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Introduction

Bernard Spolsky opens his 2004 volume reporting a short story published in the Sunday Telegraph (27/08/2000) about a Turkish woman who was refused a heart transplant in Germany, on the grounds that her lack of German would make the recovery process more dangerous, because she might not be able to understand doctors' orders or explain herself effectively were there to be complications. This incident, Spolsky argues, points to the fact that 'doctors and hospitals make language policy when they decide how to deal with language diversity' (p. 1). It also shows the critical consequences that language proficiency, or rather the lack of proficiency, can have for patients. Although not all medical cases will be of such gravity as the above example of course, it does bring home the point that having mechanisms in place to deal with cases where patients have limited proficiency in the host language is of critical importance.

This paper will look at the Irish context and explore the way in which the Irish Health organisation, Health Services Executive (HSE)[1], has tried to respond to the communication challenges posed by the increasingly multilingual and multicultural profile of the population in Ireland. This changing sociolinguistic situation is a result of the growing economic prosperity of Ireland since the early 1990s, which transformed the country from a country of emigration to one of immigration. Indeed according to the 2006 census[2], non-Irish nationals amounted to around 10 per cent of the total population (10.2 per cent or 414,512), concentrated mainly in urban centres (76 per cent). A total number of 188 countries was recorded in the census; the main countries of origin being, in alphabetical order, China, Germany, Latvia, Lithuania, Nigeria, Poland, UK and USA (with over 10,000 individuals).

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1 The HSE is responsible for the running of all the public health services in Ireland. It is by far the biggest public organisation in the country, having both the largest budget, approximately €12 billion, and employing over a hundred thousand people. Before its establishment as a single body in 2005, health care services were delivered through a range of different agencies, which worked independently and answered to the Department of Health and Children. The HSE services are now organised around four regions: Dublin Mid Leinster, Dublin North East, West and South.

2 Reports available at http://www.cso.ie/census/Census2006Results.htm (last accessed on 13 July 2010).

One of the challenges facing the HSE, as many other health bodies elsewhere, is the presence of individuals with limited or no English language proficiency. The HSE, acknowledging that linguistic and cultural barriers can have a negative impact on access to, and delivery of, quality health care, has taken a number of initiatives that target service users who speak little or no English. Adopting a language management approach, and using mainly a variety of documents produced by, or relevant to the HSE, this paper will attempt to trace the process of management and discuss its rationale and objectives. Given that such a discussion would be incomplete without reference to the broader language policy and planning landscape in Ireland, which has centred traditionally on the maintenance of the Irish language, the discussion section at the end of the paper will juxtapose the HSE's approach to immigrant languages with its approach to Irish. As we will see, although Irish is part of the linguistic diversity the HSE has to deal with, it is managed differently because it is of a different nature and stems from different imperatives. While the focus of the paper is not on Irish, some comparative points will help elucidate further the HSE's initiatives with regard to other languages.

2 A language management approach

This paper is informed by Language Management Theory (LMT), initially developed in the 1970s and 1980s by Neustupný and Jernudd as a response to language planning theory and practice. Although language management as a term is sometimes used as an alternative term for language planning (Spolsky 2008), within LMT the latter term is reserved for the specific historical period of planning after the decline of the colonial system, 1960s–1970s, which was an essential part of the process of modernisation and development in the newly established states. Language planning as a term has of course continued to be used, but it now covers a considerably larger scope of linguistic and social problems, with researchers having moved away from the assumption that language planning is an ideology-free process carried out by language experts with the aim of achieving maximum efficiency and optimal utilisation of this societal resource (Duranti 2003; Kaplan & Baldauf 1997; Nekvapil 2006). LMT, however, which was elaborated almost contemporarily, was an attempt to broaden the scope of study from language problems in the narrow sense of the word (e.g. language codification, elaboration etc) to the study of a wider range of language problems that involved discourse, politeness, intercultural communication and so on (Neustupný & Nekvapil 2003; Nekvapil 2006). At the same time, it acknowledged language management as a political process to

which various individuals and groups bring different interests and ideologies and have different access to resources (Nekvapil 2006).

LMT as a distinct theoretical approach is based on a set of key features which will guide the discussion in this paper. The first is a basic distinction between what is called *simple* and *organised* management. Simple management is the management by a speaker of problems that appear in the here and now of a particular interaction (e.g. an individual's attention to his/her own or their interlocutor's use of pronunciation, gender or politeness forms, honorifics etc). Organised management occurs at a higher level and is more complex and systematic and can involve public, or wider, discussion which may lead to specific guidelines, regulations and so on. According to Nekvapil (2006), within a LMT approach language *micro*-planning can be identified with simple, interaction-based management, and language *macro*-planning with organised language management (of various complexity). Language management theorists have argued that LMT bridges the gap between the micro and macro dimensions as it focuses on their dialectical relationship (see Nekvapil, ibid). In Neustupný's (1994: 50) words: '[…] any act of language planning should start with the consideration of language problems as they appear in discourse, and the planning process should not be considered complete until the removal of the problems is implemented in discourse'. Importantly, LMT is concerned with, and applies to, not only activities pertaining to the whole society, but also subsections in the form of individual companies, schools, organisations, as well as individual persons. Given that this paper studies the activities of one type of organisation in one domain (i.e. Health), whose language-related activities are purported to be based on, and aim to solve, language problems which appear in the communication between medical staff and patients with little English, LMT provides an appropriate theoretical frame with which to approach the management of linguistic diversity by the HSE in Ireland. The extent to which this management, however, influences *actual* interaction in such encounters is not dealt with here and is a matter which needs to be investigated.

