturally effective resources for depression management
Clinical reasoning	Recognizes that women are likely to delay their own care due to caretaking responsibilities (especially care of children)	Demonstrates comfort with culturally specific health care attitudes (e.g., amulets provide protection against illness)
Year four, advanced clinical skills and specialty-focused skills		
Knowledge		
Management and complications of disease		
Increased depth of knowledge base especially in patient management	Knows the rising prevalence of STD/HIV in adolescent girls	Understands that white girls may be screened less frequently than are minority girls
	Recognizes disproportionate economic disadvantage in women	Recognizes the added economic burden of minority women and knows how this results in barriers to care
Skills		
Advanced clinical skills		
Increased autonomy of patient care (sub-intern experiences)	Understands the role of physician advocacy in patient health care empowerment (e.g., encourages patients to take charge of sexual health by engaging in contraceptive options)	Understands cultural and societal influences on contraceptive options and offers direct, culturally appropriate advice

EVALUATING CROSS-CULTURAL OBJECTIVES IN WOMEN'S HEALTH EDUCATION

At each milestone, we in medical education need to be able to assess the student's acquisition of cross-cultural efficacy. At the heart of any evaluation strategy is the question "What should the learner be able to understand, know, and do in the real-world experience?" The learner must demonstrate insight and cross-cultural awareness in his or her knowledge, clinical skills, and attitudes about women. This learning must be observable when the student deals with a patient on an individual basis as well as with colleagues in a group setting.

As with other educational processes, assessment must match the educational objectives. Special approaches to the evaluation of women's health learning have been proposed.[11] When cross-cultural objectives are intercalated, existing strategies have some special limitations and new strategies are required.

Identifying Knowledge-driven Objectives and Minimizing Stereotyping

Standard evaluation formats for knowledge-driven goals and objectives include multiple-choice questions, objective structured clinical examinations, standardized patients, and clinical bedside examinations. (See Table 2, the rows labeled "Knowledge.") These formats are limited when assessing cultural efficacy in women's health, just as they are for professionalism, ethics, and the behavioral sciences. First, students

Table 2

Teaching and Measuring Cross-cultural Efficacy in Women's Health*

Goal Type	Educational Objectives: The Learner Demonstrates—	Instructional Method	Evaluation Tools
Knowledge	Understanding about biologic differences Understanding about cultural differences **Understanding about subcultural differences** Understanding about differences where the etiology is not yet known (biologic versus cultural) Understanding about health beliefs, traditions and practices Understanding about barriers to care and access issues Understanding of the framing of research questions when explaining the role of culture and women's health	Lectures Case discussions Problem-based learning cases	Multiple-choice questions Objective structured clinical examinations (OSCEs) and/or simulated patients (SPs) Clinical bedside examinations (CEXs)
Skills	Behaviors associated with professionalism and ethical practices Behaviors associated with the physician as a participant in the health care delivery process Physician–patient communication skills in cross-cultural setting **Nonverbal communication skills** Behaviors that include culture as a health variable in diagnosis (history and physical examination skills) Behaviors of the physician as a health advocate	Role playing Clinical reasoning exercises Other small-group exercises (e.g., nonverbal communication skills workshop) Case analyses of cultural influences of clinical presentations	Videotape evaluation Self-assessment and review OSCEs and/or SPs Observed (CEXs)
Awareness	**Ethno-relative self-awareness** Ethno-relative awareness of others Ethnocentrism in medical culture **"Tricultural" perspective in a medical encounter** Negotiating cultural differences Self-reflection on efficacy in cross-cultural health care Delivery (similar to NBME professionalism project)	Self-awareness exercises such as case discussions in ethics, on professionalism, on clinical reasoning Communication skills workshops	Learner self-reflection Faculty feedback Attitude questions on OSCEs Evaluation on interpretations of essays, journals, or video-analysis discussions

*Boldfaced objectives are discussed in the text.

can usually select the socially desirable answer, but still practice unacceptable behaviors. This is more likely to be true with a sex- or gender-based or cross-cultural issue than with a more concrete issue, such as calculating glomeruler filtration rate. Second, testing modalities such as multiple-choice questions (MCQs) tend to oversimplify culture and frequently stereotype in an attempt to write a standardized question. MCQs have a role in assessment, especially in areas such as disease prevalence, health outcomes and disparities, and the range of health beliefs and practices. The caveat, however, is that linking a health belief *invariably* to a group provides a potentially new stereotype to the naïve learner. For example, when using MCQs to test understanding of cultural differences, a stereotypic descriptor in a question regarding reasons why a Navajo woman rejects renal transplantation might read "Navajo patients refuse organ donations due to their cultural beliefs." This, of course, is incorrect and stereotypic because it does not deal with intragroup variance of cultural beliefs, nor does it include the impact of the *individual* woman's acculturation status. A more useful MCQ descriptor could include the possibility that "organ transplantation may conflict with this patient's spiritual beliefs."

