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Cross-cultural medical education and training

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Abstract: Cross-cultural medical education and training is the most appropriate response to health requirements in the current world of globalization, migration and free market economy. This article explains the background to immigrant health issues and suggests the directions that education at medical schools could take in order to foster students' knowledge and skills, to enhance the health of immigrants and to keep pace with international trends in medical education *(Ref. 54).* Full Text (Free, PDF) www.bmj.sk.
Key words: cross-cultural medical education, curriculum, immigration, Slovakia.

Immigration, culture and health

Healthcare providers need to understand that it is not only culture that makes immigrants appear to be different (in the providers' eyes) and impacts on their health. In fact, immigration is a difficult and stressful process because immigrants who leave behind their native land and family often encounter adaptation difficulties in a new recipient country (1,2) and face excessive social stress caused by social isolation, cultural conflicts, poor social integration and assimilation, role changes and identity crises, low socioeconomic status, and racial discrimination (3–5).

However, not every stressed immigrant will become ill. Nguyen explained that three sets of factors must be taken into consideration in the attempt to understand immigrants' vulnerability to illness: a) the immigrant demographic, linguistic and cultural characteristics; b) the motivation and circumstances for migration; and (c) the social climate of the receiving society (public attitudes, immigration policies and services, pre-existing ethnic community and infrastructure) (6). These factors beha ve either as facilitators or stressors of immigrant health (3).

Culture is only one of the significant determinants of immigrant health. Understanding of mental health and illness issues that differs from the concepts embraced by Western psychiatry (7–9), culturally-derived stigma associated with mental illness (10), and lack of access to culturally and linguistically appropriate health information (11–13) are only some of the factors that health professionals need to consider when providing care to patients of diverse cultures. The other important factors that influence and shape immigrants' mental health include lack of family and social support, unemployment and low income, inhospitable social and physical environment (3, 14), as well as financial (15, 16), physical (17) and communication barriers to healthcare (10). These factors often lead to underutilization of mental health services (11, 18), which may result in developing severe and chronic mental problems.

The maternity health of immigrant women is also influenced by serious problems such as women's low socioeconomic status, weak social support networks, unemployment and underemployment, challenges in understanding healthcare information and in navigating the healthcare system due to limited social opportunities to improve their language and other skills (19). Health professionals caring for immigrant women of diverse cultures need to consider that women's patterns of personal health practices and coping skills, values, and beliefs may differ considerably from their own. Moreover, some of these women may suffer from post-traumatic stress disorder or face racism and other forms of discrimination (19).

All these factors contribute to stress and changes in women's hormonal and immune systems, making some pregnant immigrant women more vulnerable to pre-term labour and their babies to low birth weight (20). Poor quality maternity care puts immigrant women and their fetuses at risk of higher mortality and morbidity (21). Therefore, care and treatment sensitive to immigrant women's needs are essential to their health and the health of their children. However, Ali found that, for instance, healthcare professionals in Britain lacked knowledge of maternity needs of their Muslim patients and displayed some discriminatory attitudes during their care of these women (21).

The difficulties surrounding the immigration process and the absence of proper healthcare services sensitive to immigrants' diverse needs may result in health and social inequalities that

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ultimately lead to ill health. As Betancourt put it, “When socio-cultural differences between patient and provider aren’t appreciated, explored, understood, or communicated in the medical encounter, patient dissatisfaction, poor adherence, and poorer health outcomes result” (22).

For these reasons, the governments and healthcare authorities of Western countries that embrace large numbers of immigrants every year support the elimination of health-related inequalities that immigrants as culturally diverse populations experience when accessing and utilizing healthcare services (23, 24). In order to eliminate these inequalities, researchers have suggested that healthcare should be built on three premises: health professionals’ understanding of the root causes of health inequali ties, their understanding of cross-cultural issues and, finally, their awareness of available community resources which may improve the health and well-being of their patients (25). Healthcare providers must also recognize the health-related effects of one’s race, culture, class, gender and sexual orientation as well as existing social inequalities (26).