A second key feature of LMT is its focus on processuality. The management process is distinguished in four main stages: *noting* a deviation from expected norms, *evaluating* it, making adjustment plans (*planning*), and finally *implementing* the adjustment. These procedural stages apply to both simple and organised management.

Finally, LMT argues that language management in itself makes little sense if it is not placed in a broader context where the aim is to remove 'problematic' language features both from actual communication and from the socioeconomic structure. Therefore, according to LMT, all three types of management should be targeted at the same time. In fact, Neustupný and Nekvapil (2003: 186) posit

a hierarchical relationship between the three with the right sequence being *'Socioeconomic Management > Communicative Management > Linguistic Management'*. Adapting this to the context of this paper, we could say that successful linguistic management (in terms of learning English) depends on the establishment of networks with the local population where foreign nationals can hear, learn and speak the language (communicative management), which in its turn depends on the provision of opportunities for work and social participation (socioeconomic management) (see Nekvapil 2006).

3 Dealing with language diversity in the Health Services

There is currently no legislation or explicitly stated overarching guidelines in place in Ireland that regulate the use of languages other than Irish. Public, and private, organisations faced with the challenges presented by an increasingly ethnically and linguistically diverse population have attempted to find their own effective, functional solutions. The government, however, acknowledging the need to cater for the linguistic needs of incoming foreign nationals and improve their access to services, has encouraged individual organisations, including the HSE, to put in place their own guidelines and policies, supporting and funding related research and initiatives. Successful communication is not only language, however so, such initiatives which target individuals with limited English fall within a broader strategy for culturally sensitive provision of health care, which in its turn falls within a more encompassing project of intercultural awareness and facilitating integration.

The discussion here is based on a number of documents prepared by, or related to, the HSE (reports, guidelines, other material) some of which are available on its website[3] and as well as a smaller number of documents on Ireland's integration strategy. It also draws on some interviews with health practitioners, which although conducted within the context of another study on the implementation of the Official Languages Act (2003) which focuses on the use of Irish and English in public bodies, include references to other languages in Ireland and to experiences of health provision to foreign nationals. I will first address noting and evaluating the situation (i.e. linguistic diversity, service

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[3] HSE website at: http://www.hse.ie/eng/.

users with limited English) at the level of organised management, and then discuss the measures with which the HSE has tried to overcome communication barriers and facilitate information and access to its services to speakers of other languages.

3.1 Noting and evaluating communication difficulties

On the basis of LMT we have outlined above, simple management of linguistic diversity occurs during the actual interactions between health staff and patients with limited English. Then, ideally, organised management undertaken by the HSE should be based on management at the interactional level. This paper does not examine the latter although as we will see here there is evidence in the written documents that this is indeed the case. At the level of organised management, noting and evaluating a divergence from expected norms signals the HSE's realisation of the presence of people from diverse linguistic and cultural groups. Some of these have little English, which poses a challenge both for its staff and for the effective provision of health care to such individuals.

That the measures taken by the HSE were informed by actual difficulties experienced by practitioners and patients on the ground is evidenced in specific statements in some documents. The 'Overview of the Emergency Multilingual Aid box' (HSE 2009b) states that it was the result of a pilot study and of consultations with frontline staff. Also, in the HSE 'Intercultural Guide' (HSE 2009c) we read that health staff had explicitly called for institutional support not only with regard to overcoming linguistic difficulties, but also more generally with providing health care to patients from a cultural background different from their own, who might have specific health and personal needs. I quote: 'staff consistently reiterating a need to develop their capacity to respond appropriately [...] The primary motivation in developing the Guide was to respond to this expressed need for intercultural knowledge, skills and awareness in the current working environment' (p. 11). Furthermore, quotes from staff and patients during the consultation for the HSE intercultural strategy included in the document 'on speaking terms' give a further glimpse into such difficulties and point to the importance of professional interpreters to address communication difficulties and protect patients. I cite two of these quotes:

(1) *One interpreter who had volunteered to interpret mistook the translation for gallbladder as a kidney problem; this nearly led to a loss of life. This is an example of how things can go badly wrong if there is no professional service."*

HSE Staff member to the Cork Consultation for the
National Intercultural Health Strategy (p. 18)

(2) *"When I arrived to Ireland I went to the GP and asked for medical treatment because I was severely beaten back home … my English is very poor and I need the interpreter all the time and very few people from my community with good English are willing to do it for free. Once I brought my son, who is 13, to help me with translation. I had to describe to the GP where I was injured, where they've hit me and my son got very upset because he never knew about it… It's not fair to put your children through that!"*