Assessing the Skill of Cross-cultural Efficacy

Cross-cultural efficacy implies the ability to use a number of skills in various settings. Current evaluation strategies for skills assessment include standardized patient (SP) examinations or objective structured clinical examinations (OSCEs), clinical bedside examinations (CEXs), role-playing in small groups, interactive case seminars, and video-based computer-aided instruction. (See Table 2, the rows labeled "Skills.") Validating skills acquisition for cross-cultural efficacy, like validating all clinical skills, is an ongoing process that requires feedback, practice, and refinement. Observed performance of a student's skills is necessary, and vigilance in avoiding stereotyping is critical.

For example, a student being tested on clinical skills should be able to demonstrate comfort with eliciting the woman's model of illness and health beliefs, taking into account her gender and culture. The health history obtained should include all of the woman's health habits. This includes her culturally based beliefs and the use of alternative or complementary medicine practices (e.g., use of therapies such as herbal medicine and acupuncture).

Expanding Evaluation Methods: Self-awareness

A relatively new evaluation strategy is that of self-awareness. Self-awareness assessments measure the impact of attitudinally-based curricula designed to address the motivational framework of feelings and values that underlie behavior. A self-awareness curriculum includes experiential exercises that enable learners to heighten their insight and empathy. Within this area, reflection exercises are an example of this interactive learning modality. For purposes of discussion, these two terms, self-awareness and reflection, are referred to interchangeably. (See Table 2, the rows labeled "Awareness.") Self-awareness evaluation is currently being considered as a way to increase a learner's awareness of attitude-based concepts and issues when addressing humanistic and professional qualities. A number of educators have incorporated self-awareness or reflection within their curricula.[6,12–15] This direction is also supported by efforts at the National Board of Medical Education in its Professionalism Project.[12,16]

Through the process of reflection, a learner can explore his or her own perspective. For example, in MCP Hahnemann's problem-based curriculum in women's health, students are asked to role-play a counseling session (described below) concerning the exploration of reproductive options after an interactive discussion about risk perception, the uses and limitations of laboratory tests, and the literature about patient–doctor communication regarding genetic counseling. Male and female students are asked to assume the role of the pregnant patient. During implementation, this invariably results in a male student's asking, "How can I play a pregnant woman, when I'm a guy?" The students are informed that physicians should learn about illnesses from the patient's perspectives and are asked to reflect on how their lives would be if they were pregnant women. This exercise increases students' awareness of difference and allows facilitators to assess students' levels of comfort and skills.

Evaluation using the process of reflection is harder to accomplish in large student groups and is often most productive when delivered in small-group settings, where learners can discuss issues and address challenging topics more easily. These small groups need facilitators trained in group dynamics to ensure a safe and conducive learning environment and to provide ongoing feedback. These educators must be taught to facilitate and evaluate in a modality very different from that used in their own educations. To train faculty as facilitators, mini-modules of student programs can be developed. This provides an opportunity for discussion, reflection, and debriefing on typical issues raised during the student sessions.

Although self-awareness strategies require additional resources and evaluation infrastructure changes, they are essential for the assessment of students' progress and for professional development in areas such as cross-cultural efficacy and professionalism.

Including Evaluation for Cross-cultural Efficacy in Women's Health Education

After the identification of necessary awareness issues, knowledge, skills, and linkage with existing objectives, how can we use current evaluation strategies to assess cross-cultural efficacy in women's health education? Standard evaluation formats that focus on knowledge-based information fall short in capturing reflective learning and attitude change. We need to broaden both the scope and the time frame in assessment in order to effectively answer the question, "Are our learners more cross-culturally effective after the educational intervention?"

Table 2 summarizes an educational plan that integrates the teaching and evaluation of cross-cultural efficacy for women's health education into the fabric of an existing curriculum. Examples from each of the three goals given in the table (knowledge, skills, and awareness) with their associated educational objectives, instructional methods, and evaluation tools are described in greater detail in the examples below.

Increasing the Student's Knowledge

Educational objective. The student should gain an understanding about subcultural differences as they relate to health outcomes.

Example of instructional method. When presenting a lecture on infant mortality in Hispanics, the lecturer highlights that among Hispanics, neonatal mortality risk is higher in Puerto Rican women than in Cuban American or Mexican American women.

Evaluation tools. Multiple-choice questions; objective structured clinical examinations, clinical bedside examinations.

Increasing the Students' Skills

Educational objective. The student should gain nonverbal communication skills so that he or she will understand how nonverbal communication styles may differ among different groups.

Example of instructional method. Students watch videos of women of different cultures interacting with one another. The volume on the videotape is turned off, and students comment on what they perceive is occurring regarding content, affect, and effectiveness of communication. The volume is then turned on and students evaluate how well they did.

