CULTURAL DIMENSIONS OF LINGUISTIC BARRIERS IN HEALTH CARE

When it hurts in your language and culture! Being a Francophone outside Quebec

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Let's think about words that are used in English to describe pain such as "Flickering,jumping, pricking , sharp, quivering , cutting , pulsing, shooting, drilling , lacerating, throbbing, sore, hurting, aching, splitting, etc..." In French we use words such as "Vive, aigue, lancinante, abominable, tranchante, fulgurante, transperçante, sourde, avec pincement, récurrente, de pierre, courbature, mal". The expressions of pain, and attitudes and behaviours related to pain are very much entrenched in each language's images and cultural context.

The purpose of this summary is to briefly 1) review and discuss a conceptual framework of culture that illustrates how individual language and culture are shaped by the environment; 2) apply this model to Francophones in minority situations in Canada; 3) identify levels of cultural and linguistic barriers to health services; and 4) explain the role of "La Société santé en français" (SSF) and its 17 networks in breaking down these barriers through community-driven innovation and advocacy.

Conceptual framework of culture

According to Erez and Gati (2004), culture can be described within a multi-level model characterised by structural and dynamic dimensions. According to the authors, culture representations and meaning are shaped within each of the structure`s levels (individual, groups, institutions, countries and beyond). The relationships between these constitute dynamic elements that influence socialisation processes and values through both top-down and bottom-up processes. In particular, culture, ethnicity and language influence how people understanding health and illness, perceive and evaluate their own health, make lifestyle choices, participate in prevention and health promotion programs, access health information and services and interact with the health care system. Dominant health care values may contribute to marginalization and devaluation of one's own language or culture for members of the official language minority.

The Francophone minority situation in Canada

One language, many regional accents, and diverse cultures characterise the Francophone population living outside Quebec. This population is aging faster than the general population of Canadians, is dispersed across the country and often live in isolated areas.
The minority situation creates challenges such as the pressure felt by youth who may be ashamed to be part of a minority and want to conform to the majority. New francophones immigrants have to face additional hurdles in trying to fit into a minority context and a different culture. When faced with 12 different healthcare systems each with its own cultures, Francophone women (Erez, M. & Gati, E., 2004), represent a familiar and safe source of caregiving in French for

children and seniors; the long- term prospects are however unacceptable and unsustainable.
Language barriers have been shown to discourage people from using preventative health services and accessing primary care. According to Bowen (2001), they are linked to increasing consultation times, the likelihood that diagnostic tests will be requested, and the probability of diagnostic and treatment error; they have an even greater influence on service quality when effective communication is crucial (mental health services, pain for example); they are also associated with lower levels of compliance and satisfaction with health services. Access to health services in language of choice is a question of quality and safety (Schyve P., 2007).

Cultural dimensions of linguistic barriers to access health services or the minority effect

Barriers to access health services in French in a minority context can be identified at the individual, community and society levels and are quite entrenched.

Minority effect at the individual level
Many individual factors related to demographics, language of preference and culture of origin are known to influence health seeking behaviours and satisfaction with care. Education and socio-economic factors are key determinants as well. The minority complex is often perceived as an additional burden that influence Francophones to keep quiet and not dare to ask for services in French. Within this minority situation, the most vulnerable become extremely disenfranchised. Often, Francophones do not have the patience to wait for services in French nor go through an interpreter, and they feel forced to accept the care in the majority language. Unfortunately even a polished speaker of English as his/her second language may lose some comprehension under stress or not find the proper words to describe his or her own health issue.

The minority effect at the community/institution level
Historical factors, especially in western Canada, explain the rampant assimilation that French-speaking individuals and communities had to face. This situation resulted in the lack or even absence of institutions and infrastructures that serve francophones, which in turn reduced the demand for services. Today, this minority is not visible despite speaking one of the official languages. As a consequence, the majority often displays a negative or dismissive attitude when the minority requests to be served in French. With regards to health services, francophone health care professionals are not strategically placed; linguistic competent service is ad-hoc and not offered openly and actively. Overall these systemic barriers perpetuate inequities in terms of access and health outcomes (Leis, A, & Bouchard L., 2013).
The minority /majority effect at the societal level
Nationally, efforts are made by federal agencies and governments to work collaboratively with their provincial counterparts. However many gaps exist and no systematic measures track equity indicators comparing services for official languages communities in majority and minority situations. Some data bases at the Canadian Institute for Health Information include a linguistic variable. However according to a senior official, data collected in 7 data bases in 2008 for example show no uniform definitions of the linguistic variable. See below how they are defined:

« La langue que le pensionnaire parle ou comprend le mieux »
« La langue que le client parle et comprend en tout premier lieu »
«Langue que le patient préfère généralement utiliser dans le cadre de ses communications courantes »
« Language Spoken - Patient »
« The primary language spoken and/or understood on a regular basis »
« Capacité d'offrir le service dans les langues officielles du Canada »

« Capacité d'offrir le service dans une autre langue »

Awareness at the policy level needs to evolve from lip service to action-oriented and tailored solutions (Bouchard L, Gaboury I, Chomienne ME, Gilbert A, & Dubois L, 2009).

La société Santé en français et ses réseaux

Key partner networking has become the cornerstone for change where the community to be served becomes an influential and integral partner of the health system as illustrated in the WHO model *toward unity for health* (Boelen C., 2000). Since 2001, the Société Santé en français, the national network of 17 provincial, territorial and regional networks for improving access to health services in French is actively promoting the importance of language for quality care and fostering strong partnerships among key stakeholders including the francophone minority community. Solutions can be found at each level of the cultural/ecological model. For example, active offer of health services is paramount in order to signal the existence of the service; without a visible service in French, francophone people think it does not exist and therefore they do no longer ask. It will require creativity in reorganizing services where Francophones consult or live. For example, in PEI, the health ministry, alongside the *réseau* re-organized a wing of a long-term care facility in order to serve Francophone seniors with human resources that can communicate with them in French. This outstanding service provision required some imagination and very little financial investment. The myth *Services in French cost automatically more money* needs to be dispelled! Targeted training to improve communication between health care professionals and francophone patients should occur in real life settings. Sometimes it only requires to build or strengthen health professionals' confidence in their own language skills. Finally, legislative and accreditation measures to enhance the official language minority health services would enshrine the obligation to provide health services in both official languages regardless of geography.

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