<div align="right">CAIRDE – Primary Care Needs Assessment 2006</div>

Interviews with HSE staff conducted by the author during a project on the Official Languages Act (OLA) provide further evidence of communication difficulties on the ground between staff and patients with limited English (Georgiou, Ó Laoire and Rigg 2010; see also Lyons *et al* 2008; Gerrish 2001). Interview participants made special reference to dealing with pregnant women and newborn babies. According to Lyons *et al* (2008), in fact, maternity services within HSE have been particularly affected by the influx of migrant workers and they report that 'the biggest issue identified by all service providers (i.e. interviewed obstetricians, key specialists, midwives and auxiliary nurses) was the inability to communicate effectively with ethnic minority women, mainly due to the women's lack of proficiency in the English language' (p. 264). The following extract from one of the interviews for the OLA project further illustrates difficulties at the interactional level, which may leave staff uncertain whether they got the message across and patients with partial information. HN denotes a public health nurse and IV the interviewer.

(3) *HN: but we have a lot of Polish in that information that we do keep separate and you know when our babies are coming in for their BCG[4] . which would be once a month we put that out*
IV: so language is an issue in some cases- maybe not Irish language but other languages coming into the picture=
HN: =OH YEAH there are a lot of different languages now particularly young babies being (x)- and you know they want information say as regards advice after an injection BCG- specific advice you know? they need to have that in their own language yeah so there are other languages definitely yeah
IV: mhm
HN: yeah it's- we don't have a lot of the ability to maybe communicate it's very unsure then you know whether you're actually getting the right message across to the person or not . they tend to be "oh yes yes" you know?
IV: yeah
HN: it's a bit like that it's hard for them to say "I don't understand" or . they tend to smile
IV: mhm

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4 BCG (Bacillus Calmette-Guérin) is a vaccination that protects babies against tuberculosis.

Identifying the need to facilitate foreign nationals' access to public services by overcoming linguistic barriers was not restricted to the HSE. This also emerged, in fact, as a strong theme in the context of the work of the 'National Consultative Committee on Racism and Interculturalism' (NCCRI)[i]. The body in question also collaborated with the HSE in the development of the latter's 'National Intercultural Health Strategy 2007–2012'.

In an advocacy paper, the NCCRI argued that low proficiency in English may entail restricted access to public services and lower quality of service, making it thus an issue of equality with potentially serious consequences, especially in the areas of health and justice (NCCRI 2007; on consequences for limited English proficiency patients in other contexts see e.g. Gerrish 2001; Robinson 2002; Bowen 2001; also the interpreting guidelines for NHS Scotland).

As a way of addressing this issue, the NCCRI called for the establishment and provision of professional, high quality interpreting and translating services. This was of vital importance, they argued, 'if people with low proficiency in English are to experience equality of access and outcomes in their interaction with key Government services such as health, justice, education and housing' (NCCRI 2008: iii). Importantly, the NCCRI clarifies that although many immigrants in Ireland may speak English or attend classes, it 'does not necessarily mean they have sufficient English to interact effectively with Government bodies; this is particularly true in stressful and critical situations, for example in a health care or justice setting' (ibid). The need to cater for the needs of persons with limited English then, led to a report published in 2008 by the Office of the Minister for Integration called 'Developing Quality Cost Effective Interpreting and Translating Services for government service providers in Ireland'. Drawing on this report and other sources, the HSE has developed its own specific guidelines for its staff on how to assess the need for an interpreter and how to access and use one ('On speaking terms' see next section). These guidelines are in fact part of the multilingual pack (EMA) the HSE rolled out in July 2009. In the section below we will look at the planning process and the rollout of the EMA in more detail, which is also in line with the HSE's 'National Intercultural Health Strategy'.

3.2 Planning and implementing

Identifying, then, the difficulties on the ground and acknowledging the need for overcoming communication barriers, at the planning stage of language management the HSE has developed the pack mentioned above called 'Emergency Multilingual Aid' Box (EMA). This, as is stated in the 'overview of the EMA'

(HSE 2009b), is the result of a pilot programme involving nine hospitals and led by the HSE Irish Health Promoting Hospitals and Health Services Network in collaboration with the National Social Inclusion Unit of the HSE. The EMA box was shaped both by international research and experience (e.g. referred sources include British Red Cross Society and NHS Scotland) and by interviews conducted with frontline HSE staff. The stated purpose of EMA is twofold. First, it aims to help *staff* communicate more effectively with such patients, and second, it aims to help *service users* by improving access to health and care services. The pack consists of:

– A *language identification card* which contains the twenty languages, including Irish, identified as the most widely spoken in Ireland at that moment (appendix 1); as an initial step to help staff ascertain the main language of a patient with no English.
– A set of guidelines entitled *'On Speaking Terms'*, which outline the importance of using professional interpreters and instruct staff when and how to access and use them.
– Twenty *phrasebooks* containing common questions and statements that health practitioners use with patients during various procedures, e.g. admission, assessment, care etc, as well as some common questions that patients may have to ask doctors and health staff.
– A *CD* which contains the digital versions of all the above.

