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The Basque Paradigm Shift: From Legislative Language Policies to Person-Centred Care

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Politiques publiques et pratiques citoyennes soutenant les services sociaux et de santé pour les communautés minoritaires de langues officielles et coofficielles. Une perspective internationale : ce qui a été accompli et ce qui reste à faire

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Résumé de l'article

Le Pays Basque a deux langues officielles, le basque et l'espagnol, la première parlé par 37 % de la population. Le Service de santé basque a mis en oeuvre des programmes linguistiques pour répondre aux exigences juridiques. Le Service de santé réalise présentement un grand virage transformationnel en délaissant les politiques axées sur le droit au profit d'une approche fondée sur des données probantes et centrée sur le patient. Cet article traite de trois mesures essentielles qui pourraient améliorer la prestation des soins dans la langue appropriée : l'enregistrement de la langue préférée des patients; les parcours de soins en basque comme approche appropriée et efficace pour déterminer la langue de service tout au long du continuum de soins; et l'établissement de dossiers médicaux électroniques bilingue qui mettent en évidence le défi des barrières linguistiques chez les professionnels. Compte tenu de ses ressources humaines bilingues, offre la possibilité d'établir des donés probantes sur la mise en oeuvre des programmes.



The Basque Paradigm Shift: From Legislative Language Policies to Person-Centred Care

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Abstract

The Basque Country has two official languages, Basque and Spanish, the first being spoken by 37% of the population. The Basque Health Service has developed language *schemes* to fulfill the legal requirements. Currently, there is a vast transformational shift from legislative policies to an evidence-based, patient-centred care approach. This paper discusses three key issues which could enhance language appropriate care: the recording of patient's preferred language; the Basque language care pathways as a suitable and effective approach for determining the language of service along the continuum of care; and bilingual electronic medical records, which bring to the fore the challenge of language barriers among professionals. Considering its bilingual human resources, it offers an opportunity for establishing compelling evidence about implementation.

Résumé

Le Pays Basque a deux langues officielles, le basque et l'espagnol, la première parlé par 37 % de la population. Le Service de santé basque a mis en œuvre des programmes linguistiques pour répondre aux exigences juridiques. Le Service de santé réalise présentement un grand virage transformationnel en délaissant les politiques axées sur le droit au profit d'une approche fondée sur des données probantes et centrée sur le patient. Cet article traite de trois mesures essentielles qui pourraient améliorer la prestation des soins dans la langue appropriée : l'enregistrement de la langue préférée des patients; les parcours de soins en basque comme approche appropriée et efficace pour déterminer la langue de service tout au long du continuum de soins; et l'établissement de dossiers médicaux électroniques bilingue qui mettent en évidence le défi des barrières linguistiques chez les professionnels. Compte tenu de ses ressources humaines bilingues, offre la possibilité d'établir des donés probantes sur la mise en œuvre des programmes.

Resumen

El País Vasco tiene dos lenguas oficiales, vasco y castellano, la primera hablada por el 37% de la población. El Servicio Vasco de Salud ha desarrollado planes lingüísticos para cumplir los requisitos legales. Actualmente, existe un gran cambio desde una orientación legislativa hacia una basada en la evidencia y centrada en el paciente. Este texto plantea tres puntos claves que podrían permitir una atención lingüísticamente adecuada: el registro de la lengua de preferencia de los pacientes; los circuitos en lengua vasca como una aproximación factible y efectiva para establecer la lengua de servicio a lo largo del proceso asistencial; y la historia clínica electrónica bilingüe, que pone en la palestra el desafío de las barreras lingüísticas entre profesionales. Considerando sus recursos humanos bilingües, ofrece una oportunidad para establecer una poderosa evidencia sobre implementación.

Laburpena

Euskal Autonomia Elkargoak bi ele ofizial ditu, euskara eta gaztelania, lehenengoa biztanlegoaren %37ak hitz egiten duenak. Euskal Osasun Zerbitzuak hizkuntza plangintzak garatu ditu, legedia betetzeko asmoz. Egun, jauzi esanguratsu bat gertatzen ari da, legedian oinarrituriko plangintzetatik ebidentzian eta pazientean ardazturiko plangintzetara. Testu honek hizkuntza aldetik arreta egokia berma dezaketen hiru alderdi aztertzen ditu: pazienteen lehenetsuneko hizkuntzaren erregistroa; euskarazko zirkuituak, arreta prozesuan zerbitzu-hizkuntza bermatzeko hurbilpen egingarri eta eraginkor gisa; eta historia kliniko elektronikoa, profesionalen arteko hizkuntza mugen erronka plazaratzen duena. Bere giza-baliabide elektronikoen kontuan harturik, ezarpenerako ebidentzia sendoa sortzeko aukera eskaintzen du.

