Search
News
Documents
Index A-Z

The News
Latest news
Newsletter

Meetings
The week ahead
Session calendar
Conferences and colloquies
All meetings

Documents
Adopted texts
Working documents
Reports under preparation
Verbatim records
How to search?

Functioning
PACE in brief (PDF)
- Origin
- Working structure
- Procedures
- Committees
Rules of procedure
Secretariat

Members
List from A to Z
By political group
By national delegation
By committee
Other bodies
Members since 1949

Political groups (www)
EPP/CD
SOC
EDG
ALDE
UEL

Links
Council of Europe
National parliaments
International partners

Download
PACE's logo
Photographs

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Dutch-speakers' right to health-care in Brussels and the surrounding Dutch-speaking municipalities

I. Opinion of the Committee on Legal Affairs and Human Rights[1]

(Rapporteur: M. Boriss Cilevičs, Latvia, Socialist group) on the petition

II. Petition of 1 October 2002

I. OPINION

I. Introduction

1. The Assembly has received a petition dated 1 October 2002 from five Belgian local councillors concerning the right of Dutch-speakers to health care in Brussels and the surrounding Dutch-speaking municipalities.

2. At its meeting on 9 December 2002, the Bureau of the Assembly referred the petition to the Committee on Legal Affairs and Human Rights to report back to the Bureau on the Committee's recommendations and conclusions;

3. The Committee on Legal Affairs and Human Rights, at its meeting on 14 April 2003, appointed me as its Rapporteur with a view to advising the Committee as to the reply it may give to the Bureau. I should like to recall that this is the limit of my mandate – it will be for the Bureau, as advised by the Committee on the basis of my preliminary findings to decide whether it considers a full-scale report useful, and if so, which Committee should be mandated.

4. The visit to Brussels was postponed because of the then forthcoming elections in Belgium. On 10 September 2003, in line with the authorisation given by the Committee, I undertook a short fact-finding mission to Brussels, which included meetings with the petitioners, representatives of the public services in charge of the administration of public hospitals in the Brussels region, the competent Dutch-speaking and French-speaking Ministers of the Government of the Brussels-Capital region, the President of the Linguistic Control Commission, and the President of the Belgian delegation to the Parliamentary Assembly, Jean-Pol Henry, along with Stef Goris, a Dutch-speaking colleague of his (detailed programme of the fact-finding mission appended hereto). (This visit had been postponed because of the then forthcoming elections in Belgium.) I should like to take this opportunity to thank the Belgian delegation secretariat for the efficient organisation of this short, but intensive visit.

5. I was presented with an elaborate study prepared by Myriam Verkouter and Dr. Luc D'Hooghe in August 2003 in support of the petition which presented not only the historical, political and legal context of the issue, but also dozens of more recent testimonials than those presented in the petition by Dutch-speaking patients who tell of the difficulties they encountered in obtaining treatment from speakers of their native tongue. This document also sums up, for the purposes of my brief investigation, a number of scientific publications presenting empirical research done in this field, and demonstrates that this issue has been considered as a serious problem for many years.

II. Preliminary findings (summary)

6. To sum up, my preliminary conclusion is that the petition is not without

substance. The complaints filed in the original petition, backed up by a number of fresh cases presented to me in Brussels, and the strong attention given to the issue in local and national media demonstrate the existence of serious discontent in the Dutch-speaking population with respect to the language situation in the hospitals in the Brussels-Capital region.

7. For this reason, the petition should therefore not simply be dismissed as a mere retaliation attempt by Dutch-speakers following what was perceived by some as a "defeat" of their side in the debate on Mrs Nabholz-Haidegger's report on the "Protection of minorities in Belgium" adopted by the Assembly on 1 February 2003. Although the issue raised in the petition must naturally be analysed in the context of the Assembly's earlier work on language issues in Belgium, your rapporteur would like to stress that the thrust of the problem under consideration is fundamentally different from one dealt with in the aforementioned report by Mrs Nabholz-Haidegger. I strongly support the main conclusions of that report, i.e. that ratification of the Framework Convention for the Protection of National Minorities will be beneficial to better implementation of the human rights of Belgian residents, that the reservation introduced by Belgium is inconsistent with the purpose and object of the Convention and should not be upheld upon ratification, and that persons belonging to minorities who reside outside of "their" linguistic territories should be recognized as belonging to minorities in the sense of the Framework Convention. In the meantime, my report, in nature, does not deal with the issues related to minority protection, as both Dutch and French languages enjoy the status of official languages in the Brussels-Capital area. Moreover, the issue of which languages be granted official status does not fall within the scope of minority rights instruments and remains exclusively within the remit of domestic legislation. Thus, I see no reason to draw any links or parallels between the two reports which consider two completely different aspects of the linguistic situation in Belgium.

