Cultural competence or speaking the patient's language?

Cultural competence has become yet another buzz word in the education of healthcare professionals. According to Prasad *et al.*,[1] 'culturally competent care assumes that healthcare providers can learn a quantifiable set of attitudes and communication skills that will allow them to work effectively within the cultural context of the patients they come across'. The questions that arise, therefore, are whether clinical trainees are being fully supported to acquire this fundamental skill and whether overloaded curricula can accommodate the ongoing demand for more 'teaching time'.

A recent survey[2] found that two-thirds of US medical schools offer a medical Spanish curriculum. These data are very encouraging until the article is read in more detail. Most of these curricula are elective, not eligible for course credit, and few schools reported the use of validated instruments to measure language proficiency after completing the curriculum. Major barriers to implementing these curricula include lack of time in students' schedules, overly heterogeneous student language skill levels, and a lack of financial resources.

What about other places in the world? For example, are non-English language proficiency skills being taught to medical students in the UK, where English is not the first language of 4 million residents (8% of the population) and the first language of up to 20% of Londoners is other than English?[3] Given this information, it is easy to argue that the number of languages spoken in the UK precludes the possibility of teaching one other useful language to students. However, according to the census, four of the five major non-English languages spoken in the UK are Indian dialects. Therefore, this argument does not really hold water and it obfuscates the need for healthcare professionals to learn a quantifiable set of communication skills that will allow them to work effectively within the communities they are mandated to serve.

It is clear from the literature that while medical schools have turned their attention to the issue of cultural competence, they have largely failed to address the challenge of non-English language competence of doctors. When this matter is reviewed through the wider lens of health professions education, the literature on non-English language proficiency in other healthcare training programmes is scant, at best. Instead, the literature continues to expand with terms such as cultural awareness, cultural sensitivity, cultural diversity and, more recently, cultural humility. Surely, the most basic need of a person seeking healthcare is the need to be heard and understood?

So, how are we doing in Africa? The issue closer to home is vastly different from the language homogeneity of the developed world. Africa has the greatest language diversity in the world[4] and most Africans speak more than one language – it has been said that 'multilingualism is the African lingua franca'.[5] South Africa, a case in point, has 11 official languages, and several universities offering degree programmes in the health professions include obligatory, credit-bearing courses in a non-English language, e.g. all health sciences students learn Afrikaans and isiXhosa at the University of Cape Town,[6] medical students learn isiXhosa and Afrikaans at Stellenbosch University[7] and isiZulu at the University of KwaZulu-Natal,[8] and pharmacy students learn isiXhosa at Rhodes University.[9] These and other training programmes have given effect to the mandate to equip graduates with a quantifiable set of communication skills that will empower them to enhance the delivery of healthcare to all South Africans. The article by Diab *et al.*[10] in this edition of *AJHPE* describes a language competence course addressing the needs of isiZulu-speaking patients. Two other articles[11,12] allude to the challenges of delivering healthcare when trainees do not speak the language of the community, and highlight the strategic importance of basic non-English competence in multilingual societies.

The issue of cultural competence is a long way from being comprehensively addressed. Non-English language proficiency of healthcare trainees in multicultural communities needs to be systematically addressed. Is this a challenge which the developed world will take on in a significant and meaningful way, or will cultural competence continue to avoid the need for patients to be heard and understood in a language other than English?

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