Introduction

Unlike a research-based article, the aim of this paper is to offer a general overview of the changes that are taking place in the Basque Health Service, based on the experience of the authors in the management of language services. Some statements and assumptions need to be carefully considered because they are based on internal data analysis. New concepts such as “normalization of care” had evolved in the Basque Country as a theoretical framework, with a lack of operational definitions. The Basque Health Service-Osakidetza uses the term ‘scheme’, which could be unusual for those unfamiliar with the Basque system, and it could be considered as equivalent to strategic plan.

Linguistic diversity is a shared heritage of humankind, and there are approximately 7,000 languages believed to be spoken in the world (Crystal, 2007). Given this, health care delivery usually takes place in a context of linguistic and cultural diversity, and communication between health professionals and users of different linguistic backgrounds during the care process is common. Similarly, migration has become a global phenomenon, increasing from 150 million migrants in 2000 to 214 million in 2010, which in turn is reflected in public

sectors such as health care (Renzaho, Romios, Crock & Sønderlund, 2013). Consequently, migration, from which language cannot be separated, has been considered the main driving force for language services in health care defined as “the services or personnel an organization provides to bridge a client’s language barrier” (Squires, 2017, p. 5). Although there is a growing body of evidence in this field, little research has been carried out in bilingual settings, like Wales or the Basque Country, where indigenous languages are minoritized. After centuries of oppression, Basque is spoken by only 37% of the population in the Basque Country, and it has not benefitted from the same status as Spanish or French. Whereas Spanish is compulsory to work as a health professional, finding qualified bilingual professionals who speak Basque remains a challenge; therefore, health care in Basque is seldom offered, even though it is an official language. Comparable situations have been described in other bilingual settings like Canada (Drolet *et al.*, 2014), where a shortage of staff capable of offering services in French has been identified. Consequently, language barriers can affect not only migrants, but speakers of an official language in a minority situation as well, leading to health inequities (de Moissac & Bowen, 2018).

Evidence shows that members of minority groups are more likely to receive lower quality services (Bowen, 2001; Flores, 2006; Johnstone & Kanitsaki, 2006; de Moissac & Bowen, 2018). Patients with limited English-language proficiency in settings in which English is the majority language of service has been associated with higher risk of adverse effects (Flores, Laws, Mayo, Zuckerman, Abreu, Medina & Hardt, 2003; Barton, Schmajuk, Trupin, Graf, Imboden, Yelin & Eisenstein, 2013), increased risk of non-compliance with treatments, longer lengths of stay at hospitals (Lindholm, Hargraves, Ferguson & Reed, 2011), or decreased satisfaction and experienced frustration (Steinberg, Valenzuela-Arauzo, Ross Decamp, Zickafoose & Kieffer, 2016). As Madoc-Jones and Dubberley (2005) and Roberts and Burton (2013) have pointed out, language barriers in health care could be particularly relevant for vulnerable people, such as children, the elderly and patients with mental health problems or cognitive impairment. Some studies have suggested that the use of the patient’s mother tongue by providers have significant influence on patient satisfaction and perception of the quality of service provided (Gonzalez, Vega & Tarraf, 2010), as well as patient engagement in prescribed treatments (Detz, Mangione, Nunez de Jaimes, Noguera, Morales, Chi-Hong & Moreno, 2014), and could be viewed as essential to effective communication.

Due to the lack of available official language professionals, qualified interpreters have been considered as an alternative (de Moissac & Bowen, 2018). Many authors have drawn attention to the fact that professional interpreters have a positive impact on the clinical process and outcomes, and also contribute to greater satisfaction and perceived quality of medical care for patients and health professionals alike (Karlner, Pérez-Stable, & Grigorich, 2017; Bagchi, 2011; Green, 2005; Kuo & Fagan, 1999; Lee, Batal, Maselli, & Kuttner, 2002). The accuracy and respect for confidentiality that interpretation services demand cannot be