8. My preliminary findings point in the direction that the issue raised by the petition is not, at least not primarily, a legal one, but one that directly concerns other fields:

- *the political field*, in that it affects the relations between the two main language groups in Belgium in a particularly sensible zone – that of Brussels and its surroundings; any quick fixes that may be proposed to solve the issue may well affect the intricate "checks and balances" on which the current status quo is based;

- *the cultural field*, as the concrete problem at issue, and the most practical solutions proposed, concern (language) education; and**,** last but not least**,**

- *the social field*, as the most direct consequences of language-induced communication problems between doctors and patients are problems of access to, and quality of health care as provided for certain segments of the population – Dutch speakers in this case.

9. The last aspect also shows the proximity to the field of human rights: the prohibition of discrimination (Article 14 ECHR) must also apply to such vital public services such as the provision of health care.

10. Your rapporteur would like to stress once again that, given the historically established and complicated system of balancing interests and political influence between the two main linguistic groups, one must be particularly cautious in recommending any measures of a punitive nature. As the experience of many other countries (including my own) shows, coercive and punitive measures are successful to a very limited extent, and tend rather to increase tensions and thus deteriorate the situation.

11. In a nutshell, the core of the problem is how effectively to encourage people belonging to the two main linguistic groups in Belgium to learn each other's languages, and in particular, how to encourage medical staff in Brussels to learn and use the Dutch language. This problem is not unique for Belgium: many other European states face similar challenges. As a rule, the answers are sought in the field of education (both in schools and for adults), as well as using other methods of promotion of the society integration. This is why your rapporteur is not completely sure that a full-scale report (if the Bureau deems its preparation necessary) would fall within the field of competence of the Committee on Legal Affairs and Human Rights.

12. It is my intention to present the situation as objectively as possible, and leave to the discussion in our Committee, and ultimately in the Bureau, what shall be the focus of the future report, and consequently, which Committee of the Assembly shall be mandated.

III. A first look at the legal and factual situation regarding the Dutch-speakers' right to health care in Brussels and the surrounding Dutch-speaking municipalities

13. To avoid any misunderstandings that may be caused by the title of the petition: nobody has cast doubt on the Brussels Dutch-speakers' right to health-care

(i.e. access to health care) as such[2]. Problems exist only with regard to the possibility for Dutch-speakers to receive treatment using their mother tongue. These language problems may in certain cases lead to problems of time (in particular, in emergency cases), and other kinds of quality problems (in particular, through misdiagnosis due to communication problems), as well as to the perceived "humiliation" of patients who feel like "second class patients" if they are obliged to communicate with medical staff in a foreign language.

A. The importance for patients to receive treatment in their own language – medical, social and legal implications

14. The above-mentioned study, and several other written and oral submissions that were made to me during my visit to Brussels, stress the importance of the understanding - quite literally - between patient and doctor from a medical point of view. It is explained how anamnesis as a fundamental part of any medical examination starts with general questions on the patient's condition (including a description of the complaints, the duration, nature, intensity of the pain or other symptoms), following which more precise questions are asked concerning different organs, prior diseases, mental and physical development, intoxications, nutrition, childhood diseases, congenital defects.. The need for appropriate language skills on the side of the care-givers was justified rather convincingly, and supported by examples derived from testimonies concerning actual individual cases.

15. Apart from medical and humanitarian reasons, functional doctor-patient communication is pre-supposed in the modern legislation and case-law on patients' rights and informed consent. In Belgium, a progressive law on patients' rights entered into force on 6 October 2002. This law prescribes respect for the patient's human dignity and self-determination, without any discrimination on whatever ground (Article 5), and it gives the patient the right to all necessary information related to his state of health and its possible evolution (Article 7). The law carefully stipulates the requirement of informed consent, including a detailed list of information the patient must receive in order for his consent to be considered as properly informed (Article 8). The importance of informed consent in the doctor-patient relationship is such that in some countries, even medically indicated physical interventions are punished as criminal acts (assault and battery) when they are not covered by the patients valid consent (i.e. based on proper information).

16. In my view, there can be no reasonable doubt that a modern doctor-patient relationship presupposes that the patient may explain his ailments, and be given the necessary explanations in a language in which he or she is functional. The question that needs to be addressed next is whether this is a legally enforceable right, at least as far as Dutch-speakers in Brussels are concerned.[3]

B. Dutch-speakers "right" to health-care in their native tongue – the legal situation

1. The Brussels language situation in context

17. Representatives of the Dutch-speaking side have stressed on many occasions that they see the protection of the Dutch-speaking minority in Brussels through its bilingual status as being linked with that of the French-speaking minority in Belgium at the federal level: the bilingual status of Brussels is seen as the counterpart of the bilingual status of Belgium as a whole. In the view of the Dutch-speakers, a roll-back of the Dutch-speakers' rights in Brussels would put into question the linguistic balance at the federal level[4] and the entire *modus vivendi* between the two main linguistic groups.