The notion that healthcare professionals can acquire these qualities throughout their medical education and training is now widely recognized in North America. According to the new standards established by the Liaison Committee on Medical Education, the presence of cross-cultural medical education (CME) in an undergraduate medical curriculum is a requirement for accreditation of all American or Canadian medical schools. The Committee stated that “the faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students must learn to recognize and address gender and cultural bias in themselves and others and in the process of health care delivery” (27). The Committee further explained that the word ‘must’ in accreditation standards implies an absolute requirement.

CME, generally, consists of three main elements: knowledge-, attitude-, and skill-based programs (22, 28). In such programs, medical students acquire information about diverse cultural issues, social determinants of health, and cultural variations in epidemiologic indicators of diseases. As well, they build sensitive and inclusive attitudes towards persons of different ancestries and cultural heritages while reflecting on their own biases and stereotypes. Medical students also learn a variety of cross-cultural communication strategies, including working with language interpreters and cultural liaisons (28).

Loudon et al. noted that CME can be delivered through lectures, workshops, elective courses, standardized patient cases, language training and other means (29). Kripalani et al. suggested that CME and training should also be given during students’ clinical rotations rather than taught solely in the first two years of their undergraduate medical education (28).

While these strategies proved to be effective in improving therapeutic outcomes and reducing health inequalities of culturally diverse patients (30, 31), several authors pointed out that medical students learned to apply the term culture narrowly and frequently overlooked the social context of patients’ health (32–34). CME must consider the role of patients’ social history in order to be truly responsive to patients’ needs (35). This means that medical students as future health professionals need to pay attention to both social and cultural aspects affecting the health of their patients – in particular, the role of social stress, support networks, migration circumstances, and life control (35).

In the following sections, I would like to discuss the problem of CME in the Slovak context. At first, I will explain a rationale for providing CME and training in Slovakia and then elaborate about the structure and format of a cross-cultural medical curriculum that Slovak medical schools could embrace.

Cross-cultural medical education: its place in the Slovak context

Before any discussion about the structure and format of a CME at Slovak medical schools can take place, one needs to consider whether there is a sound rationale for providing such an education in a country of five million which can be historically regarded as a territory which is, culturally, fairly homogenous. In fact, there are several reasons why medical schools in Slovakia should seriously consider incorporating CME in their curricula.

The most essential reason is our human responsibility to provide the sick with the quality care to which any human being is entitled. Further, since 2000, immigration to Slovakia has been increasing. According to the latest statistical data, there were about 25,600 foreign permanent residents and 3,500 asylum seekers living in Slovakia in 2005 (36). In 2006 Slovakia admitted more than 3,800 new immigrants – a number sixfold higher than the number of Slovak newborns in that particular year (37).

Historically, the immigrants who came to Slovakia were mainly from the Czech Republic, Ukraine, former Yugoslavia, and Romania; at present, however, they come from all countries of the European Union as well as from South Korea and the USA (36). All these people represent potential patients with diverse health-relevant cultural, linguistic, and religious needs that Slovak physicians need to consider.

Another reason for introducing CME and training in Slovak medical curricula is the outmigration of Slovak physicians. It is estimated that there are many Slovak health professionals working in the Czech Republic – homeland of 278,000 foreigners (36). Without appropriate CME and training, Slovak physicians practicing in multicultural European countries may face difficulties in meeting the complex needs of their culturally diverse patients and hospitals requiring cross-cultural medical competencies from their employees. In fact, since 2004 hospitals in 12 European countries started to train their staff in these competencies under the umbrella of Migrant-Friendly Hospitals Project (23). As a result of this successful project, its authors and participants recommended to all European hospitals to become migrant-friendly and provided them with specific guidelines and strategies to building cultural responsiveness.

Lastly, if Slovak medical schools are to keep pace with current standards of medical education in developed countries, they

need to incorporate CME and training in their undergraduate medical curriculum. I have already implied that CME is now a requirement in the USA and Canada. Some Dutch and British medical schools also offer compulsory medical training in multicultural medical issues (38, 39). Unfortunately, the website of current medical curriculum at the Faculty of Medicine in Bratislava does not indicate any special course or training in cross-cultural medical issues (40).

