LIFELINE: LANGUAGE ACCESS AS A HUMAN RIGHTS ISSUE

Introduction

The primary objective of the *Canada Health Act* is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[1] Although a noble objective, the Canadian health care system is still fraught with accessibility issues. One of the chief hurdles affecting health care providers and recipients relate to problems of communication precipitated by language barriers. In Canada, it is estimated that at least one in fifty people require interpretation services in order to receive a comparable level of care to the rest of the population.[2] This paper will look at the language barriers faced by varying communities in this country. The particular focus will be on the Hearing Impaired and Francophone communities. In addition, the state of First Nations and Inuit peoples as well as the Immigrant population will be canvassed.

Canada Health Act

The *Canada Health Act* contains five key principles. These include public administration, comprehensiveness, access, universality and portability.[3]

Accessibility imports a commitment that all insured persons across Canada have reasonable access to insured hospitals and medical treatment in an unimpeded and unobstructed way. In this context, access does not mean that individuals are entitled to

[1] *Canada Health Act*, R.S. 1985, c. C-6.
[2] Health Canada " Effects of language barriers on patient access and care" online: <http://www.hc-sc.gc.ca/hppb/healthcare/pubs/barriers/part6.html>.
[3] *Supra*, note 1 at s. 8-12.

receive all services regardless of location, rather, patients are to receive equal care with respect to services offered by a particular health care provider. Charges of discrimination on the basis of age or financial circumstances are often cited as barriers to access.[4]

Universality implies that all the insured residents of a province are entitled to receive health care of an equal standard. Newcomers to Canada or Canadians returning from other countries to live in Canada "may be subject to a waiting period by each province or territory not to exceed three months before they are entitled to receive insured health services."[5]

Comprehensiveness refers to the idea that the "health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners."[6] Under this section, all services that are "medically necessary for the purpose of maintaining health, preventing disease, or treating an injury, illness or disability"[7] are included. However, health interpretation services are not considered medically necessary, but rather, ancillary.[8]

The Importance of Language

Language is the vehicle by which we express ourselves and without it, we are lost. As the Supreme Court of Canada held in the case of *Ford v. Quebec*[9]:

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[4] Health Canada, "Canada Health Act Overview" online: <http://www.hc-sc.gc.ca/medicare/chaover.htm>.
[5] *Supra*, note 1 at s. 10.
[6] *Supra*, note 1 at s. 9.
[7] *Supra*, note 1 at s.2.
[8] Health Canada " The Canadian Context of Service Provision. 2003-03-09" online: <http://www.hc-sc.gc.ca/hppb/healthcare/pubs/barriers/part3.html>.
[9] [1988] 2 S.C.R. 712.

> Language is so intimately related to the form and content of expression that there cannot be true freedom of expression by means of language if one is prohibited from using the language of one's choice. Language is not merely a means or medium of expression; it colours the content and meaning of expression.[10]

Canada is considered to be a country with two cultures, the French and the English. Our society has evolved beyond this dichotomy to become one of the most diverse, multicultural societies in the world. In Canada, it is estimated that 17% of the population count their mother tongues as a language other than French or English.[11] This feature however, has brought with it unique challenges to the delivery of services, including health care.

Human Rights Code

According to the *Ontario Human Rights Code*[12] (the "**Code**") every person has a right to equal treatment with respect to employment, services, accommodation "without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, family status or disability."[13] Similarly, the *Canadian Human Rights Act*[14] (the "**Act**") sets out the following prohibited grounds of discrimination as: "race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital status, family status, disability and conviction

[10] *Ibid.*, at p. 748.
[11] Health Canada, "Effects of language barriers on patient access and care" online: <(http://www.hc-sc.gc.ca/hppb/healthcare/pubs/barriers/part6.html>.
[12] R.S.O. 1990 c. H.19.
[13] R.S.O. 1990 c. H.19, s. 5 (1).
[14] R.S. 1985, c. H-6.

for which a pardon has been granted."[15] It is interesting to note that neither the *Code* nor the *Act* specifically refers to "language" as a prohibited ground of discrimination.

