IF YOU CANNOT COMMUNICATE WITH YOUR PATIENT,

YOUR PATIENT IS NOT SAFE

Being able to speak in one's mother tongue when it concerns health is not asking a favour of health care professionals or organizations.

On the contrary, it is a basic issue of accessibility, safety, quality and equality of services.

Final Report – October 2015

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Uqauhinut Kamisinaup Havakvia Nunavunmi
Office of the Languages Commissioner of Nunavut
Bureau du Commissaire aux langues du Nunavut

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Ce document est aussi publié en français.

References (front cover)

"If you cannot communicate with your patient, your patient is not safe."[1]

Being able to speak in one's mother tongue when it concerns health is not asking a favour of health care professionals or organizations. On the contrary, it is a basic issue of accessibility, safety, quality and equality of services.[2-3]

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[1] Sarah BOWEN and Jeannine ROY, *Intégration des services d'interprétation dans la gestion des risques,* Winnipeg, 2009, p. 6.
[2] Mary Catherine BEACH, Somnath SAHA and Lisa A. COOPER, *The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality*, The Commonwealth Fund, October 2006.
[3] Joseph R. BETANCOURT, *Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care*, The Commonwealth Fund, October 2006.

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SYSTEMIC INVESTIGATION REPORT

INVESTIGATION INTO THE QIKIQTANI GENERAL HOSPITAL'S COMPLIANCE WITH THE *OFFICIAL LANGUAGES ACT*, R.S.N.W.T. 1988

FINAL REPORT

October 2015

Acknowledgments

Many individual people and organizations throughout Nunavut must be thanked for their participation in this investigation and their contributions to this report. Their time and their honesty in responding to questions about health care services at the Qikiqtani General Hospital are much appreciated.

We especially would like to acknowledge all those people at the Qikiqtani General Hospital, in Iqaluit, who took the time to attend interviews and those who shared their experience with us.

We also thank people who attended the public consultation, everyone who helped to arrange interviews and the people who responded to the call for reports and documents early in the project.

Sandra Inutiq
Languages Commissioner

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1. INTRODUCTION

The Office of the Languages Commissioner of Nunavut (hereinafter "OLC") has received for many years concerns from citizens regarding their inability to communicate with and receive services in the official language of their choice from the Qikiqtani General Hospital (hereinafter "QGH"). As the non-compliance of language rights is recurrent and seems to be an endemic issue, the procedure under these circumstances is to conduct a systemic investigation to understand the situation and establish the facts.

The first part of this report describes the systemic investigation that took place following the concerns received from citizens and from interviews. It assesses the availability of services and communications in Inuktitut and French between March 1, 2012 and March 31, 2013, and the compliance of the *Official Languages Act,* R.S.N.W.T. 1988,[4] (hereinafter "OLA") at the Qikiqtani General Hospital.

The second part of the report sheds light on the existence of language barriers and the impacts of these barriers. We realized that the situation in the hospital went beyond that of the linguistic rights of patients and obligations of the hospital to communicate with and provide services in the patients' official language of choice, as stipulated in the *Official Languages Act.* From the data collected during the interviews, the reading of the documents provided by the Department of Health and Social Services[5] (hereinafter "HSS") and the reviewing of research and studies on language barriers in health care, it is clear that there has been an impact of language barriers on the health of citizens of Nunavut: on patient safety, quality of care and accessibility to health care services.

1.1. Objectives

- To determine whether the QGH complied with its linguistic obligations as stated in OLA, between March 1, 2012 and March 31, 2013.

- To describe the repercussions of language barriers on the quality of care and access to health care services.

- To make recommendations to fix the language issues.

1.2. Approach

- To inform the population and those stakeholders involved and targeted by this investigation, including the Department of HSS and the managers of QGH, that a systemic investigation will be conducted;

[4] The OLA is the existing, and still in force in 2012, *Official Languages Act*, R.S.N.W.T. 1988.
[5] The Department of Health and Social Services was renamed Department of Health in 2013.

- To hold a public consultation;

- To prepare the systemic investigation, identify respondents, design questionnaires for interviews, and initiate the process with targeted respondents and stakeholders;

- To conduct individual interviews with the people affected by or involved in language issues: public, local organizations, members of the hospital staff;

- To collect data from:

    - interviews conducted by the OLC;
    - documentation received from HSS;

- To review the research and studies on the Nunavut's health care situation;

- To review the research and studies on the impact of language barriers on the quality of health care and access to services;

- To analyze data and information collected in order to establish an overview of the situation with regard to communications and the delivery of services at QGH;

- To write a preliminary report that will be sent to the Department of Health for comments and responses;

- To release a final report including these comments and responses from the Department of Health.

1.3. Chronology of Events

1.3.1. Public

- Ads were placed via local newspapers and radio stations to invite the public to share their experience at QGH with the Office of the Languages Commissioner;

- A public consultation was held on May 16, 2012, in Iqaluit. The event was publicized via radio stations and notices were placed throughout the community of Iqaluit. A total of seven participants attended the event, including three participants from the media and two from the general public;

- We were interviewed by Nunatsiaq News, CBC North, News North and CFRT on details of the investigation.

1.3.2 Department of Health and Social Services

- A meeting was held with the deputy minister of Health and Social Services to discuss the systemic investigation;
- Several requests for legal advice were made to our legal counsel and numerous steps to obtain documentation required for the investigation had to be taken.

Below are the steps taken by the OLC:

February 6, 2012: A letter was sent to the deputy minister of Health and Social Services, informing them that a systemic investigation would be conducted. Obtaining no response, we then contacted the Access to Information and Protection of Privacy (hereinafter "ATIPP") Office and again contacted HSS. Below are the details of these unsuccessful attempts:

July 4, 2012: Our legal counsel sent a request to the ATIPP Office. The following documents were requested in order to proceed with the systemic investigation:

1. Copy of the operation and procedures manual for the reception staff;
2. Copy of the language plan for the Qikiqtani General Hospital;
3. Minutes of the Safety Committee meetings from the beginning of its operation to present (March 2013);
4. Information about how funds received for language services (French and Inuktitut) are allocated to the Qikiqtani General Hospital, as well as a detailed report on how it was utilized;
5. Records indicating the number of employees that work for the Qikiqtani General Hospital and, among them, what number can speak French and what number can speak Inuktitut.

August 2012: The Languages Commissioner sent another letter to the deputy minister of Health and Social Services, identifying the OLC's legal authority to access the required information and asking for the following documents before September 15:

1. Procedure manual at the reception of QGH;
2. Language plan for QGH;
3. Minutes of the Patient Safety Committee since the beginning of its operation;
4. Quality assurance and safety policies and procedures;
5. Medical interpreters schedule;
6. Accreditation Report 2011-2012;
7. Translator/Clerk Interpreter job description;
8. List of available language training for QGH staff and participants in 2011-2012;
9. The 2011-2012 QGH Annual Report;
10. List of positions that receive the language bonus and the second language spoken for each position.

November 1, 2012: The OLC's legal counsel confirms that they were unable to obtain any documentation from HSS regarding the requests.

November 5, 2012: An e-mail was sent to the ATIPP Office, indicating that the deputy minister had not forwarded the documents required. That same day, our office received a reply stating that the deputy minister would send all required documents by the end of the day.

November 7, 2012: Another e-mail was sent to the ATIPP Office to inform them that we had not received the documents from the deputy minister and that we would like to appeal to the Information and Privacy Commissioner. That same day, we received a phone call from the deputy minister requesting a meeting. This meeting was scheduled for November 23, 2012.

November 9, 2012: A letter was received from HSS stating that we would not have to contact the ATIPP Office and that they would produce the documents requested directly to us.

November 23, 2012: The Languages Commissioner met with the deputy minister who agreed to forward some documents, without specifying which documents.

January 9, 2013: A letter was sent to the deputy minister, stating that no documents had been received. Also, an e-mail requesting another meeting was sent in order to explain the steps of the systemic investigation and the relevance of the documents. The deputy minister did not reply to this e-mail.

February 5, 2013: The new Languages Commissioner who took Office mid-January 2013, met with the deputy minister to introduce herself and discuss our office's activities, including this investigation.

March 5, 2013: Six of ten requested documents were received from the deputy minister's office.

Several letters and notices sent to the deputy minister of HSS as a reminder of the OLC's requests were ignored. Many documents of primary importance to conducting the investigation were not released by the deputy minister's office. It took thirteen months after the first letter issued by our office to obtain certain files required for the investigation.

2. PART 1

2.1. ALLEGATIONS

Between 2000 and 2011, we recorded six concerns relating to language services offered by the Department of Health and Social Services. Of the six concerns, three were from the Inuit community and three from the French community. The concerns are:

2001: the health care information was in English only (Inuit community).

2003: the verification notices sent out for the Nunavut Health Care Card Renewal included forms in English, Inuktitut, Inuinnaqtun and French, but the forms must be filled out in English only (Inuit community).

2010: the health care information was in English only (French community).

2011: an individual was denied being the escort of a family member because of being unilingual although the policy did not state that language is a requirement for an escort (Inuit community).

2011: an individual was turned down trying to submit his resume for a maintenance position at the Qikiqtani General Hospital because of his poor command of English (French community).

2011: the Nunavut Health Care Plan brochure distributed when people need to renew their health care card was not available in French (French community).

During the investigation, we interviewed 51 people. Below, we summarized the allegations from six cases related to language rights.

Please note that in an investigation report, it is important to retain the wording of the allegations as close as possible to how it was communicated to us and as faithfully as possible. In addition, to protect the identity of patients and facilitate reading, we used the masculine where it was possible to do so.

Case 1

This case involves a couple whose wife was pregnant. They are bilingual, comfortable with the consultations that took place in English most of the time. However, in spite of their good understanding of the English language, they sometimes did not understand the full meaning of medical terms, especially when it came to acronyms and medical jargon. The wife asked her husband to take part in the consultations in order to properly understand all the information, but they had to resort to the internet to understand the meaning of some terms.

During birth, the mother was told in English that she would have to have a C-section delivery. She did not understand the English term “C-section” (short for caesarean) and what was going to transpire. Thirty minutes later, she was in the operating room for the procedure. As her husband was not allowed to be present, he was unable to help her understand what was happening. The patient said she was in shock, confused and very vulnerable. The whole procedure took place in English and interpreting services were never offered her.

Case 2

An elderly person came to the hospital because he had difficulty breathing, which sometimes happened. The patient met with a doctor and, because the conversation was held in English, he didn’t understand some of the questions. He asked the doctor to repeat and the doctor subsequently became irritated and berated the patient. When the patient asked him why he was upset, the patient said the doctor answered: “I can’t understand you, I will send you someone else,” and he left, leaving the patient alone with his breathing problems. The patient added that, normally, when he went to the hospital because he had trouble breathing, he was immediately given an oxygen mask.