In simple words, Slovak medical curriculum still operates on the long established assumption that physicians should "treat everyone neutrally, objectively, as if they were cultureless, classless, raceless, genderless" (26). Medical students in Slovakia do not learn how to assess, for instance, the mental health status of a Vietnamese female patient who does not speak Slovak or how to embrace respectfully an African man's beliefs about the supernatural causes of his illness. Similarly, they do not discuss the nutritional needs of an elderly Indian patient, or the emotional needs that Bosnian children suffering from post-war syndrome may have. They do not study how to approach the issue of physical and sexual modesty of a Muslim female patient during a gynecologic examination, or which community health supports to recommend to a blind Hungarian-speaking diabetic patient.

Neither do students reflect on whether ethnic and cultural differences could account for a disease expression varying from taken-for-granted disease descriptions contained in their textbooks. They do not consider that patients of diverse cultural and ethnic backgrounds may respond to prescribed medication dosage – largely tested on, and designed for white European and American populations – with severe side effects (7, 10).

In the following section, I would like to elaborate about the structure and format of a cross-cultural medical curriculum that Slovak medical schools could consider developing. Taking into account the available human power and logistics involved, I consider incorporating CME into existing curriculum and courses a more practical and feasible approach than developing a new curriculum and special courses.

Cross-cultural medical education: structure and format

Reviewing literature about the available models of cross-cultural medical curricula abroad is very useful in order to avoid two pitfalls that foreign medical schools had encountered: introducing CME too early in isolation from clinical training, and teaching cultural issues in categorical terms that promoted stereotyping of patients and minimally challenged students' attitudes (22, 26, 41-43).

Focusing on CME in pre-clinical years did not prove successful as students felt a disconnect between the studied issues and real life (26). For this reason, I propose introducing CME in the third year when medical students start to learn their first clinical skills. Courses such as Internal and Surgical Propedeutics are, in particular, a very suitable platform for introducing CME. These two courses are concerned with developing important clinical tools and skills such as medical interviewing, communication, and examination. The faculty personnel could consider incorporating both theoretical and practical lessons of cross-cultural issues surrounding these clinical skills.

For instance, these lessons could tackle the problems which arise during a medical encounter involving the issues of differences in language, cultural sensitivity, and body language such as eye-contact and physical touch. Silverman et al. (44) proposed adopting the following model questions which better clarify these concepts:

1) "You mention that you are from Afghanistan. I don't know anything about Afghanistan's culture… Is it OK, for instance, for a doctor to shake the hand of a patient? What is your preference for greeting?

2) I can understand that it must be frustrating for you that I can't understand you as well as you would like. Would it help if we had an interpreter?

3) I'd like to know what sort of treatment you were expecting or hoping for. From what I know of Chinese culture, it might be quite different from what we offer here. If that is true for you, I'd like to help.

4) I know that sometimes women would prefer to be examined by a female doctor – is that important to you?"

In the same way, some culture-relevant medical issues could be discussed in Medical Psychology, which is concerned with studying psychological aspects of a medical encounter between the patient and the healthcare provider. For instance, medical students could learn about personality, emotions, and behaviour – categories strongly linked to one's culture – and how these categories influence a medical encounter. Students could be provided with some concrete examples of patients' emotions and behaviours that are culturally-derived.

Students' knowledge of cultural issues in health could be further expanded in the fourth year of medical education. For instance, several lectures on ethnopharmacology could be delivered to students within their Pharmacology course. These lectures could, for instance, increase students' awareness of ethnic differences in biological responses to drugs and their familiarity with relations between traditional cultural remedies and the development of new drugs. Such knowledge is important for appreciating diverse healing practices that students' culturally-diverse patients may embrace during their illness.

Although the contribution of ethnopharmacology to students' knowledge of cross-cultural medicine is significant, it is the Social Medicine course in their fourth year of study that could considerably broaden their understanding of cultural aspects of health. Social medicine is an interdisciplinary field of study that examines the existing intersectionalities of social science and medicine. Medical students learn that there is a wide range of social determinants of health such as employment, working conditions, income, social support networks, gender, and culture, to name just a few.