Generally, cases involving language discrimination are either argued on the ground of "national or ethnic origin" or through "place of origin". Although not related to health care, the cases of *Espinoza v. Coldmatic Refrigeration of Canada Ltd.*[16] and *Segula v. Ferrante and Ball Packaging Products Inc.*[17] do deal with language as the basis for claims of discrimination on the basis of "ethnic origin" and "place of origin" under the *Code*.

Espinoza involved a complaint from a Spanish-speaking employee of Coldmatic who claimed that he and others were routinely insulted and abused by their supervisor and other employees. The majority of the employees who were Spanish speaking had poor English skills. The Board of Inquiry (the "**Board**") who heard the complaint found that Coldmatic had created a poisoned work environment for people of Hispanic origin by verbally insulting and abusing them. It was clear that the supervisor did not like people who did not speak English and made no attempt to conceal that fact. The Board further found that Coldmatic had created a subclass of workers in its factory and that they treated their employees differently as a result of "ethnicity" and "place of origin". In defining the markers of ethnicity, the Board stated that "their ethnicity could be culturally and linguistically defined as "Latin-American", with the prominent and identifying factor being the Spanish language."[18] Interestingly, the Board of Inquiry held that "while language

[15] R.S. 1985, c. H-6 s. 3(1).
[16] (1995), 29 c.H.R.R. D/35 (Ont. Bd. Inq.). [*Espinoza*]
[17] C.H.R.R. D/412 (Ont. Bd. Inq.). [*Segula*]
[18] *Supra*, note Espinoza.

itself is not a protected ground, it can be considered as one of the many identifying features of 'ethnicity'"[19].

Segula also stands for the proposition that language, although not a protected ground of discrimination, is a prime feature in defining ethnicity. In this case, there were two complaints made by the plaintiff. The first involved allegations of sexual harassment and the second involved discrimination based on "ethnicity" or "place of origin".

Ms. Segula worked at Ball Packaging Products Inc. from 1970-1988 when she was terminated. From 1982-1988, her boss was a man by the name of Ferrante. From 1984-1988, Mr. Ferrante made comments during Ms. Segula's performance evaluations to the effect that she had an "accent" and that she spoke "broken English". The Board of Inquiry found that there is not always a correlation between language proficiency and race, ancestry, place of origin or ethnicity, but that it can exist. For instance, where proficiency in a language is not truly required of the job, then this may amount to discrimination.[20]

Espinoza and *Segula* inform us that language, although not a protected or enumerated ground, can and has been used in order to make claims under the *Human Rights Code*. That being said, these cases arose in the context of work environments where mastery of the English language was not a bona fide occupational requirement. Where, as in the health care field, proficiency and mastery of one of the two official languages is necessary, it is unlikely that someone seeking admittance into the health care field will be able to rely on these cases. On the other hand, from the patient's perspective, these two cases could serve as a precedent for a claim of discrimination against health providers for

[19] *Ibid.,*
[20] *Supra,* note Segula.

failure to provide patients with interpreters. The question the courts will have to ask themselves is whether or not interpreter services in the medical profession will amount to "undue hardship" on the health care provider.

The only cases relating to language barriers in the health care field are in relation to barriers to entry into a profession rather than from the perspective of patient's receiving improper care. In the case of *Leslie Neiznanski v. University of Toronto and John Provan*[21], Dr. Neiznanski brought a complaint before a Board of Inquiry citing discrimination on the basis of ethnic origin. Dr. Neiznanski was an ophthalmologist at the University of Warsaw in Poland. He was forced to flee Poland and came to Canada as a refugee in the early 1980's. Once here, he passed the Medical Council of Canada Evaluation Exam. He then applied for and received an un-funded residency position which if he successfully completed would allow him to write the exams of the Royal College of Physician and Surgeons of Canada which would allow him to become licensed to practice here. Dr. Neiznanski completed his first year but failed his second and was not allowed to complete his third year. In his complaint, Dr. Neiznanski claimed among other things that he had been discriminated against with respect to services and employment on the basis of 'place of origin' and 'ethnic origin' because of the admission process, the process of funding persons in the residency program and his termination from the program.