Case 3

The doctor asked for an ultrasound for a woman who was three months pregnant and saw a possible abnormality with the foetus. He wanted to send the patient to Ottawa for further tests. The patient had to have tests done before the 15th week of pregnancy in the event it would be necessary to interrupt the pregnancy. The couple requested that their file be sent to a hospital in Québec so that they could receive services in French. The process was begun and the dossier was transferred. Subsequent examination revealed an abnormality and the pregnancy was terminated.

The following year, when this woman learned she was pregnant, she consulted the doctor and was once again directed to Ottawa for further tests. The attending physician requested that the file from Québec be sent to Iqaluit as it contained relevant information for the terminated pregnancy. This physician had to return South and he left instructions for the doctor who was replacing him for this patient.

When only three weeks remained before the end of the 15-week period required to do testing, and not having received any information, the couple contacted the physician responsible for follow-up to learn that he had not received any communications from the office that handles medical transfers.

It was while investigating to find out what had happened that the doctor learned that the file had in fact been transferred to Iqaluit, but that the person who received it had put it aside because it contained documents written in French and the employee did not understand what they contained. The employee did not attempt to have the file translated, nor forward the file to a

French-speaking person. When the documents were located, unfortunately, it was too late for further tests. While the pregnancy should have been welcomed with joy and excitement, this couple lived through it in fear and confusion.

Case 4

A patient went to the emergency unit because he had a swollen throat. He waited five hours before seeing a doctor and he was the only person in the emergency room.

On another occasion, he arrived at the emergency unit at 8 in the morning and was the only person in the waiting room. He was finally able to see a doctor at 1 pm, as the file had been misplaced. It was a nurse who, after seeing him sitting alone for several hours, finally helped him get processed. The patient believes that the delay was due to the fact that he was Francophone.

He had an operation and no follow-up was ever made.

He stated that, even if French service is available, one must wait two weeks to receive services from a physician or specialist who speaks and understands French. He had asked for an interpreter on a previous occasion and it had taken several hours for the interpreter to arrive.

He believes that if the patient speaks French, getting an appointment take longer and so does the wait time. He said that he knows that several Francophones do not telephone the hospital because of language barriers. Moreover, the QGH's voicemail message is not available in French and he says that, anyway, English is favoured at QGH. He also stresses the fact that information is rarely available in French.

Case 5

A person learned that he had lung cancer. He underwent several tests and waited to learn about the treatment available to him. Because he didn't speak any English at all, he was accompanied by his daughter who acted as interpreter. During his transfer to Ottawa, the man's family contacted the Department of Health because they wanted the man's wife to accompany him to Ottawa so that his daughter could remain home. The nurse insisted that it was absolutely necessary for the escort to be able to speak English.

The patient had to end his treatments in Ottawa because his wife was not able to speak English. A concern was filed with the Office of the Languages Commissioner; we have contacted the deputy minister in order to find a solution immediately in favour of the applicant.

Case 6

A person arrived at admissions early one morning. He spoke French and the attendant answered him in English. Seeing that the patient continued speaking in French, the employee tried to contact a Francophone or someone who could speak French to have him/her come and act as interpreter. As there was no answer, and not knowing what to do, the attendant became agitated, and in her frustration she told the patient: "Well, you have to be reasonable and speak English."

In English, the patient told the employee about *e-health*, an initiative from the Department of Health that advocates that a patient's preferred language of communication be indicated in the patient file. The patient stated that the attendant had no idea what he was talking about and did not care. Once he got to the required service, he was greeted with a big sigh when he talked about requesting the service in French.

The patient said he went to the hospital a few times and each time, as there is no French-speaking interpreter, the staff in admissions do not know what to do when bilingual staff are not available.

2.2. ISSUE

The objective of the systemic investigation is to determine whether the Qikiqtani General Hospital respects its obligations under section 11 of the *Official Languages Act,* R.S.N.W.T 1988 with regard to communications with the general public (oral and written) and the provision of services. In addition, the investigation will determine whether the language rights of citizens, as provided for under sections 14 (1) and (2) of this Act, are also respected.

2.3. LEGAL CONTEXT

2.3.1. Language Laws

The systemic investigation was conducted while the *Official Languages Act,* R.S.N.W.T. 1988, was in force. Even the *Official Languages Act* of Nunavut came into effect in April 1, 2013, it does not affect the authority to investigate and make findings.

2.3.2. Right to Make an Informed Decision

In addition to general rights legislation, there are specific legal and ethical provisions guaranteeing patient rights in medical decision making, including the right to be informed of treatment options and make an informed voluntary decision about treatment.[6]

[6] Etchells, et al., 1996, quoted in Sarah BOWEN. *Language Barriers in Access to Health Care*, Ottawa, Health Canada, 2001, p.19.

Common law in Canada has recognized that where a patient does not speak or master an official language, it is incumbent on the physician to ensure that the patient understands the information that is communicated before administering treatment (Decision in *Champion*, 2000)[7].

2.3.3. Precedent for Liability

Applicants at the root of this systemic investigation submitted their concerns to the Office of the Languages Commissioner; they could also decide to go to court to enforce their language rights. Here is an example of a judgment where there was an appeal: case Suzanne Houde vs Stanton Regional[8] Hospital, Northwest Territories. The plaintiff alleged that she was not able to communicate with or receive health care services in French from hospital staff. She decided to go to court to assert her rights. A financial compensation was awarded to the plaintiff. You can read the full text: Northwest Territories (Attorney General) v. Fédération Franco-Ténoise, 2008 NWTCA 6 (CanLII).

2.3.4. Mandate of the Languages Commissioner

As stipulated in section 20 (1) of the *Official Languages Act*, R.S.N.W.T. 1988:

> "It is the duty of the Languages Commissioner to take all actions and measures within the authority of the Languages Commissioner with a view to ensuring recognition of the rights, status and privileges of each of the Official Languages and compliance with the spirit and intent of this Act in the administration of the affairs of government institutions, and notably the promotion of Aboriginal languages in the territories."

Under section 21 (1):

> "The Languages Commissioner shall investigate any reasonable complaint made to the Languages Commissioner arising from any act or omission to the effect that, in any particular instance or case, in the administration of the affairs of any government institution:
>
> (a) the status of an Official Language was not or is not being recognized;
> (b) any provision of any Act or regulation relating to the status or use of the Official Languages was not or is not being complied with; or
> (c) the spirit and intent of this Act was not or is not being complied with.

[7] *Ibid.*
[8] Now called Stanton Territorial Hospital.

2.3.5. Jurisdiction of the Systemic Investigation

2.3.5.1. Qikiqtani General Hospital: a Territorial Institution

In 1999, the Government of Nunavut's Department of Health and Social Services took over the duties of the Boards of Management that had been under the Government of Northwest Territories and thus took full control of the "management, control and operation" of the hospital. The QGH is therefore managed by the Department of Health and Social Services which is a "territorial institution" for the purposes of ILPA[9] and the new OLA,[10] and a "government institution" for the purposes of current OLA. Any documents pertaining to the operation of the QGH would thus be in the possession or control of a "territorial institution", namely, the Government of Nunavut (via the Department of Health and Social Services), and subject to investigation by the Languages Commissioner.

2.3.5.2. Languages Commissioner's Power to Investigate

Under section 20 (2) of the *Official Languages Act*, R.S.N.W.T. 1988, it states:

> "… the Languages Commissioner may conduct and carry out investigations either on his or her own initiative or pursuant to any complaint made to the Languages Commissioner, and may report and make recommendations as provided in this Act."

2.3.5.3. Systemic Investigation

It would have been a massive undertaking to conduct an investigation on HSS including all bodies providing health services delivered within the territory (general practitioners, dentists, opticians, pharmacists, etc.). For this reason, we decided to focus the investigation on the Inuit and French languages within the primary care at the Qikiqtani General Hospital in Iqaluit. The main reason of our decision: primary care is the starting point for most of us with the health service.

An investigation may take the form of a systemic investigation when non-compliance of language rights is seen as an endemic problem. The decision to conduct a systemic investigation is based on a list of criteria that follows ombudsman practices in Canada.

[9] ILPA for *Inuit Language Protection Act.*

[10] The new OLA is the *Official Languages Act* of Nunavut not yet in force in 2012. The current OLA is the existing and still in force *Official Languages Act*, R.S.N.W.T. 1988.

In the case of QGH, this type of investigation was chosen for the following reasons:

a) The number of concerns received is important. As seen previously, six concerns were registered between 2000 and 2011 regarding language services provided by the Department of Health and Social Services, three from the Inuit community and three from the Francophone community.

Factors for consideration regarding the number of concerns received:

- Communication barriers can stop or discourage patients from filing a concern;
- Patients may also not know their rights or the procedure for filing a concern;
- Some patients may be afraid of filing a concern, fearing there may be repercussions on the care they may require in future;
- Cultural factors must also be considered. Many Inuit are unfamiliar or uncomfortable with the formal "complaint" process because it has negative connotations and is something many adults were discouraged from doing as children;
- One data is important: according to statistics from the Office of the Commissioner of Official Languages, for one registered concern, there are approximately 21 people affected who do not register their concern.

One would think that a greater number of concerns would have been filed with us, or that lawsuits against the hospital would have been filed.

b) A large number of people are potentially at risk. QGH is a regional hospital located in Iqaluit that also serves the communities of the Qikiqtaaluk region (also called Qikiqtani or Baffin), comprising an estimated population basin of 18 397 people in 2012 (18 852 in 2013).

The table below was provided by the hospital and illustrates the number of patients seen at the hospital yearly:

	2009	**2010**	**2011**
Minor surgery	678	727	787
Emergency	16 004	16 589	17 651
Clinic	17 740	17 523	16 201
Psychiatry	150	121	180
Medicine	644	601	540
Obstetrics	496	459	449
Paediatrics	288	238	244
Surgery	165	161	130
Births	398	387	383
Total	**36 563**	**36 806**	**36 565**

c) The situation concerns major strategic issues. There are two important issues: sustainability and compliance with linguistic laws.

Sustainability

Language is a cultural heritage and the ongoing expression of a population's identity. It is the foundation necessary to a sustainable future for the Inuit of Nunavut as a people of distinct cultural and linguistic identity, and for Francophones as a French-language community in a minority setting.

For the Inuit community, use of the Inuit language is an indispensable element to improving the social, economic and cultural welfare of the Inuit, as provided for in the Nunavut Land Claims Agreement. Positive steps are required to protect and promote Inuit culture, of which language is an essential element.

The Francophone community is very present and dynamic in Iqaluit and, like any French-language community in a minority setting, the sustainability of the language goes hand in hand with its vitality. The linguistic and cultural minority situation greatly undermines this community and its preservation requires the protection and promotion of the French language.