It is worth noting that although this pack is intended for use with service users who do not speak or understand English well, it must be pointed out that language identification cards, guidelines and interpreters, can also be used with non-hearing patients, or people who are not functionally literate, broadening thus its scope (HSE 2009b). At the same time, the phrasebooks and language identification cards are only intended as useful practical tools for staff while waiting for an interpreter; they are *not* meant to replace in any way the need for a professional interpreter (ibid).

The HSE's development of guidelines on the appropriate use of interpreters aimed to rectify practices whereby staff, when the need emerged, asked or accepted a patient's family member or friends to act as interpreters. The guidelines 'On Speaking Terms' were a means of raising awareness among staff of the importance of using *professional* interpreters and the dangers from using family or friends. This was presented in the Guide as a matter of good vs. bad practice respectively, the argument being built around the notions of confidentiality, accuracy (clinical translation requires specialised terminology, need to translate accurately without filtering information), neutrality (the translator is not judg-

mental and on no-one's side) and protection (especially in sensitive cases of abuse). Crucially, as example (2) above points out, the use of minors as interpreters for their family is of particular concern as it can cause feelings of stress and harm the children themselves. Therefore such practices should be avoided altogether (see Umaña-Taylor 2003 for consequences of the use of children as interpreters for their families).

The importance of using professional interpreters where appropriate is also based on the legal and ethical implications from failure to do so. First, these result when the need arises to obtain a legally required, informed consent. If patients do not fully understand medical instructions, warnings or advice, it is hard to see how they can give an informed consent for a treatment. Second, the failure to inform about, and provide access to an interpreter may constitute an act of discrimination under the Equality (2000) legislation.

The extent to which these guidelines have actually helped reduce the use of unofficial interpreters or improved access to services, or indeed the extent to which professional interpreters are used in practice, is something which needs to be investigated. On a news item in the official website the Assistant National Director of Social Inclusion, HSE said that there was considerable interest in the EMA 'from our colleagues who deliver health care in the community, such as primary care teams (GPs, Public Health Nurses, dentists etc.), mental health and social workers where they would see many patients and service users who do not speak English as their first language'. Habitual practices, however, are usually hard to break and it will take time before staff, and patients are aware of the possibility of using professional interpreters and *actually* make use of their services. At least one study in Ireland has shown that their use is still limited by general practitioners despite the fact that 77% of those interviewed said that they had consultations with asylum seekers and refugees in which language assistance was required (MacFarlane *et al* 2008). The same study also reports that when these general practitioners were given a choice they would more often choose informal over professional methods of interpretation. In our own study within the context of Official Languages Act, at least one of the interviewed practitioners has also mentioned still using the patient's friends or family if communication with the patient were difficult. Future research focusing on implementation should examine the factors that contribute to the use of informal interpreters and policy should address the question of how to *effectively* raise awareness and modify staff behaviour.

Besides the rollout of the EMA box, the HSE also makes use of its official website which now includes a 'language hub'. This section of the website features amongst the quick links and it is 'developed to provide a central point for

health service information that is available for people who are new to Ireland or whose first language is not English'[5]. At the moment apart from EMA, it contains, amongst others, copies of leaflets and guides about parenting, registering a birth, living with diabetes and information about nurses and midwives as prescribers. Furthermore, service users are provided with the possibility of making a complaint/compliment in their language of choice, from a choice of six languages: Irish, Polish, Russian, French and Chinese[6]. A complaint/compliment form is made available on the website together with relevant contact numbers and information on the procedure in a question and answer format (see examples in appendix 2).

The HSE's commitment to taking into account the diversity of the population, and hence addressing the potentially different needs and concerns of its users, is also explicitly stated in its 'Customer Services Strategy' statement (HSE 2008). Interestingly, language does not feature as one of the aspects that contribute to the diversity that the HSE needs to respond to, with the stated aspects being age, colour, race, religion, ethnicity, nationality, disability, gender and sexual orientation. This could perhaps be understood in relation to the fact that language is not included in any equality legislation, e.g. the Employment Equality Act 1998; The Equal Status Act 2000. In fact, the only language-specific requirements that impinge on the HSE as a result of legislation stem from the Official Languages Act (2003), which regulates the provision of public services through Irish and/or English. Indeed, in the Customer services strategy we find a section specifically on the OLA, where the HSE reiterates its commitment to the provisions of the Act and its full implementation. However, despite the lack of explicit reference to other languages, the latter are not completely absent from the strategy document. In fact, we find them on the front cover of the document, where the HSE motto 'your service, your say' in different languages is used as a decorative background (figure 1). This use of language constitutes a *visual* display of cultural, ethnic or national diversity, the first used to index the latter.