The Board of Inquiry found that although Dr. Neiznanski did not have the same opportunities as Canadian students to be exposed to a wide range of ophthalmologists who could provide him with references, there was no discrimination with respect to competition for admission or for funded positions. In addition, the Board of Inquiry found that

[21] (1995), 24 C.H.R.R. D/187. [*Neiznanski*]

although Dr. Neiznanski was unsuccessful in finishing his program because he was in an unfunded position, this was a burden he chose to accept and was not discriminatory. Finally, there was no discrimination in terminating Dr. Neiznanski's participation in the program since he legitimately failed his exams.

Neiznanski does not discuss language as a discriminatory factor, but does show us how such a claim could be advanced. The most likely scenario with respect to human rights litigation will be with respect to individuals seeking entry into the medical profession. That is, foreign-trained professionals who wish to partake in the health professions, but cannot because their foreign training is not recognized in Canada.[22]

Hearing Impaired Community

Eldridge v. British Columbia (Attorney General)[23] is the seminal case with respect to discrimination on the basis of language in the health care context. Although argued under the enumerated ground of disability, language barriers were still central to the decision. The case stems from the experience of two hearing impaired plaintiffs and their experience manoeuvring in the health care system. *Eldridge* wove its way through the court system and, ultimately, came before the Supreme Court of Canada. The Supreme Court was left to grapple with the question of "whether a provincial government's failure

[22] Peter A. Cumming, *Access! Task Force on Access to Professions and Trades in Ontario* (Toronto: Queen's Printer for Ontario, 1989).
[23] [1997] 3 S.C.R. 634. [*Eldridge*]

to provide funding for sign language interpreters for deaf persons when they receive medical services violates s. 15(1) of the *Canadian Charter of Rights and Freedoms*"[24].

Eldridge, arose out of the province of British Columbia. In that province, medical care is delivered through two primary mechanisms. The first is that hospital services are funded through the *Hospital Insurance Act*[25], which refunds hospitals for those services they make available to the public. The other is through the Medical Services plan. Neither program paid for sign language.[26]

Until 1990, the Western Institute for the Deaf and Hard of Hearing (the "**Institute**"), a private, non-profit agency, provided free medical interpreting services for the deaf. This was until they halted their services due to a lack of sufficient funding. This meant that deaf patients were required to pay for sign language services out of their own pockets.[27]

The appellants in this case were both born deaf and preferred to use sign language as their primary means of communication. Robin Eldridge suffered from a variety of medical conditions including diabetes and was required to visit her physician and various specialists several times a year. Ms. Eldridge had relied on the service provided by the Institute in order to visit the various doctors she required in order to monitor her health.

The other appellants were John and Linda Warren. The Warrens were expecting twin daughters and had planned on hiring an interpreter for the birth. Unfortunately, Linda Warren went into labour prematurely. She had no one to communicate with her during

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[24] *Canadian Charter of Rights and Freedoms*, **s. 15(1)**, Part I of the *Constitution Act*, 1982 being Schedule B to the *Canada Act* 1982 (U.K.), 1982, c. 11. [*Charter*]
[25] R.S.B.C. 1996, c. 286.
[26] *Supra*, note 17 at para. 2.
[27] *Supra*, note 17 at para. 3.

childbirth and this proved to be a difficult and frightening experience for her, especially if there had been any complications during the delivery. Both the Warrens and Eldridge contended that "the absence of interpreters impaired their ability to communicate with their doctors and other health care providers, and thus increased the risk of misdiagnosis and ineffective treatment."[28]

The Supreme Court first had to decide whether the breach of s. 15(1) arose from the impugned legislation itself, or rather from the actions of the entities exercising decision-making authority pursuant to that legislation. The Supreme Court found that it was not the legislation itself that was suspect in these cases, but rather, the decisions of the hospital administration that were questionable.[29]

Any section 15(1) analysis requires the claimant to "first establish that there has been a distinction drawn between the claimant and others and that the claimant has been denied equal protection or equal benefit of the law. The second criteria that the claimant must satisfy is that the denial constitutes discrimination on the basis of one of the enumerated grounds listed in s. 15(1) or an analogous one."[30]

In *Eldridge*, the appellants brought their claim through the enumerated ground of disability. It is in this manner that discrimination on the basis of language was addressed. As the Court stated, "the disadvantage experienced by deaf persons derives largely from the barriers to communication with the hearing population."[31]

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[28] *Supra*, note 17 at para. 5.
[29] *Supra*, note 17 at para. 29.
[30] *Supra*, note 17 at para. 58.
[31] *Supra*, note 17 at para. 57.