In their discussions of cultural impact on patients' health beliefs, practices and coping skills, medical students could also learn to understand basic definitions such as culture and diversity. Also, it is important to ensure that culture is not discussed

in isolation from other social determinants of health. For instance, some physicians may hold patients' cultural beliefs accountable for the distribution of certain diseases (as well as patients' non-compliance with medication), but closer investigation of all the social determinants may document that it is the patients' disadvantaged socioeconomic status rather than their culture which results in a higher prevalence of certain diseases and prevents patients from adhering to therapy (45). Such a Social Medicine course could provide students with tools helpful in building general understanding of forces present in the local health conditions; as well, it could help to unmask powers, interests and discourses underlying (mis)representation of illness (46).

In the fifth year of study, the greatest potential for inclusion of cross-cultural considerations is, I believe, in the Medical Ethics course. In this course, students should focus on issues such as racism, classism, sexism and their relation to clinical decision making. They need to be aware of how a membership in certain culture or race impacts on providers' medical decisions. They should explore why, for instance, black patients are less likely than white patients with the same set of signs and symptoms to be referred to catheterization (47), or why visible minorities are less likely than a comparable group of whites to be offered counseling services, but more likely to be prescribed drugs in higher dosages and transferred to locked wards (9, 48).

A revised Medical Ethics course should offer students a platform for reflecting on their own biases, prejudices, and stereotypes when dealing with all those they perceive as "other." For instance, CME in the USA encourages medical students to reflect on statements such as these: a) "It is the responsibility of the majority population to learn about minority groups. b) Arabs do not place as much value on human life as Americans. c) Immigrants should be integrated into their new country without having to give up their own culture" (43).

The other semi-clinical and clinical courses offered to students in their fourth and fifth year should foster further the students' knowledge and practical skills important for cross-cultural medical encounter. For instance, the Epidemiology course could introduce to students the concept of disease distribution, its incidence, and prevalence among different ethnic and cultural groups. While some groups are more prone to a higher prevalence of certain genetic diseases (for example, congenital dislocation of the hip among East Europeans), other groups are protected from some diseases thanks to their cultural behaviours (for example, practicing Jewish women from cervical cancer).

The faculty teaching individual clinical courses could opt for a similar approach to introduce lessons dealing with relationships of culture and disease that they study and treat. It is far beyond the scope of this paper to address the cultural issues in all available courses. However, I will illustrate some examples of CME in psychiatry. It has been well documented for a long time that understanding, expression and treatment of mental illness is not universal and varies significantly across cultures and geographic regions (7). Medical students should learn about these differences so as to develop a multi-cultural approach to assessing and treating mental illness.

For instance, experts in trans-cultural psychiatry advocate combining pharmacotherapy with the "traditional" therapeutic models derived from the health beliefs of their patients. Marsella (49) classified these types of "traditional" therapy and healing into four useful categories: psychological (meditation, imagining, problem solving), social (family involvement, social re-integration), physiological (rest, massage, acupuncture) and supernatural (prayers, exorcism). The positive effects of combining folk and mental health therapy have been described in the treatment of Puerto Rican children (50). Similarly, Cancelmo et al. have documented the successful treatment of a diseased Hispanic man only after a traditional healer was incorporated into his treatment process (51). In general, a multi-cultural approach was found to increase patients' adherence to psychiatric treatment and care (52).

The faculty involved in psychiatric teaching and training may find the American Psychological Association's guidelines and strategies related to CME and practice (53) very useful in developing new lecture topics for students. Similarly, the instructors of oncology, gynecology, internal medicine, and surgery may find guidelines and tips in literature concerned with CME in their respective fields. However, supplying students with theoretical knowledge is insufficient. Giving them an opportunity to discuss with standardized patient cases of diverse cultural backgrounds either during their lectures or practice is essential, so that students may connect the theory with their clinical practice.