The next section will provide a critical discussion of some of the issues raised so far, juxtaposing the HSE's approach to other languages vs. its approach to Irish. As we will see, although the latter is part of Ireland's, and the HSE's, linguistic ecology it is perceived and dealt with differently.

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5 At: http://www.hse.ie/eng/services/find_a_service/languages (last accessed on 21 July 2010).

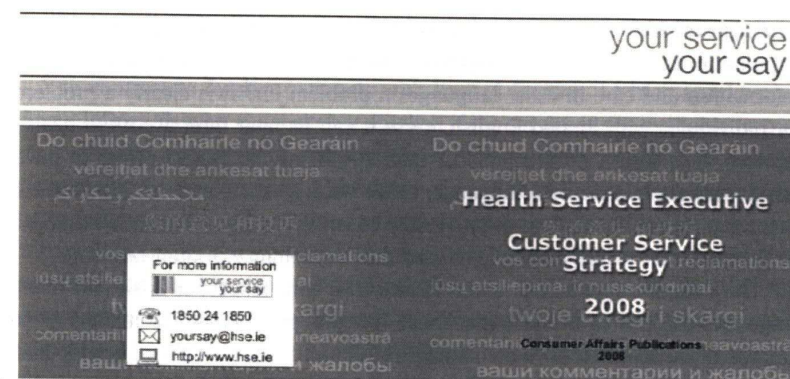**6** At: http://www.hse.ie/eng/services/ysys/Complaint/Leaflets/Leaflets.html.

Figure 1

4 Discussion

We have so far focused on the ways in which the Irish Health Services Executive has responded to the increasingly more diverse linguistic and cultural profile of Ireland, by acknowledging the need to facilitate communication in encounters between its staff and service users with limited English and taking relevant action. In light of the discussion above, we could say that the HSE has taken a *proactive* approach to managing language diversity. This section will focus on what may have prompted this proactiveness, using a comparative perspective that examines it against the HSE's approach toward the Irish language. Such juxtaposition highlights the fact that a single organisation's response to language diversity can be complex and motivated by a number of different exigencies and objectives as well as existing and potential resources. It thus can offer a more nuanced picture of language management by the HSE.

Jernudd (2010: 88)[7] reminds us that 'enquiry may begin by asking *what* exactly the problem is. And [more importantly] *whose* is the problem?'. Answering these simple questions I think reveals much about the HSE's approach to immigrant languages vs. Irish. It also links the details of a problem to actual acts of communication. So what is the problem or challenge, to put it more positively, that the HSE needs to respond to? The challenge for the HSE is the provision of health information and care in languages other than English, either to individuals whose English is very limited or to individuals whose first language is Irish, recognised as the national language and one of the two official

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7 This is from Jernudd's review of B. Spolsky's book '*Language Management*', published in Current Issues in language Planning 11/1: 83–89.

languages of Ireland but spoken as a first language only by a minority of the population. The more important question, however, is *whom* is the lack of health information and care in other languages a problem for? It is clearly a problem for individuals with limited English, since it can hamper their access to health services. It is also a problem for L1 Irish speakers who would prefer to have health services in their own language, either because some services are better if in L1, e.g. speech therapy, or because they consider it a sign of acknowledgment by the state that would also help toward the maintenance of their language.

The different approaches taken by the HSE with respect to Irish and other languages are due to the fact that these two groups of language management processes are intertwined with managing different issues; access, health and safety management in the case of immigrant languages and management of civil rights in the case of Irish. In fact, what seem to be the principle factors influencing the HSE's language management approach are the consequences from the *non*-provision of the service in a certain language, as well as how these other languages affect HSE staff and the HSE's functioning.

In the case of immigrant languages the focus is on the communicative function of language. As Neustupny and Nekvapil (2003: 318) note, 'when the communicative function of speech is not fulfilled, miscommunication occurs'. Miscommunication can occur in interactions between English speaking health staff and members of other language communities with little English. Given that the latter often have no other alternative common language to use in their health interactions, such miscommunication can potentially have serious consequences since poor communication can lead to poor diagnosis and treatment. What is important in this case then is that the correct message gets across (i.e. information, advice etc). Instead, in the case of Irish, the focus is not on the communicative function, but rather on the symbolic function of the language. The symbolic function of Irish was acquired during the struggle for independence from the British, when language was used as an identity differentiating feature from the English and vested with romantic ideas of the Irish nation, traditions and culture. After the establishment of the Irish state in 1922, language policy and planning has focused on raising the status, functions, domains and territories of the Irish language and protecting the rights of Irish speakers (see Ó Riagáin, 1997; Ó Laoire, 2005; Mac Giolla Chriost, 2005). Despite recent government policies and legislation[8], however, which impose some obligations on public

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8 Irish has gained momentum since the turn of the century, with a renewed commitment by the government, under strong lobbying by the voluntary language sector, for the promotion of English/Irish bilingualism, evidenced by the enactment of the Official Languages Act (2003), the Government statement on the Irish language (2006), and the more recent publication of a 20 year strategy for Irish.

bodies including the HSE, the latter's approach to language management seems to be the result of more 'pragmatic' decision-making processes.

