Somali Cultural Competency among Students in One Minnesota Medical School

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Minnesota has the largest Somali population in the United States. Thus, students in the state’s medical schools are likely exposed to Somali patients during their training. We assessed baseline knowledge of and attitudes about Somali patients among students at one medical school in the state. We then exposed those students to an educational intervention and reassessed their knowledge and attitudes afterward. We found students’ baseline knowledge was poor (65% of questions answered correctly, on average), but improved (80% answered correctly, on average) post-intervention. The majority of students also felt the quality of care they could provide Somali patients would be compromised because of their lack of cultural understanding. Although the results were not statistically significant due to low power, this study represents a meaningful attempt to assess students’ baseline knowledge as well as a proof-of-concept intervention to highlight ways to improve cultural competency training in Minnesota’s medical schools.

Medical schools across the United States are recognizing the importance of incorporating cultural education into their curricula in order to help students care for a more diverse patient population. Several landmark reports and studies have highlighted the need to improve cultural awareness and competency among physicians and other health care providers in order to reduce health disparities between minority/ethnic populations and the general population. One systematic review of 34 studies of interventions designed to improve the cultural competence of health professionals showed cultural competency training not only improves attitudes, knowledge and skills but also increases patient satisfaction. Despite the growing body of research supporting the efficacy and necessity of cultural competency training, the majority of medical schools have not incorporated such programs into their curricula. This is in part because of the lack of specific evidence-based guidelines for cultural competency training in curriculum development. In addition, a limited amount of research addresses the effect of cultural competency training on patient adherence to therapy, equity of services across racial groups or health outcomes.

Because Minnesota is home to the largest Somali population in the United States, students in the state’s medical schools are exposed to a significant number of Somali patients during their training. However, an informal analysis of the curriculum at Minnesota’s medical schools shows they mirror national norms in that their curricula do not include much cultural competency education. We conducted a study of students at one Minnesota-based medical school in order to characterize their baseline knowledge of and attitudes about Somali culture. We then performed a small-scale culturally-immersive educational intervention designed to improve their knowledge of, attitudes about and skills required to work with this population. We focused our intervention on eight key areas previously identified in cultural competency education: general cultural concepts, racism and stereotyping, the physician-patient relationship, language, specific cultural content, access issues, socioeconomic status, and gender roles and sexuality. We then re-evaluated students’ knowledge and attitudes following the intervention.

The Study
We assessed Mayo Medical School students’ baseline knowledge about and attitudes towards Somali patients in January 2013. All students were invited to attend a lunchtime educational session, during which a 25-question survey was administered before the intervention. The survey included 20 True/False questions to assess students’ knowledge and five questions to assess their attitudes. Forty-eight students...
attended the event and 47 completed the pre-intervention survey.

The intervention consisted of an hour-long presentation on Somali culture. Students heard from a Mayo Clinic medical translator who was native to Somalia and who regularly educates Western health professionals about how to best care for this unique population. The speaker discussed the history of Somalia, public health problems affecting this population, Somali’s barriers to accessing health care in the United States, gender-specific issues, and cultural differences in terms of behavior and beliefs relevant to health care professionals.

Students had the opportunity to learn and practice several basic Somali phrases and greetings, which they were encouraged to use to establish rapport when caring for Somali patients. They also were served traditional Somali food and were provided with recipes. In addition, the students received four case-based learning scenarios to review independently. These highlighted specific examples of barriers Somali patients experienced when trying to access health care.

We re-administered the survey at a follow-up meeting two months later to assess improvements in students’ knowledge of the Somali culture, their attitudes about Somali patients and their skills in working with Somali patients. Students who did not attend the meeting received the post-intervention survey both electronically and in paper form to maximize response rates.

Findings
A total of 47 students completed the pre-intervention survey (97.9% response rate); 18 took the follow-up survey two months later (38.3% response rate).