In its analysis, the Supreme Court stressed two underlying aspects of the section. First that s. 15(1) "entails the promotion of a society in which all are secure in the knowledge that they are recognized at law as human beings equally deserving of concern, respect and consideration."[32] The second was that it evoked "a desire to rectify and prevent discrimination against particular groups suffering social, political and legal disadvantages."[33]

The Court began its s. 15(1) analysis by pointing to the fact that in this case, we were dealing with a situation of "adverse effect discrimination". Adverse effect discrimination occurs when a rule, policy or standard is adopted which on its face appears neutral and which applies equally to all people, but that results in a discriminatory effect on a group of persons because of some characteristic that the group or person may have.[34] In the case of *Eldridge,* both hearing and deaf persons were entitled to free medical services. That being said, because of a decision not to fund sign language interpreters, the result was that deaf persons were unable to benefit to the same extent from medical treatment as the hearing population.[35] In addressing the issue of health care delivery in this country, the Supreme Court stated that:

> Effective communication is quite obviously an integral part of the provision of medical services. At trial, the appellants presented evidence that miscommunication can lead to misdiagnosis or a failure to follow a recommended treatment. This risk is particularly acute in emergency situations…That adequate communication is essential to proper medical care is surely so incontrovertible that the Court could, if necessary, take judicial notice of it….For the hearing population, conversations between doctor and patient is so basic to the provision of medical services that it is taken for granted.[36]

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[32] *Supra*, note 17 at para. 54.
[33] *Ibid.*,
[34] *Ontario Human Rights Commission v. Simpson-Sears Ltd.*, [1985] 2 S.C.R. 536.
[35] *Supra*, note 17 at para. 60.
[36] *Supra*, note 17 at para. 69.

Although *Eldridge* granted deaf patients the right to sign language interpretation for their various medical visits, the Court did not go so far as to allow this to be applied to the broader context of immigrants or the Francophone community. The Court expressly stated that "from the perspective of a patient, there is no real difference between sign language and oral language if there is no ability to communicate with a physician."[37] Moreover, it went on to state that "without wishing to minimize the difficulties faced by hearing persons whose native tongues are neither English nor French, it is by no means clear that the communication barriers they face are analogous to those encountered by deaf persons."[38] Although it might appear that the Court has closed the door on claims by immigrant or minority communities in Canada from seeking to enforce a right to health care services in the language of their choice, this is not so. The message the Court is trying to convey is that a conclusion with respect to language rights does not necessarily follow from the conclusion in the *Eldridge* case.

In *Eldridge*, the Court extended the funding of interpreters for members of the hearing impaired community, but not to all those who face a language barrier. Contrary to the health system, the justice system requires access for all. In the case of *Polewsky v. Home Hardware Stores Ltd*[39]., the Court held that there is a constitutional right of access to the courts. *Polewsky* is the precursor to a case which is currently being litigated called *Duong* where Duong, a Vietnamese immigrant, is seeking to invoke s. 14 of the Charter to reverse the dismissal of his action at trial, where he was unable to afford interpreter

[37] *Supra*, note 17 at para. 89.
[38] *Supra*, note 17 at para. 90.
[39] [*Polewsky*](2003), 66 O.R. (3d) 600 (Div. Ct.)

services. It is important that unlike *Eldridge* in the case of medical services, s. 14 gives explicit recognition to a right to understand and participate in any quasi-judicial proceedings in one's own language. The only question in Duong, which is pending before the Divisional Court of Ontario, is whether a litigant who is unable to afford the interpreter is entitled to payment by the court or the government in order to secure these services. It is likely that should this question be decided affirmatively, it could have important ramifications for the health care system.