In contrast to foreign nationals with limited English, L1 Irish speakers are fluent bilinguals who can switch to English if the service is not available in Irish yet, with the exception of small children, some elderly people and perhaps people who have reversed to L1 because of an illness. Furthermore, there is the assumption among staff practitioners and policy makers that there is no demand for services in Irish, despite the fact that this might also be because Irish L1 speakers are used to not having available most public services in Irish and hence might not use Irish in interaction with health staff unless they know the person can use it (Georgiou, Ó Laoire & Rigg 2010). What this means, however, is that lack of Irish does not prevent health staff from providing information and care to L1 Irish patients because they can communicate in English. Instead, the inability or difficulty of some foreign workers, asylum seekers and refugees to speak English creates immediate problems at the interactional level which may be the cause of stress and frustration for health staff. Indeed, while the demand for services through Irish has been coming principally from the Irish speaking community itself and its representatives, requests for other language material, intercultural education and interpreters has come also from health staff and associations of staff, who have experienced communication problems on the ground which hamper their work.

At the same time, facilitating access to health services is in the best interests of other stakeholders as well. For example, it is in the best interest of the state itself to make sure that all people living in Ireland feel confident enough to use the state health services. This is because in a contrary case, such individuals will most likely either not use health services at all or resort to some other illegal or dangerous in-group services and practices. In a report called 'Language barriers in access to health care' prepared by Sarah Bowen (2001) for Health Canada, she argues that there is evidence that providing language access services results in benefits: '[Not only to] patients/clients (improved diagnosis, avoidance of unnecessary interventions, better health outcomes and satisfaction), [but also] providers (less frustration, less risk of malpractice); administrators (decreased liability and increased efficiency); health system (more appropriate use of services, and improved health outcomes); and society in general (increased health and productivity of all citizens)'. Going back to the question of whose problem is a particular situation, then, we could say that the presence of people with limited English creates more immediate and serious problems for individual staff members, the service itself, and the state more indirectly, than the presence of Irish L1 speakers, hence their greater urgency in addressing their linguistic and cultural needs.

In fact, the HSE's top-down approach to the provision of information or services through Irish has been less enthusiastic. As I have mentioned earlier, the HSE is legally obliged to offer at least some degree of service through Irish as well, as stipulated in the 2003 Official Languages Act and subsequent statutory instruments. More quantity and better quality of services are expected to be developed gradually in accordance with language schemes agreed between individual public bodies and the relevant Ministry. However, the HSE has yet to develop an overarching language scheme. Such language scheme has in fact been the object of long and ongoing discussions and negotiation within the HSE and with relevant state departments (Language Commissioner private communication). This is partly because of the size and complexity of the organisation, and partly because of the HSE's reluctance to commit to further obligations that may not be able to deliver, chiefly because of lack in fluent bilingual personnel. The picture on the ground of course changes depending on the location of the HSE body; if in a Gaeltacht area then local commitment toward Irish is considerably higher, with service provision and material development in Irish going beyond legislative provisions[9] (Georgiou, Ó Laoire & Rigg 2010). However, while any further voluntarily expressed obligations toward Irish will be closely monitored for implementation by a Language Commissioner, obligations with regard to the provision of material, interpreting services and so on in other languages are not statutory obligations. This stricter supervision over the implementation phase in the case of Irish, by the office of the Language Commissioner, could have also contributed to the HSE's reluctance to actively implement the pro-Irish language policy. So, despite well elaborated adjustment plans for Irish at various levels of governance, it is the internal communication needs in relation to the immigrant languages that seem to be considered more important.

Furthermore, we cannot ignore that the provision of information and services in other languages, including Irish, is subject to costs for translation and interpretation. Cost is always a relevant and sensitive issue, especially given the tightening budgets across public sector services and departments. It is clear that the HSE cannot provide language services in all the languages spoken in Ireland. Nor is it easy to translate every single information leaflet. This is why it has identified and concentrated on the twenty most spoken languages and has focused on translating the most likely to be useful leaflets and handbooks, such as for example information leaflets on how the HSE works, how to register a

birth in Ireland, self care for people with diabetes, a practical guide on how to communicate with children and youth, which includes contacts for HSE Child Protection Services nationwide. When it comes to Irish, the HSE while stating its commitment to 'comply fully with the provisions laid down in the Official Languages Act 2003', it also hedges this commitment when stating that: 'We will provide services through Irish and/or bilingually and we will inform customers *where possible*, of their right to be dealt with through one or other of the official languages.'

Given that the capacity of the public services, including the HSE, in terms of fluent bilingual staff is limited (Walsh and McLeod 2008), both for Irish and other languages, and given that interpretation costs are quite high, we could point here to a successful programme implemented in the USA reported in Thomas and Lee (2010). The authors discuss the case of a children's hospital in Dallas facing similar issues which has responded to the challenge by tapping into, and developing, existing linguistic resources within the organisation, by giving incentives to bilingual staff to train as interpreters. While they mention that research has shown that the success rates for obtaining the interpreters' qualification are very low, the availability of some staff who are qualified interpreters goes some way toward raising the organisation's ability in responding to the needs of patients who do not have sufficient English.