Compliance with linguistic laws

The Government of Nunavut has to commit to meeting its obligations as a public government, notably by protecting and promoting language rights and the right to equality and non-discrimination.

The absence of legal provisions, limited accessibility and quality of language provided by the territorial institutions, when they must communicate with and offer services to the public, is contravening the requirements of OLA.

d) It is a recurring problem. There has been language issues at the Qikiqtani General Hospital for several years and the time spent shows no improvement of language services. In fact, three studies were conducted for the years 2004, 2006 and 2009. The first study was prepared by Julie Beaulieu, the second by Réseau de santé en français for the Association des francophones du Nunavut, and the third study was published by Nunavut Tunngavik Incorporated (NTI).

The 2004 study[11] on the health needs of Nunavut's Francophone population was conducted among 90 Francophones (86 in Iqaluit and 4 from other communities) using telephone surveys; below are their main findings:

- Lack of health care professionals who can provide services in French: 35% of respondents stated they had difficulty obtaining health care in French and 70% believe that there are no health care professionals who can provide services in French;

- In 2004, 89% of the services offered by professionals (clinic or hospital) were offered in English. The majority of respondents first consult their family doctor (88% of services provided in English), followed by pharmacists (100% in English) and then nurses (90% in English);

- Very few respondents (13%) participated in health promotion or prevention activities because these activities are only available in English. The same applies to prenatal and postnatal programs.

The 2006 study[12] was conducted through interviews among the Francophone population (33 Francophones from Iqaluit and two neighbouring communities), 7 health care professionals and providers offering services in French and among 8 HSS managers, primarily Anglophones.

Their study confirmed the results of the 2004 study with regard to the French community's needs and expectations and helped to identify primary health care service priorities.

[11] Quoted in RÉSEAU DE SANTÉ EN FRANÇAIS (Résefan). *Des services de santé en français dans un Nord en mutation,* Iqaluit, Association des francophones du Nunavut, 2006.
[12] RÉSEAU DE SANTÉ EN FRANÇAIS (Résefan). *Des services de santé en français dans un Nord en mutation,* Iqaluit, Association des francophones du Nunavut, 2006.

Here are some of their findings:

- 60% of the respondents (population) are unsatisfied with health care services: high turnover for physicians, loss of medical follow-up that results, directives for blood sampling, lab tests and drug doses in English only and many services only available in English;

- 95% of the hospital's patients are Inuit, who have a difficult time receiving services in their language;

- Some Anglophone managers say that all Francophones are bilingual, that they can access services in English with no difficulty and that, consequently, accessibility is not a problem;

- Some Anglophone managers said that Francophones are not a priority;

- Accessibility to health care services in French varies from one location to the next and from time to time, according to the availability of bilingual or French-speaking health care professionals.

The 2009 NTI report[13] outlined the health care situation for Inuit language speakers as follows:

> "Linguistic and cultural barriers separate health care providers from patients. These barriers can lead to incomplete or incorrect diagnosis and treatment of health problems due to health care providers' limited understanding of what a patient says. One informant noted that southern public health strategies tend to rely upon printed materials and provision of readings, resources, and web-based information. In Northern communities, the most effective communication is verbal and one-on-one. This approach, however, requires both fluency in the patient's language and familiarity with culturally relevant communication styles.
>
> Many Inuit have little faith in the current health service delivery model and, to a certain degree, in the staff at health care centres. There is a sense that their needs are not well understood at the community level, and that the communication gap is even greater when they are forced to travel to regional centres for care.

[13] NUNAVUT TUNNGAVIK INCORPORATED. *Recruitment and Retention of Inuit Nurses in Nunavut,* Iqaluit, 2009.

For communities such as Rankin Inlet, with a relatively high proportion of Inuit nurses (five out of a total of seven), informants reported a very positive impact on the impressions of Inuit patients who have been able to access health care in their own language. Several informants noted that the presence of Inuit nurses on staff reduces much of the stress experienced by non-Inuit full-time nurses."

e) **The recommendations made by the Languages Commissioner's Office were ignored**. The first of the Languages Commissioner's recommendations to the Department of Health and Social Services was included in the 2003-2004 Annual Report:

> "I recommend that the department of Health and Social Services take all steps necessary to bring their communications practices into compliance with the *Official Languages Act* of Nunavut. They must take appropriate measures to ensure that Nunavummiut can communicate to them in person, in writing or by any other means in the Official Language of the citizen's choice. I further recommend that the department assign one of their assistant deputy ministers to oversee compliance of the department's communications to the *Official Languages Act*, thus ensuring that the department does not ignore its obligations under the Act in the future."

Subsequently, on September 7, 2010, a telephone investigation was conducted by OLC among the 29 central administrations of HSS to evaluate language services. Recommendations were made following this investigation and the 2011-2012 Annual Report mentioned that these recommendations had not been implemented:

- The voicemail system of QGH and its central offices do not have a message in all official languages;
- Basic services, promotional activities and active offer are not available in Inuktitut and in French, nor are health care services;
- A slight improvement has been noticed regarding display notices. While displays and notices are available in all official languages, they are often posted in random order and do not afford the same visibility for all official languages.
- There is very little ongoing training for Inuit language medical interpreters. The participation rate in Nunavut's Arctic College translator/interpreter program is negligible.

2.4. METHODOLOGY

2.4.1. Interviews

A questionnaire (Appendix 1) was designed and we conducted individual interviews with 51 people:

- 4 physicians;
- 8 clerk interpreters;
- 6 nurses;
- 10 supervisors/managers/directors at QGH;
- 12 members of the public from different communities, including 8 Inuktitut speakers and 4 French speakers;
- 3 laboratory technicians;
- 8 Nunavut organizations and third parties from different communities.

Fifty verbal interviews were recorded with the respondent's verbal consent, and one respondent preferred to answer the questions in writing.

Members of the public are people who contacted our office to share their experience at QGH.

An initial written questionnaire (Appendix 2) had first been sent to all of the hospital's physicians, but none of them responded. Thus, we had to meet some of them in person to conduct an interview. Someone at the hospital did the coordination for all interviews. Also, we wrote a letter explaining the investigation and this letter was sent to all employees.

A third questionnaire was designed to conduct the interviews with nursing agencies (Appendix 3).

2.4.2. Documentation

Several letters and notices forwarded to the deputy minister of HSS were met with no response. Many documents of critical importance to conducting the investigation were not released by the deputy minister's office; it took more than seven months following the initial request made by the OLC's legal counsels to obtain some dossiers required for the investigation, almost thirteen months following the OLC's first correspondence with the deputy minister.

Among the requests for documentation (ten documents), only the following were received from HSS (March 5, 2013) to allow us to conduct the systemic investigation:

1. Copy of the operation and procedures manual for the reception staff;
2. Copy of the language plan for the Qikiqtani General Hospital: we received only a copy of e-mails of discussion related to this matter;
3. Minutes of the Safety Committee meetings from the beginning of its operation to present (March 2013);
4. Accreditation Report 2011-2012;
5. Information about how funds received for language services (Inuktitut and French) were allocated to the Qikiqtani General Hospital, as well as a detailed report on how it was utilized: we received only a copy of e-mails of discussion related to the French language funds and no document was provided in regards to Inuit language funds;
6. Records indicating the number of employees that work for the Qikiqtani General Hospital and, among them, what number can speak Inuktitut and what number can speak French: we received only an e-mail giving the number of speakers (staff only, no information on the position).

2.5. INFORMATION CONSIDERED WITHIN THE SCOPE OF THE INVESTIGATION

Please note that the following comments were pertaining to the existing situation at the QGH between March 1, 2012 and March 31, 2013 and were stated during the interviews. In an investigation report, it is important to retain the wording of the allegations as close as possible to how it was communicated to us. To maintain the spirit of the allegations, we have to remain impartial and avoid misinterpretation.

Following a review of the interviews conducted by us and the documentation received from HSS, the information considered within the scope of the investigation is:

2.5.1. Language Policy and Active Offer

- The hospital has no language plan or policy.

> "If you ask me to give you a policy, I won't be able to do that. I have to admit I have not seen one. But when people request services in their language of choice, we make every effort that can happen."

- There is no awareness of language training being offered. Those who wish to take language courses have a lot of difficulty doing so because of their work schedule;

- For training, a culture orientation is provided, but is limited:

> "The plane arrives at 12:00. In the afternoon, there is an orientation. There are three pages on the Inuit culture, the Inuit way of life, typical things relevant to the Inuit. There is nothing on languages."

- There is no active offer at the hospital: the patient is not informed of his/her right to request an interpreter, nor are the services of an interpreter actively offered;

- Written notification and documents, such as consent form, are not in all official languages;

- During the admission process, it is possible to enter the patient's preferred language of communication in the computer file; unfortunately, some patients say that they are not asked this question, or the information is not recorded;

- In spite of the hospital's efforts to hire Francophone or French-speaking staff, as it has already been the case, managers state that they face resistance:

> "We tried to post that [French Services Coordinator job] and the DM, who is no longer here, canceled it saying that I was violating the Land Claims Agreement by trying to put a French person in the role. And I was required to put a beneficiary in there. My administrative assistant, for example, is supposed to be designated as a French language speaker. The Department kind of overruled that. So the position was supposed to be French originally and our Department chose to have it more as an Inuktitut position. "

- Every manager of each department (of the hospital) is in charge of recruiting his own staff through Human Resources;

- For the fiscal year 2011-2012, HSS received funding from the Department of Culture and Heritage to promote the French language ($90,000) at the hospital. No document was provided in regards to Inuit language funds;

- During the interviews, an important point that surfaced was the fact that people are not aware of the language laws, not only among managers, directors and hospital staff, but also among the staff and management of HSS.

2.5.2. Language Barriers

- As stated by a physician during an interview:

> "A lot of our patients are unilingual as well. We drop the ball and we are not really providing the best services because we can't understand them and they can't understand us. It is not acceptable at all."

- Some of the members of the medical staff we interviewed say they are uncomfortable with the fact that they cannot communicate with patients due to language barriers. They are aware of current and potential problems resulting from a lack of proper communication between them and the patient. They say they try to assist the patient as best as they can and establish best communication practices given the lack of resources available to them;

- Problems relating to safety, informed consent and the administration of medication exist at the hospital;

- However, we must specify that during the interview process, patients noted the understanding and efforts of some medical staff members to overcome communication barriers.

2.5.3. Interpretation

- For some managers, language interpretation is a "luxury that cannot be offered" and "we have more important concerns than languages";

- The interpreters who are working at the hospital are clerk interpreters.