The Francophone Community

Because of its status as one of the two official languages of this country, the important issues facing the Francophone community include the preservation of rights to health care in French. A prime example of this is the case of *Lalonde et al. v. Commission de Restructuration des Services de Sante*[40].

(a) Background

In 1997, the Health Services Restructuring Commission (the "**Commission**") issued a notification to close the Montfort Hospital ("**Montfort**") located in Ottawa. The Montfort Hospital is a francophone Hospital and provides medical services and training in a distinctly francophone setting. In response to a public outcry, the Commission opted for changes in services rather than a full closure of the facility. This would have resulted in Montfort no longer functioning as a French community hospital with a variety of available

[40] (2001), O.J. No. 4767. [*Montfort*]

services in that language. *Montfort* raised important issues with respect to the language rights of the Francophone community in Ontario, especially in the context of health care.

The Montfort hospital was founded in 1953 by leaders of the Franco-Ontarian Community. The purpose of the hospital was to provide the Francophone Community with a homogeneous Francophone hospital. In 1975, Montfort adopted an official francophone policy being:

- that its Francophone character was its raison d'être;
- that it was necessary to offer all hospital services in French; and
- that it was necessary to offer a complete range of medical care, except for certain highly specialized services already available elsewhere in the region.[41]

In Ontario, at the time of this case, 44% of the population living in the five counties of Eastern Ontario counted French as their mother tongue.[42] Montfort was the only hospital to provide varying medical services and training in French in the region.[43] This included the provision of health care services at both the primary, secondary and some tertiary levels of care.[44]

The decision by the Commission to change the services offered at Montfort was challenged in the Divisional Court. The court made certain key findings with respect to the Commission's decision:

1. The Divisional Court found that the effect of the Commission's directions was to reduce the availability of health care services in French to the

[41] *Supra*, note 33 at para. 4.
[42] *Supra*, note at 33 para. 33.
[43] *Supra*, note 33 at para. 4.
[44] *Supra*, note 33 at para. 5.

francophone population in the Ottawa-Carleton region, a region designated as bilingual under the *French Language Services Act*[45].

2. The Divisional Court found that the Commission's directives affected the training program for doctors in the French language and placed insurmountable obstacles on the ability of medical personnel, particularly doctors, to become trained to adequately serve people in the French language.

3. The Divisional Court found that the Commission saw the importance of continued French language medical services only in terms of the provision of bilingual services, but did not evaluate the importance and need for a truly Francophone institution or consider the broader institutional role played by Montfort in helping to protect the Francophone population from assimilation.[46]

These findings were supported by the Court of Appeal.

(b) Section 15(1)

One of the arguments made before the Divisional Court was that the Commission's direction violated s. 15 of the *Charter*. The Divisional Court dismissed this contention, stating that the differential treatment was not based on an enumerated or analogous ground. This decision was supported by the Court of Appeal which held that "s.15 of the Charter may not be used as a back door to enhance language rights beyond what is specifically provided for elsewhere in the Charter."[47] The failure of both Courts to find differential treatment on the basis of an enumerated or analogous ground signals their reluctance to allow s. 15 of the *Charter* to be used as a vehicle to create positive obligations on the government to provide French language services beyond what was contemplated by the *Charter*. That being said, the Divisional Court did give primacy to minority rights as one of the organizing principles of the constitution:

[45] 1986, S.O. 1986, c. 45. [*FLSA*]
[46] *Supra*, note 33 at para. 52.
[47] *Supra*, note 33 at para. 96.

> Directions which replace a wide variety of truly francophone medical services and training at Montfort with services and training elsewhere in a bilingual setting -- however well those bilingual facilities may appear to work in any given case -- fail to conform to the principle underlying our Constitution which calls for the protection of francophone minority rights. This is the flaw in the Commission's deliberations and in the directions emanating from them…. Given the constitutional mandate for the protection and respect of minority rights -- an "independent principle underlying our constitution", a "powerful normative force" -- it was not open to the Commission to proceed on a "restructured health services" mandate only, and to ignore the broader institutional role played by Hôpital Montfort as a truly francophone centre, necessary to promote and enhance the Franco-Ontarian identity as a cultural/linguistic minority in Ontario, and to protect that culture from assimilation. We find this is what the Commission did. Accordingly, its directions cannot stand.[48]