Finally, the HSE's language management also begs an important question regarding the language ecology of Ireland; has the presence of other languages had a positive or negative impact on the Irish language? There are two possibilities. First, Irish and other languages compete for scarce resources and given "pragmatic" considerations Irish is losing ground. Second, the fact that other languages are now spoken, heard and debated in Ireland means that public awareness and sensitivity toward other languages (be it 'native' or 'immigrant') is greater, opening up the space for intercultural dialogue, linguistic rights and diversity. Indeed, if we look at the HSE's translated published material we find some of it, including the EMA, is available in Irish along a number of other languages: 'Emergency Multilingual Aid is available to read or download below in Arabic, Bosnian, Cantonese, Chinese, Czech, French, German, Hungarian, Irish, Latvian, Lithuanian, Mandarin, Pashtu, Polish, Portuguese, Romanian, Russian, Slovak, Spanish, Somali, and Urdu'. Muiris Ó Laoire (2006) in a note of optimism argues that Irish can have a place in a 'neo-liberal multicultural Ireland' and that 'once any antagonism to other competing languages is shed it could play a leading role in a campaign to ensure a vibrant celebration of other languages'. Only time will tell which direction it will go.

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9 With the exception of the HSE West, responsible for Galway and the Connemara Gaeltacht, which has its own language scheme.

5 Conclusion

This paper has argued that the HSE's language management approach in relation to immigrant languages in Ireland is motivated primarily by a need to respond to practical difficulties posed by the presence of individuals with limited English, such as their potentially restricted access to health information and services and miscommunication between staff and service users. The HSE's apparent greater urgency and willingness to address the linguistic, and cultural, needs of foreign nationals compared to L1 Irish speakers, should be seen in light of the fact that provision of service in other languages is not, only, a matter of moral or legal duty, respect or choice, as is predominantly the case with Irish, but a matter which directly impacts on the safety and well-being of patients. In Language Management Theory terms, at the level of socioeconomic management by the HSE the latter gives preference to managing health and safety issues in the first place, and only then socio-cultural ones.

The case of language management by the HSE in Ireland, highlights the fact that organisations make language policy when they decide how to deal with sociolinguistic diversity in society and in the population they deal with. Their language management approach may either be in line or in tension with national language policies which are often based on other prerogatives rather that dealing with practical matters, such as how to reach and satisfy more clients in the case of a business organisation, or how to make their services accessible and maintain the same quality in the case of care organisations. The fact that this is a *health* organisation is important. Kaplan and Baldauf (2007: 121) comparing health planning and language planning argue that one of the reasons that the first receives more public and political attention and is more effective is because 'health issues are more visible. Sick people in hospitals draw greater public attention than linguistically limited unemployed people. Furthermore, health settings may be more prone to accommodating policies and practices than other settings when it comes to migrant/minority issues because health care should, at least in principle, be person-centred. In fact, in the HSE website it is stated that the organisation functions in such a way as 'to put patients and clients at the centre of the organisation', while one of the components of their stated vision is 'easy access' to services[10].

This paper has shown that focus on individual organisations or settings can provide insights to the language ecology of a country that focus on the national

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10 At: http://www.hse.ie/eng/staff/central/who/ (last accessed on 26/09/2010).

language policies would overlook. Language Management Theory can be a very useful approach to use in linking the details of a problem to actual communication acts within an organisation or setting, which can then inform the actors in carrying out appropriate planning to overcome the problem, linking thus very well the micro-macro dimension. Future research on language management in the HSE should concentrate on the actual extent to which the language planning described here feeds back into the interactional level, i.e. to what extent health staff uses the material available to them and informs about and brings in professional interpreters, but also the impact that professional interpretation has for facilitating access and quality service.

Appendix 1

HSE Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Language Identification Card

1	اتكلم اللغة العربية I speak Arabic	11	Aš kalbu lietuviškai I speak Lithuanian
2	Ja govorim bosanski I speak Bosnian	12	زه په پښتو ژبه خبري کوم. I speak Pashto
3	我讲普通话 I speak Mandarin (Simplified Chinese)	13	Mówię po polsku I speak Polish
4	我講粵語 I speak Cantonese (Traditional Chinese)	14	Falo Português I speak Portuguese
5	Mluvím česky I speak Czech	15	Vorbesc Română I speak Romanian
6	Je parle français I speak French	16	Я говорю по-русски I speak Russian
7	Ich spreche Deutsch I speak German	17	Hovorím po slovensky I speak Slovak
8	Magyarul beszélek I speak Hungarian	18	Waxaan ku hadlaa Soomaali I speak Somali
9	Labhraímse Gaeilge I speak Irish	19	Hablo español I speak Spanish
10	Es runāju latviski I speak Latvian	20	میں اردو/پولتی بون۔ I speak Urdu

Appendix 2

HSE Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

your service
your say

If you wish to make a comment, compliment or complaint, then please fill in and tear off the attached sheet. You can place it in feedback boxes provided in reception areas, wards, health centres, service areas and officers.
Ask any staff member or at reception for contact details for the local Complaints Officer.