In conclusion, the structure and format of CME which I have presented should make certain that students will be exposed to its concepts over three clinical years when theoretical knowledge will overlap with practical skills and personal reflections. Incorporating all the suggested components of cross-cultural medical knowledge, skills and attitudes into Slovak medical curricula will help to ensure that students will not learn about culture in categorical terms as a stereotypical set of beliefs and values associated with certain groups of people.

Quality CME helps students to avoid "labelling the patient with the attitudes and outlook of a whole race or culture," but rather teaches them to "find out each individual patient's unique perspective and experience of illness" (44). So, for instance, while it is important to be aware of cultural and ethical issues surrounding the death of a Hindu patient whose family may believe in re-incarnation, good CME focuses on and prepares students to deal with such an event in a culturally sensitive manner even if students do not know any specific details of Hindu culture and religion. Quality CME ensures that students will not perceive a Muslim woman as a problematic patient who needs to be convinced to accept a physical examination by a male doctor but will encourage them to respect her cultural and religious requirements when offering their care – in the same way they respect the wish of a Slovak vegetarian patient for a meat-free diet.

The previous paragraphs illustrate the importance of incorporating CME in curricula at Slovak medical schools. Introducing CME will largely depend on the will of the faculty to appreciate its importance. I recognize that the teaching burden of our instructors is heavy. Also, not all instructors are aware of multi-

cultural issues in their respective areas of expertise. For these reasons, medical schools could extend their collaboration with professors of social science disciplines across the other university faculties such as Sociology, Humanities, Anthropology and Philosophy. In addition, inviting experienced health professionals such as physicians, nurses, and social workers to deliver presentations and seminars could also be a good method of easing the teaching burden of medical instructors.

In this regard, the inter-faculty collaboration would also address other problems that undergraduate medical education faces in Slovakia. For instance, Hanacek pointed out that Slovak medical schools do not teach health-relevant social and behavioural disciplines such as health sociology, medical anthropology, psychology, and philosophy, and proposed incorporating these disciplines in the undergraduate medical curriculum (54). I believe that CME is closely related to these disciplines. For this reason, the requirement to include CME in the undergraduate curriculum is in accord with Hanacek's call for a complex reform of undergraduate medical education in Slovakia (54).

Conclusion

This article explained the rationale for requiring the incorporation of CME in modern medical curricula at medical schools and proposed the structure and format of such CME at Slovak medical schools. Only appropriate education and training in health-relevant cultural matters can equip healthcare professionals with the knowledge and skills they need to address the complex issues of their socioculturally diverse patients and enable them to minimize health inequalities. Cross-cultural medical education and training is, indeed, the most appropriate response to the health requirements of a 21st century characterized by globalization, migration and a free market economy.

References

1. Liebkind K. Acculturation and stress: Vietnamese refugees in Finland. J Cross-Cult Studies 1996; 27: 161—180.

2. Sam DL, Berry JW. Acculturative stress among young immigrants in Norway. Scand J Psychol 1995; 36: 10—24.

3. Beiser M. The Health of Immigrants and Refugees in Canada. Can J Public Health 2005; 96 (S2): 30—44.

4. Reitmanova S. Mental Health of St. John's Immigrants: Concepts, Determinants and Barriers. Unpublished Master's Thesis, Memorial University, St. John's, NL, 2006.

5. Kuo WH, Tsai Y. Social Networking, Hardiness and Immigrant's Mental Health. J Health Soc Behav 1986; 27 (June): 133—149.

6. Nguyen SD. Mental Health Services for Refugees and Immigrants. The Psychiatr J Univ Ott 1984; 9 (2): 85—91.

7. Kleinman A. Rethinking psychiatry: From cultural category to personal experience. New York: Free Press, 1988.

8. Uba L. Cultural barriers to health care for Southeast Asian refugees. Public Health Rep 1992; 107 (5): 544—548.

9. Fernando S. Cultural diversity, mental health and psychiatry. The struggle against racism. East Sussex, UK: Brunner — Routledge 2003.

10. Herrick CA, Brown H. Underutilization of mental health services by Asian-Americans residing in the United States. Issues Ment Health Nurs 1998; 19: 225—240.