It is not surprising that neither the Divisional Court nor the Court of Appeal allowed the s. 15 argument. This is in line with decisions by other Courts of Appeal which have rejected the use of s. 15 as a basis for expanding language rights.[49] In the case of *R. v. Paquette*[50], the Alberta Court of Appeal rejected the notion that the failure to provide a trial in French violated s. 15. The Court stated:

> That argument elevates official language rights into a position of equality in all cases. There would be no need for ss. 16-23 of the Charter. The argument makes the official languages sections redundant, as s. 15 would transform the use of one official language into the use of both. The discrimination is not based on language and the official languages are simply not accorded equality of status by the Charter.[51]

These cases inform us of the reality that it is difficult to assert minority language rights, especially in the context of official languages, under s. 15 of the *Charter*.

(c) Section 16(3)

The Court of Appeal was given the opportunity to assess the extent of minority language rights through s. 16(3) of the *Charter*. Section 16(3) of the *Charter* holds that

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[48] *Supra*, note 33 at para. 55.
[49] *Supra*, note 33 at para. 99.
[50] (1987), 83 A.R. 41.
[51] *Ibid.*, at p. 51.

"nothing in this Charter limits the authority of Parliament or a legislature to advance the equality of status or use of English and French."[52] In deciding the issue of the interpretation of s. 16(3) in this context, the Court came to the conclusion that this section was a rights-protecting not a rights-conferring provision. That is, the provision could not be used to constitutionally entrench Montfort as this would bind the government in all instances to continue services that it had originally voluntarily provided.[53]

(d) The French Language Services Act (FLSA)

In arriving at its ultimate decision, the Court of Appeal discussed the importance of the *FLSA* to the appeal. In so doing, the Court provided a window into the importance of language not only in the context of health care but also on a broader plane. It stated that:

> The importance of language rights is grounded in the essential role that language plays in human existence, development and dignity. It is through language that we are able to form concepts; to structure and order the world around us. Language bridges the gap between isolation and community, allowing humans to delineate the rights and duties they hold in respect of one another, and thus to live in society.[54]

The Court of Appeal denied the Commission the right to issue a directive removing French services at Montfort when these services were not readily available at other regional hospitals as they were not compliant with the provisions of the *FLSA*.

Of particular interest in the *FLSA* is s. 5(1) which gives individuals the right:

> to communicate in French with, and to receive available services in French from, any head or any central office or government agency (and) the same right in respect of any other office or agency…that is located in or serves an area as designated in the Schedule.

[52] *Supra*, note 18 at s. 16(3).
[53] *Supra*, note 33 at para. 94.
[54] *Supra*, note 33 at para. 133.

In the Montfort case, the hospital was designated under the *FLSA* and was designated as a French facility. Moreover, the Court held that when an agency is designated under the *FLSA*, then there is a continuous entitlement to the same level of services as there were when the agency in question received its status under the *FLSA*[55].

The importance of the *FLSA* cannot be discounted. The preamble of the *FLSA*, although not positive law, states that the purpose of this Act is to promote the cultural heritage of the Francophone community. This commitment also exists at the level of institutional services like those offered at the Monfort hospital. Thus, in the context of the Francophone Community, although services may not be available everywhere in French, where they are available, they are to be preserved.

The Aboriginal Community

The Aboriginal population of Canada is generally recognized to have a lower health status than the average Canadian.[56] Comparatively speaking, the average Canadian, members of the aboriginal community are expected to live six years less.[57] This is due not only to historical inequities, but also to language barriers faced by Aboriginal peoples.

Prior to 1999, Aboriginal language had special protection in certain regions of the country.[58] That status changed with the creation of Nunavut and the use of Inuktituk as the official language of the government of this territory. Although members of the First

[55] *Ibid.*, at para. 159.
[56] Health Canada, "The Canadian Context of Service Provision" online: <http://www.hc-sc.gc.ca/hppb/healthcare/pubs/barriers/part3.html ">.
[57] Collen Wilson, "Aboriginal doctor shortage hurts Canada" (2001) 37 Issue 35 Medical Post.
[58] *Ibid.*,

Nations and Inuit Community have better access to health services in their languages than the immigrant minority language population, there is still progress to be made on this front.