achieved through the use of ad hoc interpreters (Flores, Laws, Mayo, Zuckerman, Abreu, Medina & Hardt, 2003; Jackson, Nguyen, Hu, Harris, & Terasaki, 2011). It has been pointed out that the provision of professional interpreters outweighs the costs (Divi, Koss, Schmaltz & Loeb, 2007; Partida, 2007). However, all of the studies mentioned address LEP (limited English proficiency) patients. It could be argued that there is a paucity of evidence on the impact of interpreter in many bilingual settings with two official languages. As Jacobs and Diamonds (2017) have highlighted, the subject of language barriers may vary within and between countries, due to the different political and cultural features of nations and linguistic groups. In this sense, the relationships between language communities may be harmonious, problematic or conflictive, following Bourhis' Interactive Acculturation Model (Bourhis & Montreuil, 2017). As such, the historical background and sociolinguistic features of the Basque Country could restrict the use of interpreters for Basque speakers. It should be noted that the Basque Country experienced three civil wars during the 19th century, a civil war during the 20th century (1936-1939), and an armed political conflict from 1959 to 2011 with over 1,000 people killed. The Spanish Constitution of 1978 makes the use of Spanish compulsory, and in France the only official and mandatory language is French. The public, educational and institutional use of the Basque language was forbidden until 1975, as well as the use of Basque symbols. Traditionally, there has been an assumption that everyone speaks the Spanish language, and the use of interpreters has not been considered, except when language barriers arise in dealings with migrants with low Spanish proficiency. For decades, the lack of proficiency in Basque has not represented an actual need for many clinicians, board directors and stakeholders. On the other hand, Basque speakers would be unlikely to accept interpretation services, and may even consider the idea as outrageous. No interpreter services have ever been offered to Basque speakers, and they have never been requested. Spanish has always been the working language in health care organizations, and clinical records and diagnostic tests are only available in Spanish. Every health professional in the Basque Health Service-Osakidetza is required to speak Spanish, so the topic of language barriers among professionals has never been considered.

As health professionals, scholars and language services managers, the authors acknowledge that there is strong evidence linking language and quality of care. They observe that there is an increased demand for health services in the minority language (*i.e.*, language concordance between users and providers), as well as growing demand for clinical records in Basque by both professionals and users, but not for interpreter services. It could be argued that the historical background of the Basque Country and growing demand for health care in Basque makes our setting quite different from that of other countries, where the relationship between health care and language has been studied.

In this context, bilingual pathways have been proposed as a tailored approach for providing health care in the patient's mother tongue, including medical records and, at

the same time, avoiding language barriers (Montes Lasarte, 2015; Tolosa, Montes Lasarte, Petralanda & Agirregoitia, 2017). A bilingual pathway would be an established protocolized clinical pathway from primary to specialized care, in which patients' preferred language and bilingual professionals are identified, so that language concordance between user and provider is ensured at all levels of care, and in which the minority language can be adopted as the working language.

Basque Language Schemes: Background of the Legislative Approach

The Basque Country (Euskal Herria in Basque) is a small country in Europe that is not recognized as a nation. It has its own language, called euskara by native speakers (Basque in English or French), and is an isolate language, the only remnant of languages spoken in southwestern Europe before the region was Romanized (Michelena & De Rijk, Encyclopedia Britannica). Its origins remain unknown. The Basque language straddles the boundary between France and Spain, and its speakers call themselves 'euskaldunak' or 'those who speak Basque', regardless of their origin or where they live. In France, it is spoken in the department of Pyrénées Atlantiques. In Spain, the Basques are under different administrations or autonomous regions, which, in turn, affects the status of the Basque language. It is an official language only in the Basque Autonomous Community (called Euskadi) and northern Navarre, but not in southern Navarre nor in France. In the last thirty years the language has made progress and gained almost 300,000 speakers (Baztarrika, 2010, p. 176), with more people speaking Basque now than thirty years ago. Today, 27% of the population in the Basque Country, or Euskal Herria (including Euskadi, Navarre and the French Basque Country), speak Basque; 14,7% understand it, and about 58% are French or Spanish unilinguals. At present 800,000 people speak Basque to some extent in both France and Spain, and almost 20% of the population in the Basque Country use it on a daily basis (Soziolinguistika Klusterra, 2015).

The Autonomous Community of Euskadi is bilingual, with a population of approximately 2,100,000 people and two official languages, Spanish and Basque. Here the percentage of Basque speakers rises to 37%, whereas approximately 19% understand the language and 44% speak Spanish only. The Basque Health Service-Osakidetza, is in charge of the provision of public health care services, and offers free, public universal care, at every point of delivery. The funding, planning, managing and regulation of the health system are the responsibility of the Basque Ministry of Health. Currently organized into 13 Integrated Health Organizations (IHO), Osakidetza has adopted an integrated approach, by merging hospitals and primary care units to achieve better quality of care, and improve patient safety and efficiency.

When we refer to Basque Health Service-Osakidetza, we exclude private health care. The private health services, incurred by citizens primarily through private insurance, represent 26.8% of the total health care expenditure (Arauzo, 2018), and are excluded from considerations in this article, the focus of which is public health.