11. Sadavoy J, Meier R, Ong AYM. Barriers to Access to Mental Health Services for Ethnic Seniors: The Toronto Study. Canad J Psychiatry 2005; 49(3): 192—199.

12. Takeuchi DT, Leaf PJ, Kuo H. Ethnic differences in the perception of barriers to help-seeking. Soc Psychiatry Psychiatr Epidemiol 1988; 23 (4): 273—280.

13. Loo C, Tong B, True RH. A bitter bean: Mental health status and attitudes in Chinatown. J Community Psychol 1989; 17: 283—296.

14. Canadian Task Force on Mental Health Issues. After the Door Has Been Opened: Mental Health Issues Affecting Immigrants and Refugees in Canada. Ottawa, ON: Ministry of Supply and Services Canada, 1988.

15. Woodward AM, Dwinell AD, Arons BS. Barriers to Mental Health Care for Hispanic Americans: A Literature Review and Discussion. J Ment Health Adm 1992; 19 (3): 224—236.

16. Cheung FK, Snowden LR. Community Mental Health and Ethnic Minority Populations. Community Ment Health J 1990, 26 (3): 277—291.

17. Leong FTL, Lau ASL. Barriers to Providing Effective Mental Health Services to Asian Americans. Ment Health Serv Res 2001; 3 (4): 201—214.

18. Mclean C, Campbell C, Cornish F. African-Caribbean interactions with mental health services in the UK: experiences and expectations of exclusion as (re)productive of health inequalities. Soc Sci Med 2003; 56: 657—669.

19. Hyman I. Immigration and Health. Working Paper 01-05. Ottawa, ON: Health Canada, 2001

20. Patrick TE, Bryan Y. Research strategies for optimizing pregnancy outcomes in minority populations. Amer J Obstet Gynecol 2005; 192 (5S): S64—S70.

21. Ali N. Experiences of maternity services: Muslim women's perspectives. London: Maternity Alliance, 2004.

22. Betancourt JR. Cross-cultural medical education: Conceptual approaches and frameworks for evaluation. Acad Med 2003; 78 (6): 560—569.

23. Migrant-Friendly Hospital Project Group. Project Summary. Migrant-Friendly Hospitals Project. European Commission, 2005. Retrieved November 5, 2007 from http://www.mfh-eu.net/public/files/mfh-summary.pdf.

24. Kinnon D. An overview of Canadian research on immigration and health. Draft Discussion Paper. Third National Metropolis Conference, Vancouver, Canada, 1998.

25. Jacobs EA, Kohrman C, Lemon M, Vickers DL. Teaching physicians-in-training to address racial disparities in health: a hospital-community partnership. Public Health Rep 2003; 118 (4): 349—356.

26. Beagan BL. Teaching Social and Cultural Awareness to Medical Students: „It's All Very nice to Talk about It in Theory, But Ultimately It Makes No Difference." Acad Med 2003; 78 (6): 605—614.

27. Liason Committee on Medical Education. Accreditation Standards. Functions and Standards of a Medical School, LCME 2007. Retrieved November 1, 2007 from http://www.lcme.org/functions 2007 jun.pdf.

28. Kripalani S, Bussey-Jones J, Katz MG, Genao I. A prescription for cultural competence in medical education. J Gen Intern Med 2006; 21 (10): 1116—1120.

29. Loudon RF, Anderson PM, Gill PS, Greenfield SM. Educating medical students for work in culturally diverse societies. J Amer Med Ass 1999; 282 (9): 875—880.

30. Beach MC, Price EG, Gary TL, Robinson KA, Gozu A, Palacio A, Smarth C, Jenckes MW, Feuerstein C, Bass EB, Powe NR, Cooper LA. Cultural competence: a systematic review of health care provider educational interventions. Med Care 2005; 43 (4): 356—373.

31. Brach C, Frasier I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Med Care Res Rev 2000; 57 (Suppl 1): 181—217.

32. Carrillo JE, Green AR, Betancourt JR. Cross-cultural Primary Care: A Patient-Based Approach. Ann Intern Med 1999; 130 (10): 829—834.