The greatest need for interpretation services exists in the West. Cities such as Winnipeg, Brandon, Thompson and Regina already provide language access services.[59] That being said, there are still many places where such services are not available. In the Eastern part of the country, 80-90% of Aboriginal people speak one of the official languages. In the West, this percentage is lower and there are many people in this community which may not be able to effectively communicate when trying to seek medical attention. Consequently, the First Nations and Inuit Community remain under-serviced.

The language barrier is exacerbated by Canada's failure to graduate enough Aboriginal doctors. Currently, there are roughly 150-200 Aboriginal doctors in Canada. A rough study by Malcolm King, Professor of Medicine at the University of Alberta has shown that given the Aboriginal population and the number of physicians in Canada, the number of Aboriginal doctors should be closer to 1,800.[60] Currently, the ratio of Aboriginal people to doctors is 1: 30,000.[61] The need for more Aboriginal doctors is palpable. Moreover, from a health care perspective, those with a solid grounding in Aboriginal languages have the potential to improve the health of the community at large.

While there have been no cases to date where a member of the First Nations or Inuit Community has brought forward a human rights claim, the door is not shut on this possibility.

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[59] *Supra*, note 50.
[60] Malcolm King, "Commentary on Training Aboriginal Health Professionals in Canada" online: <http://www.acadre.ualberta.ca/MKing/20commentary.pdf>.
[61] *Supra*, note 50.

The Immigrant Community

Unfortunately, the issue of language barriers in the health care context has been poorly assessed.[62] That being said, language barriers have been consistently identified as one of the barriers to health care in both Canada and abroad.[63] Particularly with respect to the immigrant population of Canada, the effect of language barriers can at times be troubling and deadly.

In Canada, it is estimated that 17% of Canadians have a mother tongue other than English or French. Upon arrival to Canada, an estimated 42% of immigrants speak neither of the official languages.[64] The estimate of those who require interpretation services for medical visits, changes greatly depending on the region of the country. In 1999, a study by the Minister of Public Works and Government Services Canada found that one in 50 Canadian residents required an interpreter for health care.[65] "Studies have found language barriers to be associated with lower frequency of general check ups, fewer physician visits, and lower likelihood of having a regular source of care."[66]

In a report produced by Statistics Canada in 2001, called Health Status and Accessibility to Health Care Services for New Immigrants, the government found that language barriers were cited by 15% (or 4,400) of the 122,500 immigrants who tried to

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[62] Health Canada, "Part II Language Barriers to Health Care" online: <http://www.hc-sc.gc.ca/hppb/healthcare/pubs/circumstances/partII/doc2_effects.html>.
[63] *Ibid.,*
[64] Health Canada, "Effects of language barriers on patient access and care" online: <(http://www.hc-sc.gc.ca/hppb/healthcare/pubs/barriers/part6.html>.
[65] L. Marmen & J.P. Corbel, "Languages in Canada: 1996 Census", (Toronto: Minister of Public Works and Government Services in Canada, 1999)
[66] Health Canada, "Language barriers in access to health care" online: <(http://www.hc-sc.gc.ca/hppb/healthcare/pubs/circumstances/partII/doc2_effects.html>.

access health care services. This was the third rated barrier after costs/financial difficulties and waiting lists/line-ups.[67]

Communication barriers can affect a patient's access to preventive programs.[68] In this area, most of the research has focused on screening programs such as mammograms or cervical cancer screening. Although most of the studies in this area are from the United States, they can serve as a reference for the Canadian context. A study by Fox and Stein in 1991, entitled "the effect of physician-patient communication on mammography utilization by different ethnic groups"[69], found that the most important factor in prompting a woman to have a mammogram was whether her doctor had discussed this with her. Hispanic women, which is the immigrant population focused on, were less likely to have physicians who discussed screening with them.[70] In the case of Canadian women, the failure in communication could well mean that immigrant women are not getting proper preventative treatment.