Passed in 1979, The Statute of Autonomy of the Basque Country, recognized Basque, together with Spanish, as an official language, through the Language Normalization Act (*Básica de normalización del uso del euskera*) of 1982. Accordingly, Basque citizens have the right to receive service in Basque in their interactions with public administration. In turn, Decree 67/2003 (*Decreto 67/2003*) is the legislation governing the application and implementation of the Language Normalization Act in health care. This Decree established the aims, priorities and key measures to start the process of normalizing the use of Basque in Osakidetza, which are the foundations of the language schemes. The term ‘*normalization*’ could be considered a concept used in Catalonia and the Basque Country, which is likely not used in other settings, and it is not interchangeable with other terms like regularization or standardization. The term ‘*normalization*’ implies placing the Basque language at a level of equity with Spanish or French, to attain the same legal status and use in all spheres of daily life and public administration.

Taking into account the sociolinguistic features and legal framework in which it carries out its activities, the Basque Health Service-Osakidetza has developed its own language schemes, the first in 2005 and the second in 2013. Basque Language Schemes are a set of measures and recommendations designed to progressively improve bilingual care, over a six-year periods. It should be noted that the first Basque Language Scheme was launched in 2005, 22 years after the foundation of Osakidetza, which implies a considerable delay in the normalization process of the Basque language, in comparison to other fields of public administration. Additionally, it was developed by language management officers, without the participation of patients and clinicians. No scoping review of the existing evidence on language and healthcare was undertaken as a basis for its development. For this reason, it could be argued that the first Language Scheme was clearly legislative oriented.

For the implementation of bilingual services, the Scheme established three levels of priority. Services defined as priority 1 (mostly primary care and paediatric units) were required to provide bilingual services during this period (2005-2011). Units defined as priority 2 (broadly specialized units) were required to establish various levels of bilingual service offerings, with a gradual increase in availability over time. Units defined as priority 3 (primarily administrative and general services) did not have to fulfill any requirement. It should be noted that these priorities were established within the sociolinguistic landscape, taking into account the characteristics of each unit, rather than patient needs. For instance, pediatric mental health service and adult neurology units, which deal with

extremely vulnerable patients, were assigned a priority 2 level, or were excluded. Patient safety was not mentioned or included in the language planning. The first Scheme focused on bilingual signage in health care facilities and increasing the number of staff members with accredited language profiles or requirements that were aligned with units priorities. The policy on language profiles will be described later in this paper when examining the rationale of the bilingual pathways.

The first planning period ended in 2012, with a one-year delay, due to difficulties encountered during the mid-term evaluation of 2010 and the need for corrective measures, which made it impossible to carry out the final evaluation in 2012. User surveys, a thorough examination of external and internal signage, and focus groups and interviews in which 765 staff members took part were used for the 2013 evaluation. When the first Language Scheme was completed, a gradual advance in the normalization of the use of Basque was noted (Osakidetza, 2013a). This progress was mostly attributed to image (signage) and an increased knowledge of Basque among employees, since, in order to hold certain positions, knowledge of the Basque language was required and Osakidetza provided resources to this end. The number of employees holding the accredited language requirement for their positions was doubled in 6 years. Accordingly, bilingual information services began to be offered in various services, mainly in the area of admissions. To a lesser extent, bilingual services were also offered in primary care, hospital nursing services and hospital emergency services.

In terms of the Scheme's implementation process, vast differences among organizations were found; and the sociolinguistic features of the catchment areas in which integrated care units carry out their activities were identified as a key determinant. Despite the achievements, some weaknesses were clearly pinpointed. Firstly, there was a lack of leadership and a need for a greater commitment of board directors and managers, since they were responsible for transmitting the guidelines and integrating them into the daily activities of their organizations. Secondly, the need for a proactive offer of bilingual services (*i.e.*, to be one step ahead of public demand, without leaving the responsibility of requesting language appropriate services to patients and users) was highlighted.

Clinicians stressed the need to align coming schemes with the modern paradigms and conceptual frameworks of health care. Although the use of the minority language in health settings has been suggested as a driver for the revitalization process of minority or endangered languages (Montes, 2016), concomitantly the term '*normalized care*' has been proposed as an adequate approach for health care settings, instead of the more likely controversial concept of language normalization or revitalization, considering the historical background of the Basque Country and its risk of social disruption. From a Basque perspective, and taking into account that Osakidetza follows an integrated care model, normalized care has been defined as an "indarrean eta eskura dagoen ebidentzia zientifikoan oinarrituriko eta,

aldi berean, pertsonan zentratutako osasun arreta eredu integratua; edonon, edonoiz, maila guztietan, ahoz zein idatzizko komunikazioetan [evidence-based, person-centered, integrated care that is delivered in the patient's language at any time and anywhere, at all levels (primary or specialized care), in oral and written communications] [loose translation]" (Montes Lasarte, 2018).