Name of service about which you want to make a comment, compliment or complaint

Name of location (Hospital, Health Centre, Administrative Office)

Date of experience giving rise to the comment, compliment or complaint

HSE Staff Use Only

Date received:

Comment, compliment, complaints number:

Location:

Complaints Officer:

Please give full details of your comment, compliment or the nature of your complaint in the space provided overleaf.

Your Service Your Say

Your Service Your Say

Your comments, compliments, and compliments are welcomed and valued. They allow us to continually improve our services.

This leaflet gives you information on how to make a comment, compliment and complaint

Step 1
How do I make a comment, compliment or complaint?
- Fill in the attached sheet and place it in the feedback boxes provided
- Talk to any member of HSE staff, service manager or complaints officer
- E-mail yoursay@hse.ie with your feedback
- Send a letter or fax to any HSE location
- Ring us: 1850 24 1850
- Use our website comments and compliments facility at www.hse.ie

Step 2
What will happen next?
- In the case of a comment or a compliment we will send you a letter of acknowledgement if you gave us your contact details.
- We will pass on your comment or compliment to the relevant service or staff member. They will acknowledge your verbal complaint immediately or as soon as possible.
- A written complaint will be acknowledged by a complaints officer in writing within five working days.

Step 3
How will my complaint be dealt with?
Depending on the nature and seriousness of your complaint
- a staff member/service manager will attempt to resolve your complaint locally; or
- a complaints officer will look into the issues raised in your complaint.

Step 4
How long will it take the complaints officer to look into my complaint?
- The complaints officer will look into your complaint within 30 working days of the date when it was acknowledged.
- If it takes longer to look into all the issues raised in your complaint the complaints officer will notify you within 30 working days and will give you an update on what is happening every 20 working days after that.

Step 5
What do I do if I am not satisfied with the recommendations made by the complaints officer or the way my complaint was dealt with?
- You may request a review from the Head of Consumer Affairs, Oak House, Millennium Park, Naas, Co. Kildare. Telephone: 1890 424 555.
- You have 30 working days from the date of the final report sent to you by the complaints officer to request a review.

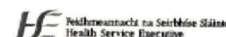
您的服务,您做主

欢迎您提出意见、表扬和投诉，这对我们非常重要。您的意见、表扬和投诉会督促我们不断提高服务水平。

本座页将为您提供关于如何提出意见、表扬和投诉的信息。

第1步
我如何提出意见、表扬或投诉？
- 填写附带的表单，并将其投入所提供的意见反馈箱中
- 与HSE工作人员、服务管理人员或投诉受理员进行谈话
- 将您的反馈意见发送到电子邮件 yoursay@hse.ie
- 以信函或传真方式将您的反馈意见发给任意HSE部门
- 电话联系我们：1850 24 1850
- 使用我们在www.hse.ie上提供的网上意见和表扬工具

第2步
接下来该怎么办？
- 在您提出意见或表扬时，如果提供了您的详细联系信息，我们将为您发送一封确认函。
- 我们将把您的意见或表扬转达给相关的服务或工作人员。口头投诉将得到立即或尽快的答复。
- 书面投诉将在五个工作日之内得到投诉受理员的受理确认。

第3步
将如何解决我的投诉？
根据您的投诉的性质和严重程度：
- 工作人员/服务管理人员将尽力在当地解决您的投诉问题；或者
- 投诉受理员将对您在投诉中提到的问题进行调查。

第4步
投诉受理员调查我的投诉需要多长时间？
- 投诉受理员将在受理确认之日起30个工作日之内进行调查。
- 如果调查您在投诉中提到的所有问题需要更久的时间，投诉受理员将在30个工作日之内通知您，并自此后每隔20个工作日向您通报调查的进展情况。

第5步
如果我不满意投诉受理员给出的建议或处理投诉的方式，我该怎么办？
- 您可以向Head of Consumer Affairs（消费者事务中心）申请进行审查，地址是 Head of Consumer Affairs, Oak House, Millennium Park, Naas, Co. Kildare，电话：1890 424 555
- 申请审查的期限是自您收到投诉受理员的最终报告之日起30个工作日之内。

HSE Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

您的服务,
您做主

如果您要提出意见、表扬或投诉，请填写附带的表单并将其撕下。表单的投放地点可以是接待处、病房、保健中心和服务区设立的意见反馈箱中，也可以交给工作官员。询问工作人员或到接待处咨询以获取当地投诉受理员的详细联系信息。

您的意见、表扬或投诉所针对的服务名称

部门名称（医院、保健中心、行政办公室）

您的意见、表扬或投诉所涉及的经历的发生日期

仅限于HSE员工使用

收到日期：

意见、表扬、投诉编号：

部门：

投诉受理员：

请在背页空白处详细写明您的意见、表扬或投诉性质。

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