33. Fuller K. Eradicating essentialism from cultural competency education. Acad Med 2002; 77 (3): 198—201.

34. Gustafson DL. Transcultural nursing theory from a critical cultural perspective. Adv Nurs Sci 2005; 28 (1): 2—16.

35. Green AR, Betancourt JR, Carrillo JE. Integrating social factors into cross-cultural medical education. Acad Med 2002; 77 (3): 193—197.

36. Jurcova D, Lukacova M, Meszaros J, Pilinska V, Stankovicova, I. Populačný vývoj v okresoch Slovenskej republiky 2005. Kapitola 6: Migrácia. Bratislava, Slovakia: Infostat, 2006, 47—50. Available at http://www.infostat.sk/vdc/pdf/reganal2005final.pdf

37. Statistical Office of the Slovak Republic. Ukazovatele ekonomického vývoja. Obyvateľstvo. 2006. Retrieved Jul 1, 2007 from http://www.statistics.sk/webdata/slov/tabulky/dem/dem01.htm.

38. van Wieringen JC, Kijlstra MA, Schulpen TW. Medical education in the Netherlands: little attention paid to the cultural diversity of patients. Ned Tijdschr Geneeskd 2003; 147 (17): 815—819.

39. Dogra N. The development and evaluation of a programme to teach cultural diversity to medical undergraduate students. Med Educ 2001; 35 (3): 186—187.

40. Faculty of Medicine. Medical Curriculum. Retrieved July 12, 2007 from http://staryweb.fmed.uniba.sk/www/enINDEX.html

41. Rapp DE. Integrating cultural competency into the undergraduate medical curriculum. Med Educ 2006; 40: 704—710.

42. Crandall SJ, George G, Manon GS, Davis S. Applying Theory to the Design of Cultural Competency Training for Medical Students: A Case Study. Acad Med 2003; 78 (6): 588—594

43. Dogra N, Karnik N. First-Year Medical Students' Attitudes toward Diversity and its Teaching: An Investigation at One U.S. Medical School. Acad Med 2003; 78 (11): 1191—1200.

44. Silverman J, Kurtz S, Draper J. Skills for Communicating with Patients. Oxford, San Francisco: Radcliffe Publishing, 2005.

45. Farmer P. Infections and Inequalities. The Modern Plagues. University of California Press, 1999.

46. Good BJ. Medicine, rationality, and experience. Cambridge, UK: Cambridge University Press, 1994.

47. Schulman KA, Berlin JA, Harless W et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. New Engl J Med 1999; 340: 618—626.

48. Callan A, Littlewood R. Patient satisfaction: Ethnic origin or explanatory model? Int J Soc Psychiat 1998; 44 (1): 1—11.

49. Marsella AJ. Culture and mental health: an overview. In: Marsella AJ, White GM (Eds). Cultural conceptions of mental health and therapy. Boston: Reidel, 1982.

50. Constantino G, Malgady RG, Rogler LH. Cuento therapy: a cultural sensistive modality for Puerto Rican children. J Consult Clin Psychol 1986; 54: 639—645.

51. Cancelmo JA, Millan F, Vazquez CI. Culture and symptomology: The role of personal meaning in diagnosis and treatment: a case study. Amer J Psychoanal 1990; 50: 137—150

52. Kirmayer LJ, Groleau D, Guzder J, Blake C, Jarvis E. Cultural Consultation: A Model of Mental Health Service for Multicultural Societies. Canad J Psychiat 2003; 48 (3): 145—153.

53. Constantine MG, Sue DW. Overview of the American Psychological Association's Multicultural Guidelines: Implications for Multicultural Competence. In: Constantine MG, Sue DW (Eds). Strategies for Building Multicultural Competence in Mental Health and Educational Settings. Hoboken, NJ: John Willey & Sons, Inc, 2005.

54. Hanacek J. Undergraduate medical education in Slovakia — present state and future needs. Bratisl Lek Listy 2001; 102 (9): 438—443.

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