- There are six English-Inuktitut clerk interpreters and no English-French clerk interpreter. The majority of them have not been trained to intervene in the medical environment and have little or no knowledge of medical terminology and the vocabulary used to describe anatomy. No medical terminology training is offered to clerk interpreters;

- Members of the public are asked to act as interpreters;

- There is a high level of absenteeism among clerk interpreters;

- Outside of normal business hours (weekends, evenings, nights), clerk interpreters are not available;

- Interpreters are not always on site:

> “At times, there is nobody in this building that speaks Inuktitut. We don’t function well when we don’t have someone. This year, it has been very bad, at the point we only had one interpreter. She only worked one shift and we have four shifts to fill; three shifts went on without someone being here.…What I see from being in the North a long time is that Inuit are really accepting but it is certainly not a reason not to serve them in their language. ”

- Several employees spoke about the lack of bilingual staff and qualified interpreters. They expressed their discomfort with the fact that they could not communicate with some patients. They mention that they are aware of the risks involved for the health and safety of patients who do not speak English.

> “The patient is at risk if there is a communication gap and the patient is at risk if nobody seems to get the message right: it should not be about the quantity of care but about the quality. ”

- People who are asked to act as an interpreter rely on gestures to try to understand the patient when verbal communication is difficult;

- When a patient who speaks Inuktitut is not accompanied by a family member or friend, a request is made for an interpreter and this one is not on site, it is primarily the other patient in the room, housekeeping staff or security staff who are called in to interpret. Other people who may be asked to act as interpreter are nurses and clerical staff who speak Inuktitut, if they are available.

> “The worst case I saw is that we had to use other patients as interpreters. Obviously it is a breach of confidentiality, but I also feel that if I use a patient to translate for another patient it transgresses medical rights. You are here to get better and you are being used as staff. Sometimes the patient has to give it a try, but it is the best solution we can come up with.”

- When a patient who speaks French is not accompanied by a family member or friend, it is said that it is primarily Francophone and French speaking staff from the laboratory who are called in. Other people who may be asked to act as interpreter are Francophone nurses and doctors or interns, or other bilingual Francophone medical staff, if there are any and if they are available;

- We noted, within the minutes and through interviews, the difficulty of working with interpreters not qualified to work in a medical setting and the discomfort at the idea of using laboratory staff as interpreters for Francophone patients;

- The consequences of displacing employees from their regular duties to act as an interpreter include decreased performance in their respective responsibilities, imposing an increased workload on their colleagues and demotivating these employees and coworkers in their own work;

- In reading the minutes, we noticed that the lack of interpreters is a concern and that solutions have been identified, such as: establishing and distributing a list of bilingual staff and interpreters. Unfortunately, most of the time, people said they are not aware of this list;

- There is a common belief that the bilingual bonus is automatically offered to those staff members who speak Inuktitut and English. Those who can communicate in French and asked to act as interpreters say they had to fight with Human Resources for more than two years to obtain the bonus.

2.6. FINDINGS

In light of the facts, concerns are well-founded and the systemic investigation allowed us to see that the Qikiqtani General Hospital does not respect its language obligations as provided for under section 11 of the *Official Languages Act,* R.S.N.W.T. 1988, and violates the language rights of citizens, as granted under sections 14 (1) and (2) of this same Act.

Below are the findings drawn from the systemic investigation:

2.6.1 Language Policy and Active Offer

1. There is no language policy or procedure in effect at the Qikiqtani General Hospital;

2. There is no active offer in effect at the Qikiqtani General Hospital;

3. The large majority of communications with patients and services offered is in English only;

4. Management at QGH are facing resistance from Human Resources as their policies promote the hiring of beneficiaries, thus limiting the possibility of hiring Francophone staff;

5. Training is offered only on Inuit language and culture while other cultures are present, primarily in Iqaluit, and nothing is said about language laws or legal requirements;

6. Every manager of each department (of the hospital) is in charge of recruiting his own staff through Human Resources.

Recommendation 1

The Department of Health should:

- develop a language plan and directives;
- integrate language skills requirements in quality and safety standards;
- identify the practical steps that could be taken to ensure continuous improvement.

Recommendation 2

The Department of Health and the Department of Finance should review hiring policies that consider priority hiring to include those with the ability to communicate in French and English, after considering Land Claims Agreement obligation.

Recommendation 3

The Department of Health should ensure that:

- all their employees are aware of language rights and that language choice is understood as a meaningful practice;
- it is incorporated in day to day practice.

Recommendation 4

The Department of Health should provide and promote an active offer and enable it to be implemented systematically and effectively across primary care services, including escorts and medevac services.

Recommendation 5

The Department of Health should build and implement accountability measures within their senior management on language obligations.

2.6.2 Language Barriers

7. Language barriers do exist at the Qikiqtani General Hospital;

8. Patients who speak Inuktitut and French language are faced with significant and serious language barriers;

9. Inuit and Francophone patients do not benefit from the same health care ethical standards as English patients;

10. Language barriers have a negative impact on quality of care, patient safety and access to health care services;

11. Patient-provider communication problems may result in a misdiagnosis and relevant follow-up treatment;

12. Patient confidentiality rights and informed consent may not be protected.

Recommendation 6

The Department of Health should establish strategies that outline the methods used to eliminate language barriers which would facilitate access to health care services and improve health care.

Recommendation 7

The Department of Health should develop a clear goal on the importance of providing equality of primary health care services to all official language groups.

2.6.3 Interpretation

13. Clerk interpreters for Inuktitut speaking patients have very little or no training to work in the medical field. Anatomical and medical terminology and jargon are not understood;

14. There are no professional French language interpreters;

15. Outside of normal business hours (weekends, evenings, nights), there are no clerk interpreters;

16. Members of the public are asked to act as interpreters;

17. There is a high level of absenteeism among clerk interpreters;

18. People are asked to act as interpreter when there are no interpreters available:

    a. For Inuit language speaking patients: family members, housekeeping and security staff, patients in the room, nurses and clerical staff (if available);

    b. For French speaking patients: family members, laboratory staff, nurses, physicians, medical staff (if some and if available).

19. There is no alternative plan in place in the event a clerk interpreter is not available.

Recommendation 8

The Department of Health should establish standards of services regarding interpretation at QGH for all hours. Interpretation / translation services should be available to patients all times.

Recommendation 9

The Department of Health should ensure that once a patient has chosen to communicate in an official language, it is followed through the chain of services, including escorts and medevac services.

Recommendation 10

The Department of Health should address the need for bilingual (Inuktitut-English, French-English) workforce planning and for professional interpreter hiring.

Recommendation 11

The Department of Health and the Department of Finance should review hiring policies to comply with the language legislation and to emphasize the recruitment of skilled bilingual health professionals.

Recommendation 12

The Department of Health and the Department of Finance should give interpreters a professional status to address pay equity issues to facilitate the recruitment and the retention of interpreters.

Recommendation 13

The Department of Health, in collaboration with Inuit Uqausinginnik Taiguusiliuqtiit (IUT), should develop competency tools to evaluate language proficiency of medical interpreters.

Recommendation 14

The Department of Health should work with the Department of Finance, language training providers and Nunavut Arctic College (NAC) to train employees at QGH in order to meet language provision requirements in the primary care sector.

3. PART 2

Part 2 of the report presents the health care situation in Nunavut, the needs of the Inuit and French communities, the importance of a good communication in a patient-practitioner relation and the impacts of language barriers in health care.

3.1. Health Care Situation in Nunavut

3.1.1. Health Care Network

The information contained in this section was obtained from Canada Health Act Annual Report 2012-2013 and the Progress Report 2013 on Health Care Renewal in Canada drafted by the Health Council of Canada (May 2013).

Nunavut has very few primary care practitioners for its size: approximately 1 doctor for every 3000 residents, compared to 1 doctor for 400 residents in Canada's southern regions. In 2012, only 46 nurses and nurse practitioners served the whole region.

The Department of Health has three regional offices that manage the provision of health care services at the regional level. In 2012-2013, guaranteed hospital services were provided in 28 facilities located throughout the region, including a general hospital (Iqaluit), two regional health care centres (Rankin Inlet and Cambridge Bay), 22 community health care centres, two public health facilities (Iqaluit and Rankin Inlet) and a family medicine clinic (Iqaluit). Rehabilitation services are offered at the Timimut Ikajuksivik Centre in Iqaluit.

The provision of health care in Nunavut is based on a primary health care model, delivered by family doctors, nurse practitioners and community health nurses. For example, consultations with family doctors, nurses and nurse practitioners, and advice received from pharmacists are considered common primary health care services.

Nunavut recruits and hires its own family doctors and, for the most part, calls upon specialized centres in Ottawa, Winnipeg and Yellowknife for specialist services. Nunavut has agreements in place with a number of out-of-territory regional health authorities and specific facilities to provide medical specialists and other visiting health practitioner services.

When insured services are unavailable in some places in Nunavut, the patient is referred to another jurisdiction to obtain the insured service. Nunavut has in place health service agreements with medical and treatment centres in Ottawa, Winnipeg, Churchill, Yellowknife and Edmonton. These are the out-of-territory sites to which Nunavut mainly refers its patients to access medical services not available within the territory.

The Ikajuruti Inungnik Ungasiktumi (IIU) Telehealth Network has existed in Nunavut since 1999 and telehealth services are available in the communities. Telehealth is vital to the delivery of health care services in the territory's three regions; it facilitates communication between patients and health care centres in Manitoba and Ontario for consultation with specialists.

Qikiqtani General Hospital (QGH)

Located in Iqaluit, the Qikiqtani General Hospital is the only short-term health care facility in Nunavut that provides a wide range of hospital services to hospitalized patients and out-patients within the meaning of the *Canada Health Act*. The hospital has a total of 35 beds available for acute, rehabilitative, palliative and chronic care services; currently, 20 general purpose beds are in use due to capacity and need. There are also four birthing rooms and six day surgery beds. The facility provides in-patient, out-patient and 24-hour emergency services (including obstetrics, paediatrics and palliative care), surgical services, laboratory, diagnostic imaging and respiratory therapy; it also produces medical dossiers and health information.

In 2012, QGH reports directly to the Department of Health and Social Services (HSS), renamed the Department of Health in 2013, and activities in Iqaluit are managed separately. There is no governance structure for this organization and some essential support services, including human resources, finance, procurement, communications, information technology and property management, are external services provided through the Government of Nunavut.

On-site physicians provide emergency services on rotation. Medical services provided include an ambulatory care/out-patient clinic, limited intensive care services and general medical, maternity and palliative care. Surgical services provided include minor operations in orthopaedics, gynaecology, paediatrics, general surgery, emergency trauma, otorhinolaryngology, ophthalmology and urology. Patients requiring specialized surgeries are sent to other jurisdictions.

In 2011, the department noted that wait times for transportation to another jurisdiction often reached 12 hours, which could result in up to 16 hours before receiving medical care. A new contract for medevac services was awarded to a supplier that uses jet aircraft, which reduces the waiting time to about 4 hours.