The Second Basque Language Scheme and the Paradigm Shift

The second Basque Language Scheme was approved in 2013, and it will be in force until late 2019. Its aims are based on three principles that complement each other: respect for language rights, improved service quality, and the principle of progressivity present throughout the process to normalize Basque in Osakidetza. Although there is a legal duty to deliver health services in both official languages, the Scheme recognizes probably for the first time in the Basque setting, that communication is the most important tool in the health care process. Consistently, it emphasizes that ensuring that citizens have the option of communicating in the official language in which they feel more comfortable and confident is an essential part of quality service. For this reason, its aim is to promote the use of Basque as a language of service both oral and written; this would encompass clinical records, as well as the working language of all departments and units that are required to meet the necessary conditions for this demand.

Three initiatives can be identified as key areas for enhancing policy improvements and making it possible for a change of perspective, to enable a shift from a legislative, language-rights based approach to language-appropriate, patient-centred quality health care. The initiatives would involve the following: the language choice of patients, Basque language clinical pathways (with the identification of bilingual services and professionals), and the development of bilingual medical records.

The Patient's Language of Choice

To avoid language barriers along the continuum of care, and thus provide linguistically competent services, identifying the language needs of patients has been considered a key issue (Karlner, 2017). However, not all health organizations have collected patient language data, and even then through different approaches and methodologies (de Moissac *et al*, 2017; Health Standards Organization, 2018). Although identifying patients' preferred language is a critical step, it has been handed over to registration clerks without specific training, which could lead to neglecting the importance of patient-doctor (or nurse) relationship in the delivery of care. This gap was identified by the workgroup of the Canadian Health Standards Organization, during the drafting of the Standards for Access to Health and Social Services in Official Languages, of which one of the authors has been a member. To

tackle this issue, evidence-based protocols have been suggested to collect patients' required or preferred language at every stage of care. The need for the appropriate training of the staff involved in this process has been identified, in other words, how and when to ask patients about their language of choice. At the same time, patients should be informed about their right to receive health care in their preferred official languages.

Osakidetza launched the registration of patient language choice in 2015. As the second Basque Language Schemes establishes:

Osakidetza staff will always start the conversation with the users in Basque (the greeting, first phrase or question, telephone response, etc.) and after that, if the interlocutor wishes to communicate in Basque, they will proceed the following way: at the reception, admission and information units, the language option of the interlocutor must be complied with in all the cases, without him/her being forced to express him/herself in another language nor to create any kind of awkwardness for him or her. (Osakidetza, 2013b)

This task has been conferred on clerks who do not have formal training. Currently, service users are being asked if they would like to record their preferred language. This information is clearly visible in the medical records, so that professionals can easily identify their language needs at all levels of care. By late 2018, 55% of the population had been offered this choice, of which 20% had chosen Basque, currently over 270,000 people. However, it is less than what might be expected, given that 37% of the population is bilingual. This significant shortfall warrants further investigation around the professional and organizational perceptions of language use within a minority context. Although the sociolinguistic features must be taken into account and might be crucial, the reality seems more complex. Available data in the Basque Country suggest that the role of professionals could be a determinant factor, and there is a considerable room for improvement.

In 2018, in the catchment area of Aramaio (Debagoiena Integrated Health Organization) 68% of the users chose Basque as their preferred language, while 13% chose Spanish and another 19% had not been asked or had not answered. In the town of Elgeta, 67% chose Basque, 17% Spanish and 16% had not reported. It should be remarked that in both towns, registration was carried out by committed bilingual primary care doctors, not clerks. In stark contrast, in the surrounding towns with similar sociolinguistic features, it has been carried out by clerks, with different outcomes: in Antzuola, only 49% of the patients chose Basque, 38% in Bergara, 59% in Oñati and 39% in Leniz. This seems to be in keeping with the challenges identified for Francophones who live in minority contexts in Canada, who usually do not request services in French, even though it is an official language (Drolet, Bouchard, Savard & Van Kemenade, 2017) and their preferred language. Some of the reasons for this include linguistic insecurity, fear of not receiving services in a timely manner, the assumption that it is not possible to receive health services in one's mother tongue, or that the care they will receive in French could be of lesser quality than in English.

