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English 100

Linguistic Chasms of Injustice: The Fallacy of Official Language Supremacy and the Language Barriers that Enable the Deprivation of Medical Care

The right to health care is deeply entrenched in the legal, moral, and political identity of Canada, and as a fundamental element of the Universal Declaration of Human Rights, it is often assumed that Canada's universal health care system, is, in fact, universal. However, language barriers prevent many individuals from accessing the care to which they are entitled, from being able to provide informed consent, and from being properly examined, registered, and discharged (Segalowitz and Kehayia 481). As is discussed in "Language Barriers to Healthcare for Linguistic Minorities: The Case of Second Language-Specific Health Communication Anxiety," language barriers disproportionately affect "immigrants, historical national minorities, [I]ndigenous minority populations, and refugees" (Zhao et al. 334), which results in certain linguistically marginalized groups experiencing the consequences of "inappropriate medical diagnoses, higher rates of treatment dropout, recurrent hospitalizations and longer stays, … and greater risk of medical errors with more serious consequences" (Brisset et al. 1238). This begs the question: do language barriers exacerbate social inequalities in health care, and do we have a collective responsibility to address them? Through the examination of language barriers within broader political, cultural, and epistemological contexts, the exploration of linguistic barriers that immigrants and Indigenous Peoples experience in health care institutions, and the ethics and obligations associated with upholding universal health care and human rights, it is clear that

language barriers in health care drastically exacerbate social inequalities, and we have an indisputable responsibility to mitigate all barriers to health care in order to establish a more just and equitable system that reflects the ideals of universal health care.

The intersectionality of language barriers demonstrates that they necessarily reinforce other manifestations of societal inequity and require a significant reconceptualization of Canadian medical care systems. Political discussions surrounding the accessibility of health care often rely heavily upon the understanding of language barriers as challenges that can be overcome through the provision of translators and interpreters. However, the complex cultural and historical nature of language barriers is far more nuanced, as they illustrate not only practical issues in health care settings, but also the existing inequalities, biases, and cultural ideologies that must be acknowledged in order to adequately mitigate the negative effects of language barriers on patients. Translators and interpreters provide invaluable services in what are described in "Language Barriers to Healthcare for Linguistic Minorities: The Case of Second Language-Specific Health Communication Anxiety" as "language discordant" contexts (Zhao et al. 334). However, they alone cannot serve as substitutes for the cultivation of understanding and trust between health care providers and patients. One glaring instance in which language barriers can prove to be virtually insurmountable occurs in the context of the translation of medical vocabulary and concepts. Scholars Norman Segalowitz and Eve Kehayia discuss Anna Wierzbicka's work on the presence of "underlying cultural scripts" (Wierzbicka as qtd in Segalowitz and Kehayia 494) in translation and the misunderstandings that can arise from attempting to discuss topics such as informed consent, death, and loss across language barriers. Through their exploration of Wierzbicka's argument that "cultures can be characterized by different linguistic scripts underlying the meanings of certain concepts that are said to be key to

understanding aspects of the culture" (Segalowitz and Kehayia 494), Segalowitz and Kehayia demonstrate that practitioners' ignorance of the challenges presented by "cultural scripts" and the epistemological hubris of Western medicine create additional invisible obstacles to receiving meaningful care.

Yael Peled posits a similar argument about the marginalization of those with limited English proficiency in her article, "Language Barriers and Epistemic Injustice in Healthcare Settings," in which she contends that since concepts of health, illness, and wellness are deeply rooted in specific cultural and linguistic ideologies, they cannot be easily explored in the context of monolingual or bilingual medical systems like that found in Canada. Peled notes that English pain scales that are translated into other languages are often insufficient in characterizing the subjective terminology used to describe pain and often adhere to the erroneous assumption that understandings of pain and topics such as chronic illness and mental health are universal (Peled 362). She also notes that due to the emphasis on personal relationships in many health care institutions, patients experiencing language barriers are more likely to have their symptoms (as well as their intelligence) underestimated by practitioners due to a lack of communication and a subconscious bias on the part of the health care provider due to a patient's style of speech, accent, or vocabulary. Peled emphasises that negative consequences resulting from the minimization of patients' symptoms are even greater in mental health settings due to the centrality of conversation and the pre-existing societal stigma associated with mental health treatment regardless of language barriers (362). Given many patients' reluctance to seek mental health treatment and the Western practice of ignoring mental health challenges, the added difficulty of navigating a language barrier may prevent individuals from seeking mental health treatment, particularly if they have experienced previous discrimination in medical institutions.