Evaluation tools. Self-assessment; faculty feedback.

Increasing the Student's Awareness

Educational objective. The student should demonstrate an ethno-relative self-awareness.

Example of instructional method. During a diversity orientation program, students are asked to define themselves in short descriptors such as those used in medicine (e.g., 24-year-old white female). They are asked to discuss whether these descriptors portray them effectively. This exercise enables each student to begin to see his or her own culture; understand the influence of it on his or her values; and experience being stereotyped.[16]

Evaluation tool. Reflection by the learner; faculty feedback.

Increasing the Student's Awareness

Educational objective. The student should demonstrate an understanding of a "tricultural" perspective in a medical encounter, that is, awareness of the influences of the medical culture, the student's own culture, and the patient's culture in health care delivery.

Example of instructional method. A Latina adolescent presents to the emergency department with abnormal vaginal bleeding. Despite assurances that a female nurse will be in the room, she refuses to be examined by the male resident unless her mother accompanies her. Students are asked to assess this situation from the perspective of the resident, the patient, and the medical culture (a tricultural approach).[6] Issues regarding culturally based attitudes towards modesty are discussed. This exercise enables learners to uncover the implicit values and structure within all three cultures; to create what I call "differential diagnosis of interpretation of behavior" based upon using different cultural lenses; and to develop strategies to resolve misinterpretations.

Evaluation tool. Self-assessment; faculty feedback; objective structured clinical examinations, clinical bedside examinations.

What Must Happen Next

I believe that cross-cultural education to produce physicians who practice cross-cultural efficacy is essential for students being graduated and stepping into the diverse world that exists within and outside the walls of our educational institutions. Knowledge about the differences in disease presentation by gender, race, ethnicity, and circumstance is essential in providing adequate health care in the year 2000 and beyond. More specifically, skill in communicating with a female patient, regardless of how different she may be from oneself, is essential in gathering data to arrive at a diagnosis, communicating findings and a treatment plan, and monitor-

ing the patient's progress. The physician's awareness of his or her own biases and willingness to take remedial action are essential to achieve cross-cultural efficacy for all patients, including female patients.

These skills will not be attained in a vacuum. They must be intentionally integrated into curricula throughout the four years of training and across all disciplines. It would be foolhardy to expend effort to integrate women's health into the medical curriculum without a clear plan to address cross-cultural perspectives.[18] Only in this way can our future practitioners become competent to provide comprehensive women's health across the lifespan and in the full context of women's lives.

Students must be held accountable for learning these skills. Medical educators must be innovative in determining whether the students are achieving competence in cross-cultural efficacy. This process is not easy and cannot occur without an ongoing commitment by individuals within the institution to brainstorm, troubleshoot, and at times cajole. Some existing evaluation strategies can be used to assess cross-cultural efficacy if principles of cross-cultural education are used. Perhaps even more important, our learners, women as well as men, need guidance on developing insight and empathy towards their female patients. Investment of evaluation infrastructure resources are needed to assess students' progress using self-awareness strategies so that we can foster the development of an excellent physician—one who is a well-rounded scientist, thinker, clinician, and humanist. Our profession and our patients—including our female patients—deserve no less.

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See Appendix on page 1080.

APPENDIX

What is Ethnocentrism? What is Stereotyping?

Ethnocentrism and egocentrism are similar in that they both approach the world from a monocular view. Egocentrism is where the individual views the world only as it relates to the viewer at the center and object of all experiences. Ethnocentrism is the belief that one's own group is superior to and the basis for judging all other groups. An ethnocentric perspective holds that one's own values, beliefs, traditions, and viewpoints constitute the only valid approach. Actions or customs are interpreted based upon one set of beliefs. An example of ethnocentrism is in the interpretation of body language. A smile, based upon mainstream Western values, is usually interpreted as a sign of friendliness or agreement. In some cultures, a smile may mean condescension, anger, fear, or embarrassment.

Behaviors or customs that appear foreign, from an ethnocentric perspective, are often described in terms of rigid, preconceived traits that are assumed to apply to all members of the other culture, despite the fact that logic or experience indicates otherwise. This results in stereotyping. A stereotype is a preconceived, often negative value judgment about a group. It is a label to put on someone without any knowledge of that individual. It is akin to having someone else select your clothes, in colors that you would never wear and a size too small. Stereotypes are minimizing, have a negative impact on the individual, and can be deleterious to his or her health.

The dangers of stereotyping in health care are illustrated in the following example: A student presented the case of a 68-year-old Latina with longstanding diabetes who was blind from complications of her disease. The complaint of this pleasant woman was that she had nausea. When asked to present the differential of her nausea, the student first presented a psychiatric syndrome that he understood to be an ailment of Latinos (un ataque). His incomplete learning about panic-attack–like syndromes led him to stereotype the patient and miss her actual diagnosis, diabetes-induced gastroparesis.