Therefore, beyond programs and schemes, the need for leadership and commitment have been proposed as useful tools, as well as including language awareness and active offer in the ongoing training of health professionals. Active offer has been defined as a “verbal or written invitation to users to express themselves in the official language of their choice. The active offer to speak their language must precede the request for such services.” (Bouchard, Beaulieu, & Desmeules, 2012). It seems reasonable to assume that Basque speakers could feel uncomfortable choosing their mother tongue as their preferred language, if this option is not actively offered, or if it is being asked by clerks, instead of primary care nurses and doctors. In an attempt to resolve this problem, ongoing training on language awareness has been proposed, through summer courses, and degree projects, massive open online courses (MOOCs) and even as a subject of the medical degree program. In this regard, a postgraduate course will be carried out in 2020 at the University of the Basque Country (UPV/EHU) in partnership with the Udako Euskal Unibertsitatea (UEU) and the Basque Health Service-Osakidetza. The aim of the postgraduate is to make health care professionals aware, by acquiring evidence-based competencies, of the importance of languages in health care, and thus to be in a position to provide appropriate language practices as they progress in their career. The ultimate goal of this training is to create ‘active agents’, or health professionals who are involved with the active offer, and who would encourage minority communities and patients to use their language of choice in health care settings at all levels.

Clinical Pathways in Basque

Clinical pathways in Basque could be regarded as the major Basque contribution to language appropriate health care. We will explain their rationale in a concise manner. The shortage of bilingual health professionals has been identified as one of the greatest barriers to language appropriate services in a minority context (Savard *et al*, 2017; Steinberg *et al*, 2016), and the Basque Country is not an exception. Language concordance between patients and providers is recognized by health systems as the gold standard for the provision of health care (de Moissac & Bowen, 2018; Ohtani, 2015), and this has been the approach to the language issue in the Basque Health Service.

Osakidetza has made great stride in recent years to improve the number, or percentage, of bilingual professionals through language accreditation programs. In late 2018, the number of employees with language proficiency sufficient for their position was 46.6% compared to 31.7% in 2013. Of these professionals, 87% are directly involved in medical care and 13% in administration. The Basque Language Scheme establishes that staff members could be required to fulfil language requirements, called language profiles, assessed on four levels. Staff over the age of 45 who have not yet accredited language profiles can be spared of any requirement. At the organizational level, three levels of priority have been appointed, with the highest level being assigned to primary care, the second to specialized

care and the third to administrative and general services. Consequently, the mandatory fulfilment of a minimum percentage is established for every health care unit. Regarding primary care, language requirements are determined by the percentage of Basque speakers in the populations served by each unit, and the staff category concerned. For instance, in areas where over 70% of the populations speaks Basque, all staff in admissions must be bilingual; in addition to 80% of the staff in paediatric services or paediatric nursing, general medicine and occupational health. On the other hand, in specialized care the number of positions with language requirements is significantly lower, about 60% in the above-mentioned areas. In 2018, knowledge of the Basque language was mandatory for only 39% of Osakidetza positions.

This approach, based on sociolinguistic features and percentages, has been strongly criticized by clinicians (Montes Lasarte, 2015), mainly because it is not aligned with the contemporary paradigms in medicine. Firstly, the opportunity of language concordance between user and provider may be left to chance, and the likelihood of this opportunity decreases significantly if a minority language speaker lives in a predominantly Spanish-speaking environment. Secondly, the possibility of language concordance may vary based on a variety of factors, such as the type of medical specialty, location, and the characteristics of the health facilities, all of which are unrelated to the patient's language or health needs, and which could hardly be considered patient-centred. As a result, vulnerable patients (the elderly, persons with mental health problems or cognitive impairment) could be excluded. For instance, palliative care units have not been given priority. Finally, there is no evidence demonstrating that language profiles ensure language-appropriate services along the continuum of care, if no other specific measures are taken. A patient-centred approach, focused on patient needs and prioritizing vulnerable people, has been preferred as a more pragmatic and effective approach, rather than the traditional one based on sociolinguistic features and legal frameworks. For these reasons, bilingual clinical pathways have been proposed, as a suitable, effective and tailored approach to offering appropriate language services (language concordance) along the continuum of care in an official language minority context.