The dehumanization of patients with limited proficiency in an official language and the profound lack of cultural and linguistic consciousness surrounding "cultural scripts" demonstrates the necessity of meaningfully addressing language barriers in health care, as they are often representative of more general forms of oppression, marginalisation, and ignorance.

Immigrants, refugees, and temporary residents are disproportionately deprived of adequate treatment in "language discordant" (Zhao et al. 334) situations, indicating that injustice is deeply intrenched in the Canadian health care system. The medical care that immigrants receive in Canada is discussed at length in "A Scoping Review of Immigrant Experience of Health Care Access Barriers in Canada," in which the authors cite "language barriers, barriers to information, and cultural differences" as the predominant factors generating "inequities in access to Canadian health care services for immigrant populations" (Kalich et al. 697). Although it can be difficult to differentiate between linguistic barriers, socio-economic barriers, and barriers imposed by systemic racism and discrimination, the authors note that many health care professionals and legislators acknowledge that language barriers play a significant role in preventing immigrants from receiving care (703). It may be argued that the onus lies with immigrants, refugees, and temporary residents to become proficient in English or French in order to receive health care in Canada. This sentiment, however, is not consistent with the ethical and moral obligation to provide health care to all individuals residing in Canada. In addition, the expectation of assimilation into Canadian society upon emigrating to Canada is deeply colonial in nature, as it implies that the adoption of a certain way of being and thinking is necessary in order to be an acceptable recipient of health care. Not only does this idea of linguistic integration deprive Canadians of the cultural benefits of an inclusive and multilingual society, it also neglects to acknowledge that Indigenous languages pre-date the use of English and French

and should also be recognized in health care systems in order to facilitate reconciliation and justice.

Indigenous Peoples have experienced, and continue to experience, widespread discrimination, abuse, and cultural genocide. The issue of language barriers in regard to Indigenous Peoples is referenced in "Language Barriers to Healthcare for Linguistic Minorities: The Case of Second Language-Specific Health Communication Anxiety," in which it is stated that some Indigenous groups "report higher rates of disease, disability, and death, … even after controlling for access-related factors such as insurance status, income, and socioeconomic status" (Zhao, et al. 334). This data demonstrates not only that the maintenance of language barriers in Indigenous communities drastically exacerbates existing social inequalities, but also, given Canada's proclaimed commitment to Truth and Reconciliation, that there is an undeniable ethical obligation to ensure that health care is accessible in Indigenous languages. In his article, on the subject, Paul Webster reports that Nunavut residents (the majority of whom cite Inuktitut as their first language) are subject to language barriers that affect "patient confidentiality, access to mental health services, compliance to treatment plans, and health care costs" and can result in "misdiagnoses, medical errors and improper medication" (Webster E754). Webster argues that as such, the Canadian government is obligated to dedicate funds to providing health care that can be accessed in Indigenous languages (E754). The fact that language barriers in Nunavut remain an issue exemplifies the degree to which language barriers serve as a marker for a lack of medical prioritization of Indigenous Peoples. The Canadian government allows the presence of language barriers to serve as a vehicle for the continued oppression of Indigenous peoples. The fact that linguistic accessibility in health care remains largely undiscussed in public and political

arenas further illustrates the fact that it is, ostensibly, a symptom of the colonialism and racism that is latent in the Canadian medical system.

As is established in the Universal Declaration of Human Rights, "food, clothing, housing, and medical care" are inalienable rights that cannot be denied due to a lack of proficiency in an official language (UN General Assembly art. 25). In order to uphold this most basic standard of humanity, we as a society must challenge colonial notions of English and French supremacy, celebrate and support multilingualism, and foster humility, compassion, and cultural and linguistic consciousness in health care settings. Those who have the privilege of benefiting off of the supposed 'universal health care' system must ensure that all people can receive health care in order to prevent the continuation of exploitative, hegemonic patterns of discrimination, colonialism, and xenophobia. In working to ethically and meaningfully mitigate language barriers in health care, we will also be able work towards eliminating the barriers that exist within the English and French languages that prevent us from challenging the ubiquitous discrimination and hatred that exists within seemingly-inoffensive issues such as language barriers. Our government and society are responsible for ensuring the health of all people, and the intersectionality of language barriers provides us with an indispensable opportunity to challenge racism, colonialism, and stigma in health care in order to meaningfully reconceptualize our cultural interpretation of health, language, and identity.

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