3.1.2. Groups Affected by Language Barriers

In Nunavut, the health care system has to provide its services to citizens from multiple linguistic groups but it must above all meet the linguistic needs of citizens from the Inuit language community, French language community and the English language community.

Communications and the provision of services are for long been offered primarily in English, in spite of the language laws in effect in Nunavut. Two communities may encounter language barriers when accessing health care and services: Inuit and Francophones.

3.1.3. Needs of the Communities

Inuit and French language communities must be able to ask for and receive care in the official language of their choice, in order to clearly explain their pain, understand professionals' questions, their diagnosis, follow prescribed medications and properly follow recommended treatment.

The quality of care has to be equal to that offered to the Anglophone community, throughout the health care process, from admissions, treatment, notices to documentation. When a patient must go for a blood sample, but returns home because he or she does not know how to say "blood sample" in English, there is a problem. How can the patients follow instructions that are only available in English? How can they clearly understand and sign a consent form that is only written in English? This is a question of health care safety and quality.

The need to properly understand and be understood is very important for those who often require health care services because they are more liable to use a variety of services for which interpretation is required (visits to the doctor's office, to a public health facility, health promotion and prevention activities). This is especially true for those suffering from chronic illnesses, mothers with young children and the elderly.

Moreover, these community groups must have access to health promotion and prevention in their own language to be able to prevent future health issues.

3.1.4. Language: a Key Factor

In Nunavut, citizens whose mother tongue is not English, or who do not master this language, are more at risk and may be confronted with barriers in terms of the quality of care and accessibility of health care services.

Testimonies clearly reveal to what point those Inuktitut and French speakers interviewed believe it is essential to have access to health care services in their language. Various factors such as pain, vulnerability or stress sometimes result in having a patient who has a good command of Inuktitut and English, or French and English, to lose the ability to clearly express themselves in their second language under certain circumstances. In that case, the patient is becoming unable to understand health care professionals or make themselves understood.

Specialists and doctors do not always realize that the patient has not understood a word of what they discussed. They are not always aware that from a given moment, patients, or their families, no longer fully understand what is happening. Speaking about a particularly traumatizing medical situation, a patient told us that “Even if up to then I hadn’t requested interpreting services, I must say that right then I could have used it tremendously.” Most of the patients whose mother tongue is not English fear that they have not made the right decision.

Studies indicate that even those who perfectly master an official language may face communication problems during a medical consultation. The complexity of certain cases and their level of emotional stress can, in specific situations, influence their ability to communicate in a second language.

These communication problems can have serious consequences for the patient who does not have access to health services in their language and can lead to an incorrect diagnosis that results in inappropriate treatment. Language barriers can thus have a direct impact on the patient’s safety and quality of care received.

An interpreter may not be required for a minor visible injury, but when it concerns understanding a more serious diagnosis and recommended treatment, the patient may require an interpreter. Moreover, in the literature dealing with the subject[14] and during our interviews, mental health and sexuality were recognized as health sectors where the need for interpretation services are the greatest given cultural values and beliefs, and the emotionally charged content of consultations.

[14] Stevens, 1993b; Dolman et al., 1996; Jackson, 1998; Betancourt & Jacobs, 2000, quoted in Sarah BOWEN. *Language Barriers in Access to Health Care*, Ottawa, Health Canada, 2001, p.34.

What medical providers must understand is that when one is placed in a situation of vulnerability, it is often difficult to understand medical jargon and to clearly express one's needs, fears, pain, etc. It is even more difficult to express these concepts in a language that is not our own.

Studies and research also indicate that many who lack proficiency in an official language underutilize prevention programs in general or avoid seeking services where interpreters are not available. Estimates of need based on current service utilization of one institution may therefore dramatically understate the actual need.[15]

3.2. LANGUAGE BARRIERS AND HEALTH CARE

In Nunavut, there are many challenges in the health care sector and added to these is the importance of offering Inuit and Francophones services in their mother tongue and this, for their safety, to obtain quality health care equal to that provided Anglophones and the respect of citizens' linguistic rights. The *Canada Health Act* stipulates that all citizens must have equal access to health care.

According to studies on this subject, linguistic and cultural competency is essentially a question of service quality. For Sarah Bowen, cultural competence is defined as the "provision of health care that responds effectively to the needs of patients and their families, recognizing the racial, cultural, linguistic, educational and socio-economic backgrounds within the community". [16]

An equitable society recognizes and respects the right of all its citizens to obtain the health care they require and ensures that these cares are provided equally, regardless of who requests it or who receives treatment. To accomplish this, health care services must be accessible and every patient must be able to communicate (understand and be understood) with all providers. Other elements to consider include outpatient services, emergency services, signage, admission procedures, documentation, as these are factors that favour access to health care services.

The Canadian Medical Protective Association identifies communications as the major source of lawsuits against its members; other issues related to malpractice claims are delays and diagnostic errors, which are also more likely when a language barrier is present[17].

It is generally agreed that the best communication is obtained when providers and patients speak the same language. Nevertheless, language interpretation services will always be required for some patients.

[15] Sarah BOWEN, *Languages Barriers in Access to Health Care*, Ottawa, Health Canada, 2001, p. 35.
[16] D[r] Ralph Masi, quoted in Sarah BOWEN*, Introduction to Cultural Competence in Pediatric Health Care,* Ottawa*,* Health Canada, 2000.
[17] THE CANADIAN MEDICAL PROTECTIVE ASSOCIATION, [https://www.cmpa-acpm.ca/en/home].

Linguistic and cultural competence is important because it:

- Allows equal access to primary health care;
- Reduces disparities in health care services;
- Impacts on the health of groups from diverse cultures;
- Responds to changing demographics in Nunavut, an increasingly diversified population.

3.3. IMPACT OF LANGUAGE BARRIERS

3.3.1. Direct Effects on Health Care

Our interviews, the documents received from HSS and the studies on this subject allowed us to note that language barriers are systematically mentioned as a major barrier, if not the most important barrier to health care services.

More precisely, according to these studies and our findings, language barriers have the following impact:

- ✓ **On quality of care**: language barriers may result in misdiagnoses, medical errors, lengthy delays and often improper medication in treating pain. The patient is less protected and less safe when provider-patient communication is poor, thus affecting the quality of care received.

  Language barriers can also result in increasing the length of the hospital stay and significantly increasing the wait time to obtain an appointment or to access emergency services.

- ✓ **On initial access to health care**: if people must face significant barriers when establishing first contact with a variety of providers, it may result in a delay in receiving care or lead some patients to avoid accessing regular care. These first contacts are: reception, booking appointments, admission, information on services provided. Asking basic questions like where to go, who to meet, steps to take for blood samples and other tests, become additional barriers. Not to mention the telephone system and voice recording that do not allow everyone to properly understand instructions and leave a message in the official language of their choice. In short, these barriers can hinder a person from showing up for an examination and treatment.

- ✓ **On confidentiality:** any lack of respect for confidentiality can have disastrous consequences for patients. The use of untrained, ad hoc interpreters (family members, friends, volunteers, members of the public, maintenance staff, patient in next bed, hospital staff, etc.) compromise confidentiality. These untrained

interpreters not only run the risk of improperly interpreting key concepts, but they may also distort the message by omission or by direct intervention in the process, thus increasing the risk of a misdiagnosis and inappropriate treatment. Also, this situation affects the confidence citizens have in the medical system.

- ✓ **On respecting ethical standards and the provision of services**: respecting professional ethics means obtaining informed consent and ensuring confidentiality. However, open and frequent communication is essential for informed consent to occur. When patient and provider do not share the same language, there is an immediate barrier to informing the patient of his/her situation and the choices available.

  When compromises are made with regard to respecting ethical standards, it affects the quality of health care. There may be failure to provide care to the same standard as received by other patients, failure to protect patients' confidentiality and failure to adequately ensure patients' informed consent to treatment. When professional standards are not adhered to, there is a higher risk of legal sanctions.

  Documentation is also important and the patient must be able to understand the forms he/she signs. At the time of the investigation, the consent form was only available in English.

- ✓ **On access to mental health services and consultation**: language barriers greatly reduce access to mental health services, especially given that nonverbal signals vary from one culture to another and that we are dealing with complex and very emotional situations where the quality of verbal communication between patient and provider is a very important factor.

  Canadian researchers have identified language as the most ubiquitous barrier to accessing appropriate mental health services[18]. There is perhaps no other health area where diagnosis and treatment is as dependent on language and culture, and the risks of inadequate interpretation have been raised by a number of authors.

  As one of the greatest risks of using untrained ad hoc interpreters is compromising confidentiality, this risk is particularly high when dealing with sensitive areas like mental health, sexuality and reproductive health issues, HIV/ AIDS counselling and testing, or counselling for a number of issues including addictions and family violence[19]. Fear of losing confidentiality when professional interpreters are not

[18] CANADIAN TASK FORCE ON MENTAL HEALTH ISSUES AFFECTING IMMIGRANTS AND REFUGEES (1988). *After the Door Has Been Opened: Mental Health Issues Affecting Immigrants and Refugees*, Ottawa, Minister of Supply and Services Canada, 1988.

[19] CANADIAN COUNCIL ON MULTICULTURAL HEALTH. *Substance Abuse and Cultural Communities: Report of the Provincial Health Promotion Workshops*, 1990.

available may result in both avoidance of care and reluctance to disclose information that may be embarrassing or stigmatizing.

- ✓ **On patient observance of and compliance with the treatment plan:** language barriers threaten the treatment plan and follow-up when patients do not understand the instructions given to them. The same applies to following prescriptions. At the time of the investigation, all recommendations, instructions, prescriptions and other types of related information, both verbal and written, were available in English only.

  The research conducted on provider-patient communication indicates that communication is a key factor to patients following the treatment plan[20]. Language barriers make it difficult to obtain accurate information, while good communication may be a source of motivation, comfort and support, and an opportunity to clarify expectations. In addition, when the patient does not follow the recommended treatment, this increases the probability that less than optimal levels of medication will be maintained, resulting in poorer symptom control and higher risk of acute episodes.

- ✓ **On the effectiveness of providers:** language barriers also have a negative impact on providers' effectiveness. Finding a solution to eliminate these barriers would lead to less frustration, less risk of malpractice and lawsuits, fewer unnecessary interventions, better diagnoses and increased satisfaction among patients and providers.

  Language barriers to accurate diagnosis and informed consent may also place a provider at greater risk of liability. A case in British Columbia illustrates these risks. The B.C. Supreme Court found a doctor negligent in his examination and diagnosis of a man whose leg was amputated as the result of this misdiagnosis. The ruling stated that the patient's language difficulty should have made the doctor especially careful in conducting his physical examination. The patient was awarded $1.3 million[21].