The first bilingual pathway was established in 2015 in the adult urology unit of the Debagoiena Integrated Health Organization, and at the same time in the paediatric urology unit of the Araba Integrated Health Organization. Pathways are initiated from general practitioner (GP) surgeries. Medical consultations, information booklets, test results and informed consents are all bilingual. When specialized care is needed, an on-line request to the specialist is made, in which the language preference of the patient is clearly visible. During the first year, 987 consultations in Basque were counted in the Debagoiena unit, or 21.3% of the total (Tolosa *et al*, 2017). These figures partially reflect the sociolinguistic features of the catchment area where, although 60.5% are Basque speakers, only 28.3% use the language on a daily basis. Considering that 25% of the urologists in this unit were fluent

Basque speakers, only 56% of these patients could be offered the full pathway in Basque, which, once again, reaffirms that the shortage of bilingual professionals is a key challenge for providing language appropriate care. The most remarkable results were found among the Araba IHO users in the paediatric urology department, where 18,6% of consultations were made in Basque. Considering that just 23% of the population speaks Basque, this appears to be considerably high. All those who requested provision in Basque benefited from this service, as all the urologists at this unit were bilingual, and 100% of the patients asserted their satisfaction with the pathway. Although patients were given assistance in Basque, the majority of online notifications between consultants were responded to in Spanish. In other cases, both referral and response were written exclusively in the minority language. Basque language pathways have shown their effectiveness to measure the number, or percentages, of patients who receive care in their mother tongue, compared with other departments in which there are bilingual professionals available but pathways have not been established (Petalanda, 2018). It could be argued that language profiles do not ensure language appropriate care, but language pathways could do so. The second Basque Language Scheme has included the need for bilingual clinical pathways. It establishes that:

in the case of hospital Specialist Care that has the participation of several bilingual specialists, an offer of specialisations in which care in Basque is assured will be gradually formed and expanded with the aim of eventually offering citizens a full care circuit in Basque.

At present, every unit is developing scoping studies to start up bilingual pathways.

Aligned with the pathways, Osakidetza has launched a corporate project to identify bilingual professionals and services, the aim of which is to allow citizens who cite Basque as their preferred language to learn which departments and professionals communicate in their language of choice. To this end, the Handbook of Corporate Graphic Identity has been published. The aims and measures to normalize the use of Basque will be included among the quality requirements highlighted by the Annual Procurement Programme which, every year, defines the relationship between the Basque Ministry of Health and Osakidetza. The percentage of services or units of a priority nature that have been identified as bilingual is precisely one of the indicators of quality, with a mean compliance of 81% in 2018. This measure allows the patients to easily identify those services that offer language appropriate care, filling the gap of the previously-mentioned approach on percentages; and it could be regarded as essential to implementation of the bilingual clinical pathways.

The Challenge of Bilingual Medical Records

A third policy improvement has been developed with the proposition of bilingual medical records. For this purpose a workgroup on bilingual clinical records was established in 2013, which concluded that there were no legal obstacles to recording medical histories

in Basque. The patient is the owner of her or his records and, consequently, has the right to receive clinical records in the official language of choice, which could enhance the quality of care. The workgroup stated that the Basque Health Service—Osakidetza—has the full responsibility and obligation to provide medical records in the preferred language of the patient. Some circumstances can address this challenge. For instance, all health professionals at every unit at all levels—from primary care to specialized care—share the same electronic clinical records, available in both official languages. Also, close to 50% of staff are currently bilingual, and, remarkably, over 80% of those are under the age of forty. At the same time, there is increasing demand for medical records in Basque, both among users and clinicians. However, Basque is not a commonly used language between professionals, as the bilingual pathway at the urology unit demonstrated in 2015.

The issue of electronic medical records in the minority language reflects two big challenges. Firstly, at least in the case of Basque language, that has been minoritized and isolated for centuries and which has traditionally been limited to oral use, there is a lack of standardized terminology.

Moreover, for decades, bilingual doctors have received training exclusively or primarily in Spanish, and, although fluent in Basque, they experience difficulties when writing medical documents in Basque. Secondly, many doctors and nurses do not understand Basque, which brings to the fore the shift from language barriers between users and providers to language barriers among professionals. This could be regarded as a patient safety hazard.

Conscious of these challenges, an algorithm for semiautomatic translation has been proposed by the IXA multidisciplinary research group (Perez de Viñaspre & Oronoz, 2015), using SNOMED CT terminology, and has been approved by the Basque Health Service—Osakidetza in partnership with the University of the Basque Country (UPV/EHU). Its aim would be to strengthen the use of Basque in the biomedical area, by offering health professionals a vast base of standardized terminology, while avoiding safety issues. Over the past two years, artificial intelligence has revolutionized machine translation through neural networks and machine learning (Etchegoyhen *et al.*, 2018), greatly improving the quality of translations. The main hypothesis of the above-mentioned research project is that if Osakidetza manages to train the system with actual bilingual clinical texts, it may count on a reliable and rigorous clinical text translator for Basque and Spanish in the future. At the end of 2020, results will show whether the hypothesis is confirmed.