Overall, the results showed that the students had relatively poor baseline understanding of Somali culture, as they answered an average of 65% of questions correctly on the initial assessment. On follow up, the students’ knowledge of Somali culture improved, as they answered 80% of the questions correctly, on average (Figure). Those averages were obtained using the mode of the pre- and post-intervention surveys. This change was not statistically significant ($p=0.241$).

In terms of attitudes, students felt strongly that members of the Somali community faced more challenges than the general population in scheduling appointments. This was reflected in both the pre- and post-intervention survey scores (1.63 and 1.53, respectively, using a scale of 1 to 5 [1= strongly agree, 5 = strongly disagree]). When asked to respond to the statement “I feel uncomfortable treating Somali patients,” 27 students answered “No,” and 20 said “Yes” in the initial survey; five students answered “Yes,” and 13 responded “No” in the follow-up survey ($p=0.273$). Of the students who said in the pre-intervention survey that they felt uncomfortable, most cited the following reasons: “I do not understand how to meet their needs,” “I am frustrated by their practices” and “I greatly dislike having to use a translator.” Of the students who said they felt uncomfortable in the post-intervention survey, three responded “I do not know much about their culture”; one said, “I am afraid”; one said, “I do not know how to meet their needs”; and two said, “I greatly dislike having to use a translator.”

When asked to respond to the statement, “I look forward to interacting with Somali patients,” most students responded positively on both the pre- and post-intervention surveys (average response =1.87 and 2.11, respectively [1= strongly agree, 2=agree]). This difference was not statistically significant ($p=0.257$). When responding to the statement “I feel like the quality of care I provide to Somali patients might be compromised due to a lack of understanding of their culture,” 82.6% of students (38 out of 46) agreed with it in the pre-intervention survey and 88.8% of students (16 out of 18) agreed with it in the follow-up survey. These results were not statistically significant ($p=0.539$). When asked to respond to the statement “My knowledge of Somali culture is excellent,” students disagreed with this statement (4.1304; 4=disagree) in the pre-intervention survey. They felt slightly more neutral following the educational intervention (3.56; 3=neutral). This change was statistically significant ($p=0.0154$).

Overall, the results demonstrated minimal baseline knowledge on the part of students about Somali history, culture and the unique barriers faced by this population in terms of accessing care. Although statistically significant improvements in students’ perceptions of knowledge about Somali culture were observed following the intervention ($p<0.05$), the majority of students indicated that they felt like the quality of care they could provide to Somali patients might be compromised because of a lack of understanding of their culture both before and after the intervention. Of the minority of students who felt uncomfortable treating Somali patients overall, the most commonly cited reasons were: the need to use a translator, fear, and lack of knowledge about how to meet these patients’ unique needs.

Discussion
Our study was designed to understand, improve and call attention to the need to incorporate cultural competency training in Somali culture in one Minnesota medical school’s curriculum. A review of the online curricula and informal student interviews indicate similar gaps may exist in other Minnesota medical schools. Because the intervention was only performed...
in one school and the level of curricular detail available online for other schools may not have fully characterized all formal learning experiences, the external validity of our data are limited. Additional information should be collected from other medical schools in the state to verify the need for such education.

Most changes in student knowledge and attitudes following the intervention were not statistically significant and were limited by small sample size and low follow-up response rates. Although not enough to change their attitudes about the quality of care they could provide Somali patients, the students’ reported confidence in their knowledge about Somali culture did significantly improve following this intervention. In addition, students’ baseline knowledge and attitudes about Somali culture have now been characterized for the first time in the literature.

This was one of the most well-attended medical student lunch meetings of the year. More than half of the members of the first- and second-year classes were present, indicating their interest in learning more about Somali culture and how to care for this population. This show of interest in itself speaks to the desire for more formal education on Somali culture and cultural competency training in general.

Conclusion

Improved medical student understanding of cultural barriers to health care will lead to improved quality of care among Somali patients and other vulnerable populations. Our intervention serves as a proof-of-concept study, which we hope will lead to more formal integration of Somali cultural competency training into existing curricula in Minnesota’s medical schools. MM

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