- ✓ **On patient satisfaction:** patient satisfaction is the most recognized and widely used measure of effectiveness of provider-patient communication. It goes without saying that a patient who cannot, or has difficulty speaking in English, or who is not clearly understood, is at higher risk of receiving a misdiagnosis with all the resulting complications. As patient satisfaction is proportional to the quality of care received, patients who do not receive the best of care are unsatisfied.

[20] Sarah BOWEN. *Languages Barriers in Access to Health Care*, Ottawa, Health Canada, 2001, Executive Summary, p. VII.
[21] *Ibid,* p. 90.

Respondents to a study on the subject indicated that communication with the provider included 5 aspects[22]: 1) “medical staff listen to what you have to say,” 2) “they answer your questions,” 3) “they provide explanations about prescribed medications,” 4) “they provide explanations about tests and procedures,” and 5) “your doctor and support staff reassure you and provide support.”

- ✓ **On equality:** a health care system must ensure that services offered do not vary according to personal characteristics such as gender, language, ethnicity, culture, geographical location or socio-economic status. When health care services are not easily accessible, often the resulting effect is that patients do not adopt preventive care measures and avoid or delay going for treatment.

- ✓ **On costs:** language barriers may have important effects on health care costs, through their impact on service utilization and health outcomes. Facts indicate that in many cases, use of services increases when there is no common language between the patient and provider. Studies on the subject indicate that adults who did not speak the same language as their provider had a 70% greater chance of being admitted to hospital than patients who spoke the same language[23]. The authors of these studies proposed that a provider, when treating patients with whom she/he could not communicate effectively, would be more likely to admit them to hospital as a precautionary measure. These studies also found that when an interpreter was used, the risk of admission decreased.

  Another hypothesis was that providing interpretation services, as an input variable for limited English-speaking patients, would save money by avoiding delayed care. This would result in reduced complications, reduced hospitalizations and hospital emergency department utilization, reductions in laboratory work and reductions in the number of unnecessary tests[24].

  In spite of limited research on the costs and benefits of health interpretation, some hospitals have concluded that, based on a partial analysis, provision of paid interpreters is saving money. A quick look at the various costs of language barriers (e.g. reallocated staff time, use of diagnostics, missed appointments, drug complications, hospitalizations, physiological health outcomes, inefficiency, delays in work and excess workload for work colleagues when a staff member must stop work to act as interpreter somewhere else in the hospital) is making the provision of interpretation programs more attractive.

[22] *Ibid,* p. 76.
[23] *Ibid,* p. 70.
[24] *Ibid*, p. 93.

Advantages for patients include a reduction in the chances of death attributable to medical complications and less suffering resulting from inadequate treatment or misdiagnoses.

3.3.2. Indirect Effects on Health Care

Among those who face language barriers, research has shown an increase in the number of additional tests ordered to compensate for inadequate communication between the provider-patient, and much lower participation rates in preventive and screening programs, health promotion activities and first aid courses. Language is a barrier to participation and not the lack of interest in prevention programs.

Other services affected include the pharmacy, ambulance services and medevac services. Understanding English increases access to these services, while the inverse is true for those who do not master this language.

According to the Department of Health policies, when a unilingual Inuk must be transported outside the territory for medical reasons, or must travel to an authorized centre that does not provide interpreting services, a travel escort is authorized. It is the patient's responsibility (or legal guardian) to submit a request for a travel escort. The Nunavut physician will approve the request or indicate the reasons for refusal then the request must be approved by the regional director of the Department of Health.

The medical travel policy applies to all residents of Nunavut with a valid Nunavut health care card and a referral from a Nunavut practitioner. However, in the case of an escort, there are no measures in the policy governing medical travel, which specifies that an escort may be authorized for a Francophone patient. According to the supplier, on a medevac flight there is a good chance (not a guarantee) that onboard staff will speak French. Despite that, there is a good chance that the patient will require an English speaker since there will be no interpreter at the point of arrival.

In summary, language barriers have negative effects on service quality and on the efficiency and effectiveness of the health care system. Language barriers create risks for patients, because they jeopardize their safety. Communication problems may lead to[25]:

- lowered probability of following treatment;
- reduced access to preventive care/services;
- mistaken diagnoses and medical errors;
- increased number of tests and medical consultations;
- negative health repercussions;
- critical incidents;
- lowered patient and provider satisfaction;
- higher healthcare costs.

[25] Sarah BOWEN and Jeannine ROY, *Intégration des services d'interprétation dans la gestion de risques,* Winnipeg, 2009, p. 6.

3.4. INTERPRETATION: THE RISK OF USING UNTRAINED INTERPRETERS

In the studies and research on the subject, the authors outlined the risks of using untrained interpreters such as family or community members, or employees who do not have any interpreter training. In addition to errors that can be made, using a patient from the next bed, housekeeping staff or security agents as interpreters presents a high risk. We are dealing here with professional medical care where the safety of individuals is at stake. The first responsibility of hospital management is to ensure respect for ethical standards, the Code of Ethics and quality of care provided, from admissions to healing.

Typical errors made by these ad hoc interpreters have been listed in various studies and include the following[26]:

- Omission of facts provided by the patient or provider;
- Adding more information to what the patient or provider has stated;
- Substitution of words, concept or ideas;
- Use of inadequate terminology for anatomy, symptoms or treatment;
- Refusal to interpret a message;
- Inappropriate comments;
- Role substitution (e.g. assume the role of health care provider).

The risks relating to the use of untrained persons are as follows:

- Distortions related to the interpreter's language skills and ability to translate;
- Distortions related to the interpreter's lack of medical knowledge;
- Distortions related to the interpreters attitude.

Results:

- Technical terms incorrectly translated;
- Sentences incorrectly translated or not translated at all;
- Poor interpretation of the patients words;
- Distortion of the message;
- Increased risk of misunderstanding when there are cultural differences. For example, the meaning of the word 'consent' may vary from one culture to another;
- Breach of the code of ethics regarding confidentiality and informed consent;
- Impact on diagnosis and possibility of medical errors;
- Impact on treatment with real or potential chemical consequences;
- Issue from an ethical point of view when it is family members who act as interpreters: obligation to translate, stress, uneasiness, imposed responsibility, ignorance of medical terms.

[26] Sarah BOWEN, *Languages Barriers in Access to Health Care*, Ottawa, Health Canada, 2001, p. 80.

As regards to using bilingual staff members, if these individuals are not members of the medical staff, there is a risk that they will not know the medical jargon or medical terminology. Working in the hospital does not make these employees doctors or medical interpreters. Just because a person speaks French or Inuktitut, it does not mean that they can act as a medical interpreter.

Lastly, Canadian research indicates that there is a much higher satisfaction rate with professional interpreter compared to volunteer interpreters. A survey conducted by the Montreal Interregional Interpreters Bank of 68 patients found that 76% of patients preferred dealing with a professional interpreter when consulting medical personnel; 88% had more confidence in the accuracy of interpretation provided by professional interpreters and 83% had more confidence in the discretion of a professional interpreter.

3.5. LANGUAGE SERVICES

> "Health services – and the barriers to access of these services – function as determinants of health. When health systems fail to provide equitable care, or equitable access to care, they may worsen social disparities and be a factor in lowered health status."[27]

Offering professional language services could have the following advantages[28]:

- For patients: obtaining informed consent, a better description of the illness, improved diagnoses, elimination of unnecessary interventions, better clinical results, increased safety and satisfaction;
- For providers: less frustration, reduced risk of misconduct;
- For administrators and managers: reduced responsibility and increased effectiveness;
- For the health care system: better use of services and improved clinical results;
- For the general population: better health care for citizens, greater accessibility to services and more confidence in the health care system.

In order to assist those parties concerned prepare a strategic action plan that addresses the recommendations, in the next section, we described what an active offer is.

[27] HEALTH CANADA. *Certain Circumstances: Issues in Equity and Responsiveness in Access to Health Care in Canada,* Ottawa, 2001, Foreword.
[28] Sarah BOWEN, *Languages Barriers in Access to Health Care*, Ottawa, Health Canada, 2001, p. 95.

3.5.1. Active Offer

> "Providing service of equivalent quality in […] official languages is a matter of professionalism, respect, integrity and social justice."[29]

The definition of active offer varies among provinces and territories. Essentially, actively offering a service means indicating spontaneously and clearly to the public that they can receive services of comparable quality in either official language.[30]

Under section 12 (7) (a) of the *Official Languages Act* of Nunavut, there is a definition of active offer:

> "The administrative head of a territorial institution […] shall take appropriate measures consistent with this Act, including posting such signs, providing such notices or taking such other measures as are appropriate
>
> (a) to provide an active offer of the services in question, making it known to members of the public that they have the right to communicate and receive available services in their Official Language of choice;
>
> (b) to ensure that the services in question are
> (i) available to members of the public on request,
> (ii) delivered with attention to cultural appropriateness and effectiveness, and
> (iii) of comparable quality"

An active offer is also a matter of justice: ethics requires all persons to be treated with the same level of integrity, dignity, equality and justice. A patient must not be subjected to an unwelcoming response or gesture, longer wait time, inferior quality service or longer suffering period just because he or she requests service in Inuktitut or French rather than in English. Accessibility is one of the fundamental principles of the Canadian healthcare system.

The public has to be made aware of the active offer during initial contact. This may be through a display and welcome in all official languages, by telephone, or in person. All communications intended for the public, all documents, correspondence, voicemail messages, signage, e-mail messages, website and other means of communication with the public must be offered in all official languages.

[29] Dyane ADAM, *National Report on Service to the Public in English and French: Time for a change in Culture,* Office of the Commissioner of Official Languages, Ottawa, 2001, p.4.
[30] TREASURY BOARD OF CANADA SECRETARIAT, *Policy on Active Offer,* p.1.

An active offer must ensure that once a patient has chosen an official language of choice, it is followed through the chain of services, including escorts.

An active offer is an offer focussed on the patient. An active offer of quality health care services is not limited to simply offering services in the patient's language, it also involves an overall approach to planning and providing health care services to Nunavut's three distinct language communities. The targeted goal is to improve the quality of care for all patients.

4. CONCLUSION

4.1. Observations

4.1.1. Quality of Health Care

On July 16, 2014, on CBC, there was a news saying that an Elder was hurried into the hospital, shaking, pale and in a lot of pain. The Elder, nurse and doctor all looked at an Inuk patient desperately to interpret because there was no interpreter in the whole hospital. The on-call interpreter couldn't come for another 45 minutes.

On November 6, 2014, a CBC investigation reveals a history of complaints about a nurse and a government that refused to fire her. Entitled "Death and Denial in Cape Dorset", this article was about a baby in a Nunavut hamlet who died of a lung infection in 2012.