The Government, in other reports, has found that patients who do not speak English or French receive treatment that is inferior to that received by English or French speaking Canadians.[71] The practical reality of this is that individuals who seek the care of physicians in Canada are at a greater risk for misdiagnosis, injury or death. A study by Leson & Gershwin, of young adults aged 20-34 who suffered from Asthma showed the differential treatment that results from ineffective communication. The focus of the study

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[67] Statistics Canada, "Longitudinal Survey of Immigrants to Canada: Process, progress and prospects" online: <www.statcan.ca/englishfreepub/89-611-XIE/article.htm>.
[68] S. Bowen, *Access to Health Services for Underserved Populations in Canada*, (Ottawa: Health Canada, 2000).
[69] S.A. Fox & J.A. Stein, "The effect of Physician-Patient Communication on mammography utilization by different ethnic groups" (1991) 29 Med. Care, 1065-1082.
[70] *Ibid.,*
[71] *Supra*, note 56.

was to determine the risks associated with intubation. Holding all variables equal, the study found that those patients who spoke another language and were not able to communicate with the health care provider, were more than 17 times more likely to be intubated than patients who spoke English. As a result of the findings of these and other studies, it is clear that patients facing language barriers are more likely to receive improper care.[72]

Another area where interpreter use is necessary is in mental health, rehabilitation and counselling. Not only are there barriers to initial contact with a physician, but there are concerns related to cultural differences in service provision and stigmas associated with mental health issues. Even where a patient seeks treatment for mental health problems, they are often unable to because of language constraints.[73]

One way to get around language barriers is to use competent, trained interpreters when required. In Canada, it was found that interpreters were used in 26% of the cases surveyed. However, in another 22% of cases, they were not used, even though the patient felt they required those services.[74]

All these studies go to show that immigrants do not receive a comparable level of treatment to the rest of the population. This has consequences for their health and well being and is an issue which needs to be addressed.

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[72] S. Leson & M. Gershwin, "Risk Factors for asthmatic patients requiring intubation" (1995) 33 J. Asthma 27-35.
[73] Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, *After the Door has Been Opened: Mental Health Issues Affecting Immigrants and Refugees* (Ottawa: Minister of Supply and Services, 1988).
[74] S.B. Stevens, *Community Based Programs for a Multicultural Society: A Guidebook for Service Providers* (Winnipeg: Panned Parenthood Manitoba, 1993).

Health Care Practitioners

Language barriers can lead to violations of ethical standards of care by doctors who are unable to effectively communicate with their patients. There are three identified ways in which care can be compromised:

a) failure to provide the same standard of care to all patients;

b) failure to protect patient's confidentiality; and

c) failure to ensure that the patients properly consent to treatment.[75]

(a) Standard of Care to Patients

As we have seen in the above case analogies, the standard of care patients receive can be gravely affected by differences in languages. Those that do not speak either of Canada's official language are at risk of receiving inferior treatment.[76] The practical reality of this is that individuals who seek the care of physicians in Canada are at a greater risk for misdiagnosis, injury or death. In essence, these individuals are being unnecessarily discriminated against.

(b) Confidentiality

Where family members or ad hoc interpreters are used, confidentiality can be violated. Patients who face language barriers can have sensitive medical information relayed to individuals who were not the intended recipients.[77]

(c) Consent to Treatment

Another area of concern in the context of language has to do with obtaining informed consents from patients. When a patient who does not speak one of the official

[75] *Supra*, note 56.
[76] *Ibid.*,
[77] *Ibid.*,

languages gives their consent to a procedure, there is often doubt as to whether or not the consent is valid. Often, the patient may not understand what he or she is consenting to. This problem is further compounded when untrained interpreters or family members are used to gain the consent.[78] These individuals may not relay key concepts or can alter the message that the health care practitioner is trying to relay.

Conclusion

Language barriers will continue to predominate as issues in the provision of consistent health care in Canada. Although the Courts have taken steps to remedy the injustices with respect to the hearing impaired community and have guaranteed the right of Franco-Ontarians to a French hospital, the First Nation, Inuit and Immigrant communities continue to face hurdles to proper health care services.

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[78] *Ibid.,*