This topic remains controversial, and two approaches are under discussion. As seen above, semiautomatic translation has been proposed as a practical and affordable solution. On the other hand, prioritizing the pathways that encourage health professionals to write clinical records in their patients' preferred language (*i.e.*, in Basque or Spanish) has been proposed (Montes, 2018a) as a more equitable approach. It would be aligned with the

capability-based approach, described by Lewis (2017) as a tool for achieving what is defined as linguistic justice, that is, “the establishment of background conditions under which people have an opportunity to use their favoured language and to strive for its continued success and survival”. To have medical records *artificially* translated from the minority language to the majority language, in an environment where medical records have always been unilingually Spanish, could be controversial for many patients and health professionals. Although the aim of the semiautomatic translator would be to avoid safety issues, it could have the opposite effect in the view of one of the authors of this paper. In his view, it could send the message to patients that this type of care (*i.e.*, in their mother tongue at all levels) might compromise their safety and wellbeing, thus worsening their linguistic insecurity, anxiety, concern, and negatively impacting their minority identity, particularly for those in a vulnerable condition. In this regard, though the drafting of bilingual records has been identified as a tedious work and a misuse of their time (Perez de Viñaspre & Oronoz, 2015) it should be noted that health professionals who write clinical records in Basque do not write them in Spanish simultaneously. It does not mean that every patient’s records are bilingual, but rather that the record of every patient is written in the language of choice. Establishing protocolized language pathways, where language concordance is ensured along all points of the continuum of care, could foster a work and service environment where medical records are actively offered to official minority language speakers, on a basis of patient safety, equity and linguistic justice. Translation accuracy brings another concern: an inadequate translation might pose a patient safety risk, if language concordance is not ensured.

Conclusions

Whereas it has its own specificities, the Basque Country is a bilingual setting, that shares a common cultural framework with Canada and Wales. Two clearly differentiated official languages are present, with Basque as a minority language. A compelling need to ensure health care in patients’ preferred language is arising, strengthened by legal requirements and social commitment. In recent years we have witnessed a shift from a legislative approach to a patient-centred one, with the involvement of clinicians and a focus on quality and patient safety.

Little research has been done in the Basque Country in the field of language and health care. More research is required, with a focus on the issues faced by health professionals and patients in a bilingual context: their experiences, challenges and opportunities, and scoping-approaches that could be more effective to tackle the issue of language barriers are also required. The authors suggest considering this issue from within a strategic framework, with the prospect of making the Basque Health Service-Osakidetza a leader and reference in the field of language appropriate health care in a bilingual setting. Taking into account our

growing number of bilingual professionals this topic has great potential, in terms of developing national and international collaborative work relationships and research, in partnership with other bodies and institutions in the Basque Country, Wales, Finland and Canada.

Identifying the language needs of patients, actively offering health care in the minority language through bilingual pathways, and clearly identifying bilingual services and professionals could be seen as the current Basque approach to language appropriate care in an official language minority context. Bilingual clinical pathways have proven to be more effective than the traditional model of language profiles and requirements, suggesting that recruiting bilingual staff alone does not ensure language appropriate health care, if no other specific measures are taken.

The shift from language barriers between users and providers to barriers among professionals seems to be another novel contribution of the Basque setting. It makes it perfectly clear that language barriers are the entire and exclusive purview of the health services provider. Currently, it remains a controversial issue that must be addressed, with two approaches: bilingual clinical pathways and semiautomatic translation. Both options could be considered complementary, with the ultimate goal of actively offering health care to official minority language speakers at all levels, both oral and written (including electronic medical records), from primary to specialized care, or what has been defined as a ‘*normalized care*’. However, language justice, seen as the establishment of fair background conditions under which people have the opportunity to use their preferred language should be a priority as well, and expressly, in the field of health and social care. Considering the sociolinguistic features of the Basque Country and the bilingual workforce of Osakidetza, the Canadian active offer may have found a noteworthy testing ground across the ocean, in a place where quality of care, patient safety, equity and linguistic justice may go hand in hand. Titan is already stirring his feet.

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Keywords

patient-centred care, bilingual pathways, language appropriate care, preferred language, active offer

Mots clés

soins centrés sur le patient, parcours bilingues, soins dans la langue de appropriée, langue préférée, offre active.

Palabras clave

atención centrada en el paciente, circuitos bilingües, atención lingüísticamente adecuada, idioma de preferencia, oferta activa

Gako hitzak

pazientean ardazturiko arreta, zirkuitu elebidunak, hizkuntza aldetik arreta egokia, lehenasunezko hizkuntza, eskaintza aktiboa

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