The issues raised in this news story are troubling, about the manner in which the government handled concerns about the services being provided at Cape Dorset Health Centre.

We retain the following of these news stories:

- the link between how the Department of Health handled these concerns and the denial of the seriousness of the situation regarding the major impacts of language barriers on the health of two linguistic communities;

- the language barriers still exist at QGH and this systemic investigation report is still relevant.

During our investigation, we noted that there were three factors influencing the quality of health care: the language barriers, the refusal to see that patient safety is not ensured and the lack of willingness to find solutions.

4.1.2. Production of Documents

Although there is a four month period where the Languages Commissioner position was vacant, this should not have affected the prolongation time the Department of Health and Social Services took to produce the requested documents.

4.2. Shared Responsibilities

The Government of Nunavut, the Department of Health, hospital managers and care providers must be made aware of the existence of language rights and their importance with regard to accessibility to health care services, quality of care and, consequently, patient safety.

The issue of language and cultural proficiency greatly exceeds the individual responsibility of stakeholders in the field of health care. The problem is complex and engages the responsibility of stakeholders on several levels: the health care system, organizations and individuals.

- ✓ **The responsibility of the health care system and organizations** includes establishing an environment, policies, resources and training to offer services adapted to the language of patients.
- ✓ **The responsibility of health care professionals** includes developing attitudes, behaviours and knowledge to allow them to create a quality therapeutic relationship with patients and their families, when they come from a different culture and speak a different language.

Both the Department of Health and QGH authorities must :

- Ensure there is a clear commitment on the part of directors and decision-makers, both at QGH and the Department of Health;
- Establish standards governing responsibility and accountability;
- Promote the cultural and linguistic diversity we find in Nunavut, through ongoing training for management and all personnel;
- Introduce changes that are manageable, measurable and viable (step-by-step strategy);
- Work with the Department of Finance to review the human resources employment policies in accord with the *Official Languages Act* and to the *Inuit Language Protection Act;*
- Work with local organizations that are active in the health care sector to better understand current needs and better match available means.

Accessibility forms part of the basic principles of the Canadian health care system and the active offer is one of the ways to improve health care accessibility and quality. It is a matter of safety, quality and legitimacy, and an inherent question of ethics.

Sarah Bowen is a Canadian researcher who conducted three major studies for Health Canada. She stated:

> "Codes of ethics that regulate the conduct of health and social service professions stress the need for the provider to obtain informed consent, provide explanations, ensure confidentiality, and refrain from practicing the profession under conditions that may impair service quality. This means that in addition to a requirement to comply with external regulations defined in law, professionals are also required to meet the standards of their professional associations. **For these ethical standards to be achieved, it is necessary to address language barriers**."[31]

In order to improve the active offer of quality health care services in the official languages, **a cultural change must be implemented** within the department and the hospital. Health care professionals cannot be solely responsible for this transformation. Improvements will have to be met with a spirit of common understanding, collective accountability and collaboration.

Various approaches must be taken to ensure that there is an active offer of services in all official languages. It is important that health care providers establish policies, procedures and practices that clearly reflect the importance and presence of an active offer that is consistent and continual throughout various services: a person seeing a doctor, going to the lab or having an X-ray, receiving medication, etc. should receive services in the official language of his/her choice.

It is up to **decision-makers, as Government of Nunavut,** to maintain and strengthen their efforts to support the implementation and improvement of health care programs and services in all official languages in health care facilities. This is a necessary condition to facilitate satisfactory access to health care services in an ethical and equitable manner.

[31] Sarah BOWEN, *Language Barriers in Access to Health Care,* Ottawa, Health Canada, 2001, p.20. (Emphasis added by the OLC).

5. RECOMMENDATIONS

5.1. LANGUAGE POLICY AND ACTIVE OFFER

Recommendation 1

The Department of Health should:

- develop a language plan and directives;
- integrate language skills requirements in quality and safety standards;
- identify the practical steps that could be taken to ensure continuous improvement.

Recommendation 2

The Department of Health and the Department of Finance should review hiring policies that consider priority hiring to include those with the ability to communicate in French and English, after considering Land Claims Agreement obligation.

Recommendation 3

The Department of Health should ensure that:

- all their employees are aware of language rights and that language choice is understood as a meaningful practice;
- it is incorporated in day to day practice.

Recommendation 4

The Department of Health should provide and promote an active offer and enable it to be implemented systematically and effectively across primary care services, including escorts and medevac services.

Recommendation 5

The Department of Health should build and implement accountability measures within their senior management on language obligations.

5.2. LANGUAGE BARRIERS

Recommendation 6

The Department of Health should establish strategies that outline the methods used to eliminate language barriers which would facilitate access to health care services and improve health care.

Recommendation 7

The Department of Health should develop a clear goal on the importance of providing equality of primary health care services to all official language groups.

5.3. INTERPRETATION

Recommendation 8

The Department of Health should establish standards of services regarding interpretation at QGH for all hours. Interpretation / translation services should be available to patients all times.

Recommendation 9

The Department of Health should ensure that once a patient has chosen to communicate in an official language, it is followed through the chain of services, including escorts and medevac services.

Recommendation 10

The Department of Health should address the need for bilingual (Inuktitut-English, French-English) workforce planning and for professional interpreter hiring.

Recommendation 11

The Department of Health and the Department of Finance should review hiring policies to comply with the language legislation and to emphasize the recruitment of skilled bilingual health professionals.

Recommendation 12

The Department of Health and the Department of Finance should give interpreters a professional status to address pay equity issues to facilitate the recruitment and the retention of interpreters.

Recommendation 13

The Department of Health, in collaboration with Inuit Uqausinginnik Taiguusiliuqtiit (IUT), should develop competency tools to evaluate language proficiency of medical interpreters.

Recommendation 14

The Department of Health should work with the Department of Finance, language training providers and Nunavut Arctic College (NAC) to train employees at QGH in order to meet language provision requirements in the primary care sector.

6. RESPONSE FROM THE DEPARTMENT OF HEALTH

The Department of Health was provided with an opportunity to make representations concerning our preliminary findings, conclusion and recommendations. We received a letter from the Deputy Minister of the Department of Health indicating what steps the Department would be undertaking to implement our recommendations. The response is attached at Appendix 4 of this report.

The Department did not comment on the findings, conclusion and recommendations included in the report. As the Department provided single responses to several recommendations, for this reason, we cannot present a table showing their response to each recommendation.

The responses from the Department do not deal with the substantive and immediate issues at hand, which leaves too much room for continuation of language rights violations. This means continued barriers to access health care for Inuktitut and French language speakers. More work needs to be done identifying a plan for the short, medium and long term on how services and communications in Inuktitut and French will be delivered, with the same quality as services in English.

We think that our report should serve as an excellent road map to the Department to build on the measures they have already taken, and will have to take, to strengthen compliance with the *Official Languages Act*, accountability and availability of services and communications in Inuktitut and French at the Qikiqtani General Hospital. We will continue to monitor its progress in implementing the recommendations.

Appendix 1 : Questionnaire For Patients

SUBJECT: QGH SYSTEMIC INVESTIGATION
TOPIC: QUESTIONNAIRE - PATIENTS

Interview with patients at the Qikiqtani General Hospital

Anonymity of interviewed persons will be protected. However, you should be aware that we cannot guarantee it. The information gathered during the interview will be used for the purposes of the investigation and can be published in the final report of the investigation that will be made public.

Information / Statistics

Name of the organization:

Last and first name of the respondent:

Region of origin:

Respondent's age:

How many years in Nunavut?

Main language:

Second language and proficiency in the second language:

Personal experience at the hospital

Are you familiar with the hospital?

Do you know anybody who works at the hospital?

Which services have you used at the hospital?

Was language a problem on each occasion when you had to use the services at the hospital?

If a situation was a problem

Can you explain for me, preferably in chronological order, what happened during each of the visits? Begin with the hour you went to the hospital; what happened in detail? This could include:

Why were you at the hospital?

Who was with you?

Who gave you the treatments and how were you treated?
Did you ask for services in your language?

How long did you stay in the hospital?

If admitted, details on the stay.

Did you make any attempts to receive services in the language of your choice?

What happened? Did you resort to the use of translation services?

What was their comprehension?
What were your expectations?

Were you aware of any available or visible notices or brochures in the language of your choice?

Were you informed of the translation and interpretation policies in place and the reasons why they could not be applied?

What happened when the employee realised that you had difficulty understanding what you were saying, and what was his or her reaction?

Were the instructions on how to take one or more drugs available in the language of your choice?

Witnesses

Who else was with you when this happened?

Documents

Do you have letters, documents, notes etc. that would be relevant to the investigation?

Impacts

What were the impacts of the lack of services in the language of your choice?

Did you have positive experiences at the hospital?

Solutions

If there is a problem, what, in your view, would be a reasonable solution?

Another person

Do you know anybody else who has had a positive or negative experience with respect to language services at the hospital?

Documents/Persons

Is there anybody else who has relevant evidence that we should talk to?

Are there documents or other subjects that would be relevant to what happened to you and that you think we should examine?

Others

Would you like to add another element to the interview?

Consent to obtain the hospital record if necessary:

Is it possible to get your consent to access your hospital record? It is not essential for this investigation, but it would be very useful to determine who treated you. The hospital record will be confidential.

Reprisals

Do you fear reprisals? If yes, why?

Appendix 2 : Questionnaire For Physicians

SUBJECT : QGH SYSTEMIC INVESTIGATION
TOPIC : QUESTIONNAIRE - PHYSICIANS

Interview with physicians at the Qikiqtani General Hospital

Thank you for your time and valuable collaboration. Anonymity of interviewed persons will be protected. However, you should be aware that we cannot guarantee it. The information gathered during the interview will be used for the purposes of the investigation and can be published in the final report of the investigation that will be made public.

Upon your arrival in Iqaluit, did you attend an orientation session?
Please specify:

If so, were you introduced to the official languages and linguistic rights of Nunavut?
Please underline: Yes or No

How was your first day at the hospital?
Please specify:

What type of orientation would you have liked to receive on your first day at the hospital?
Please specify:

When you were contacted for an interview, were you offered to pass this interview in the official languages of your choice?
Please underline: Yes or No

Do you have access to a list of interpreters available at all time at the hospital?
Please underline: Yes or No

In your opinion, are there enough French interpreters at the hospital?
Please underline: Yes or No and specify if necessary.

In your opinion, are there enough Inuit interpreters at the hospital?
Please underline: Yes or No and specify if necessary.

Did you ever encounter a situation where you had no access to an interpreter or the interpreters were simply not available?
Please underline: Yes or No

If yes, what did you do?
Please specify:

How did you react?
Please specify:

Did you ever encounter a situation where you had to ask a patient to interpret for another patient?
If yes, please specify:

Did you ever encounter a situation where you had to ask a maintenance person, a lab technician, a cook or a clerk to act as an interpreter for a patient?
Please underline: Yes or No and specify if necessary.

If yes, what was the position of this or those people?
Please specify:

How did you react?
Please specify:

If such a situation occurred, did you address your concerns to your supervisor?
Please underline: Yes or No

If yes, how did he or she react?
Please specify:

Do you know about the language legislation and linguistics rights of Nunavut?
Please specify:

Were your offered to take Inuit language courses by your employer?
Please specify:

Were your offered to take French language courses by your employer?
Please specify:

Are you eligible to the Government of Nunavut bilingual bonus?
Please underline: Yes or No

Do you have access to medical terminology tools?
Please underline: Yes or No and specify if necessary.

How did you learn about the availability of doctor positions in Iqaluit?
Please specify:

Does your employer raise your awareness to the importance of the language services in a hospital environment?

In comparison with previous experiences, do you find the Qikiqtani General Hospital linguistic practices and procedures consistent with Canadian medical standards?

Please add any comments or suggestions:

Please suggest any document that could be useful or necessary to this investigation:

Appendix 3 : Questionnaire For Nursing Agencies

SUBJECT: QGH SYSTEMIC INVESTIGATION
TOPIC: QUESTIONNAIRE – NURSING AGENCIES

Interview with Nursing Agencies providing services to the Qikiqtani General Hospital

Anonymity of interviewed persons will be protected. However, you should be aware that we cannot guarantee it. The information gathered during the interview will be used for the purposes of the investigation and can be published in the final report of the investigation that will be made public.

How many nurses are hired for QGH each year? You hire mostly nurses? What is your mandate?

Is your agency aware of its obligations under the Nunavut's language legislation and if so, which procedures or policies are in place for your agency in order to fulfil its obligations? Is there any directives given by the Department of HSS?

Are there any clear directives or policies from the GN about promoting the hiring of bilingual staff that speak both of the official languages in Canada as well as the official languages in Nunavut (French, English and Inuit language)?

Are there any clear directives or policies from the Department of HSS directed to your office regarding hiring priority in Nunavut? If not aware already, Article 23 (2) (1), Land Claims Agreement states that: ….

Are there any clear directives or policies from the Department of HSS on where advertise positions in Canada? Or is it left to your discretion.

What if you can't find any nurses beneficiaries? Are positions being advertised in other regions in Canada where the Inuit language is spoken?

Where are the positions at QGH generally advertised? Any particular reasons for this?

Are you aware of your obligations as third party under the Inuit Language Protection Act? Would you like one of our staff to discuss it with you?

To conclude, anything you would like to add?

Appendix 4: Response from the Department of Health

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Building *Nunavut* Together
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Bâtir le *Nunavut* ensemble

Nunavut

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Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

RECEIVED Oct.22/15

Iqaluit, 9 October, 2015

Commissioner Sandra Inutiq
Office of the Languages Commissioner of Nunavut
P.O. Box 309
Iqaluit, NU X0A 0H0

RE: Response to the Systemic Investigation Report – Qikiqtani General Hospital (File LANG-1329-01)

Dear Commissioner Inutiq,

The Department of Health appreciates the opportunity to respond to the recommendations arising from the systemic investigation of language services at the Qikiqtani General Hospital (QGH) that your office conducted for the period ranging from March 1, 2012, to March 31, 2013.

The Department has given serious consideration to the findings and recommendations included in your office's preliminary report. Since the end of the period covered by the investigation, the Department has put in place measures that we trust will alleviate many of the concerns you have expressed. We are also pleased to share additional actions that the Department of Health plans on implementing as a result of your recommendations.

Recommendations 1, 3, 4, 5, 6 and 7

Summary of the Recommendations: The office of the Languages Commissioner recommended that the Department of Health makes it an objective to offer equal services to all official language groups and that it develops plans, directives as well as strategies to ensure the attainment of that objective. The Commissioner further recommended that employees be informed of language rights, that an active offer be in place, and that senior officials be accountable for the implementation of language measures.

Current Status: The Department of Health appreciates the importance of offering all language groups services of equal quality, and recognizes its obligations under Nunavut's *Official Languages Act*.

In the fall of 2015, the Senior Management Committee has begun its work to revise the territory's model of care. As its work progresses, the Committee will integrate access to services in the official languages into Nunavut's revised model of care.

Additional Actions:
With the objective of giving effect to the Commissioner's recommendations, the Department will:

A. Develop a language plan as well as directives and procedures pertaining to service access in the official languages at QGH. The instigation of an active offer will be a part of this plan.
B. Ensure that the right to access services in the official languages is a topic covered in the training modules delivered to QGH workers.

Office of The Deputy Minister
Department of Health, Government of Nunavut
P.O. Box 1000, Stn. 1000
Iqaluit, NU X0A 0H0
Ph: 867-975-5702 Fax: 867-975-5705

Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble

Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

Recommendations 2, 10 and 11

Summary of the Recommendations: The office of the Languages Commissioner recommended that the Department of Health plans for the development of a bilingual workforce, that the hiring process respects language obligations and that the selection of bilingual candidates be favoured once Nunavut Land Claims Agreement (NLCA) obligations have been considered.

Current Status: The Government of Nunavut is taking action to develop a workforce that is representative of the territory's population. With this goal in mind, the Department of Health is taking the following concrete steps:

- Giving priority to qualified applicants who are NLCA beneficiaries for all positions during the hiring process;
- Offering financial assistance and return of service agreements to nursing students at the Nunavut Arctic College (NAC). To date, a total of 16 NLCA beneficiaries have graduated from the NAC nursing program. For academic year 2015/16, a total of 10 NLCA beneficiaries are enrolled in the program. An additional 16 NLCA beneficiaries are enrolled in the Pre-Nursing Certificate;
- Developing a program to allow NAC nursing graduates to immediately transition from schooling to employment with the Department of Health at its Iqaluit facilities;
- Hiring the three Midwifery Diploma Certificate holders who are NLCA beneficiaries;
- Reserving a seat for Nunavut residents in McGill University's Medicine Program, which is currently filled by a student who is a beneficiary of the NLCA.

Training NLCA beneficiaries is a key step in developing a workforce that is capable of directly providing health services to Nunavummiut in Inuktut - and significant progress is being made in that direction. Recognizing that not all NLCA beneficiaries are fluent in Inuktut and that training health professionals takes several years, the Department of Health has also put in place interpretation services. The steps that the Department is taking to enhance its interpretation services are detailed in the next section of this response.

The Government of Nunavut ensures that its job postings are available in all official languages.

With the goal of enhancing service access in all languages, the Department of Health is currently working towards the creation of a trilingual (English, French and Inuktitut) patient relations position to be based at QGH.

Additional Actions:
With the objective of giving effect to the Commissioner's recommendations, the Department will:

C. Explore options to increase the number of workers who are bilingual; and
D. Continue to deliver training to current employees and to increase the number of NLCA beneficiaries trained to offer health services hired at QGH.

Office of The Deputy Minister
Department of Health, Government of Nunavut
P.O. Box 1000, Stn. 1000
Iqaluit, NU X0A 0H0
Ph: 867-975-5702 Fax: 867-975-5705

Recommendations 8, 9, 12, 13 and 14

Summary of the Recommendations: The office of the Languages Commissioner recommended interpreters at QGH be available 24/7, professionally trained and evaluated, paid an equitable salary and available to provide services throughout the continuum of care.

Current Status: There are 12 medical interpreter positions at QGH. Of these, 6 are filled by indeterminate employees, 2 are filled by casual employees, 1 is filled by an individual who is on leave, 2 are out for competition, and one is vacant.

Exactly in the same vein as the Commissioner's recommendation, the Department of Health began to enroll its employees in Medical Terminology Courses delivered by the Nunavut Arctic College shortly after the end of the period covered by the systemic investigation. The next page shows the number of interpreters and other health employees who have received such training.

Table 1. Number of individuals who completed the Medical Terminology Modules in 2013-2015

Course Title	Interpreters	Other Health Employees	Total
Anatomy & Physiology I	18	15	33
Anatomy & Physiology II	15	14	29
Diseases & Ailments I	17	12	29
Diseases & Ailments II	16	12	28

These modules are of professional caliber, and each of them is delivered on a full-time basis over the course of four weeks. Successful completion requires that the participants pass evaluations and examinations. The syllabi for these modules are enclosed with this letter, and the College has signified its intention to update them over the course of the year.

The Department of Health is currently planning for the 2015/16 medical terminology training and will develop a training plan that places particular emphasis on offering training to QGH interpreters.

The Department also looks forward to hiring more interpreters trained in Nunavut. The current enrollment numbers in the Interpreter-Translator Program at the Nunavut Arctic College are encouraging with three students in their second year in Kugluktuk, three in their in their first year in Rankin Inlet and nine in their first year in Iqaluit. Upon graduation, these individuals will have the potential to add to the body of professionally trained interpreters at QGH as well as at other health facilities.

Additional Actions:
With the objective of giving effect to the Commissioner's recommendations, the Department will:

E. Revise the job description for the vacant interpretation position so it requires English-French interpretation skills and post it for competition;

Office of The Deputy Minister
Department of Health, Government of Nunavut
P.O. Box 1000, Stn. 1000
Iqaluit, NU X0A 0H0
Ph: 867-975-5702 Fax: 867-975-5705

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Building *Nunavut* Together
*Nunavu*liuqatigiingniq
Bâtir le *Nunavut* ensemble

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Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

F. Submit the medical interpreter and clerk interpreter positions for job evaluation to ascertain that individuals in these roles are compensated at a level that is commensurate with their responsibilities and training requirements according to the Government of Nunavut guidelines;

G. Review scheduling and staffing levels with a view of rendering QGH interpretation services available 24/7.

We thank you for the recommendations put forward in your preliminary investigation report.

You can be assured of the Department of Health's full collaboration in any future matter your office may wish to investigate.

Sincerely,

Colleen Stockley
Deputy Minister of Health

CC: Paul Okalik, Minister of Health

Office of The Deputy Minister
Department of Health, Government of Nunavut
P.O. Box 1000, Stn. 1000
Iqaluit, NU X0A 0H0
Ph: 867-975-5702 Fax: 867-975-5705

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You can contact us by phone, e-mail, mail or in person.

Phone
(867) 975-5080
Toll-free 1 877 836-2280

E-mail
langcom@langcom.nu.ca

Mailing address
P.O. Box 309, Iqaluit, Nunavut, X0A 0H0

Civic address
630, Queen Elizabeth II Way, 3rd Floor
(Qamutiik – First Nations Bank Building)

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Uqauhinut Kamisinaup Havakvia Nunavunmi
Office of the Languages Commissioner of Nunavut
Bureau du Commissaire aux langues du Nunavut