18. This *modus vivendi* is the outcome of an evolution over more than 100 years during which the French language lost its dominant status throughout Belgium and Dutch-speakers obtained the recognition of the equal status of their language. This evolution was accompanied by the economic and demographic growth of the Dutch-speaking North of Belgium and the relative decline of French-speaking South. Dutch-speakers' attitudes are still largely shaped by the collective experience of past discrimination and disdain for their culture by a francophone elite. This defensive attitude may explain some over-reactions and the shrill tones used against perceived attempts to "roll back" hard-won advances. Conversely, French-speakers fear – in view of economic and demographic developments – ending up in turn dominated by the country-wide Dutch majority. This equally defensive attitude may explain some of the perceived "arrogance" of French-speakers towards their Dutch-speaking compatriots which shines through many of the testimonies presented in the petition and additional materials. Both sides see the situation in Brussels and its periphery as a "litmus test" for the sincerity of the other side's intentions.

19. In a nutshell, the current compromise solution is based on a federal-type state organisation including territorial and personal elements.

20. The language boundary has remained unchanged since the "language compromise" reached in 1962-63. The language laws put into place at that time

divided Belgium into four language areas: (1) the Dutch language area in the North (provinces of Antwerp, Limburg, Flemish-Brabant, and East and West Flanders); (2) the French language area in the South (provinces of Liège, Hainaut, Namur, Luxembourg and Walloon-Brabant); (3) the German language area comprising nine municipalities in the Eastern cantons, and (4) Brussels-Capital, whose 19 municipalities were given a bilingual status. In addition, in some municipalities near the "language border", speakers of the other official language were given special "facilities", allowing them to communicate with public authorities in their own language. The 1963 language laws also protect bilingualism at the federal level, in the fields of administration, the Court of Justice and other public services. Both sides concede that the language laws, as a result of a political compromise, are highly complex and often seem illogical. They are also sometimes interpreted differently by the Flemish or French-speaking communities, and the enforcement mechanisms are chronically weak. This weakness may well be part of the compromise solution which in my view, as an outsider, seems to be designed for, or at least result in protecting a certain linguistic "status quo" which the country as a whole seems to be willing and able to live with. Any proposals to change this delicately balanced status quo must therefore be considered very carefully.

21. The current federal structure of Belgium developed through a number of constitutional reforms in 1970, 1980, 1998 and 1993, which turned Belgium into "a federal State constituted by Communities and Regions". Belgium is composed of three regions: Flanders, Walloon, and the Brussels-Capital region. In parallel, the population of Belgium is sub-divided into three Communities: the Flemish, the French-speaking and the German-speaking communities. The Communities, which have their own Councils (parliaments) and Governments, have competences for "personal" matters (including health care, social assistance, and education). The Regions, also endowed with Councils and Governments of their own, are responsible inter alia for economic development. Whilst in Flanders, the Council and the Government of the Region fused with those of the Flemish Community, the Councils and Governments of the Walloon Region and of the French Community remained separate.

22. This set-up, which is not easy to grasp for outsiders, is even more complicated in Brussels: the Region Brussels-Capital has its own Council and Government, but some competences are also in the hands of the (Flemish and French-speaking) Communities. These include the respectively Dutch- and French-speaking health-care, welfare, and cultural organisations and schools. In order to exercise these Community powers regarding the inhabitants of Brussels, the "Joint Commission for Community Matters" has been created, which works independently from the Region of Brussels-Capital, the federal government and the individual Communities. It has a legislative branch – the United Assembly consisting of the 75 members of the Brussels Council, respectively the Assemblies of the Flemish and the French Community Commissions in Brussels, and an executive branch: the United College composed of the five Ministers of the Region of Brussels-Capital. This Joint Commission for Community Matters controls and supervises the major part of the health care in the capital which have not chosen to belong exclusively to either the French or Flemish Community (so-called "dual community health care institutions"). In addition, the Governor and the Vice-Governor of the Brussels-Capital region, as representatives of the federal government, and the Standing Commission for Language Supervision exercise certain supervisory functions regarding the respect of the language legislation.

23. The organisation of public hospitals in Brussels underwent major restructuring in 1996, when they were they were joined together in an "umbrella" type organisation - IRIS[5]. This "umbrella" is inter alia in charge of staffing issues, including the implementation of the language regulations.

2. Substantive language rules governing the hospitals in the Brussels-capital region

24. The language rules are not the same for all hospitals located in the Region. Three categories of hospitals have to be distinguished:

a. The three academic hospitals (ULB/Université Libre de Bruxelles) in Anderlecht; VUB/Vrije Universiteit Brussels in Jette, and UCL (Université Catholique de Louvain) in Sint-Lambrechts-Woluve). These are so-called mono-Community institutions, having chosen to attach themselves to the respective Flemish (VUB in Jette) or French-speaking Communities (ULB and UCL). The three hospitals have over 2400 beds and are all located on the outer borders of the Brussels Region. For this reason, and because they can offer cutting-edge medical services, they are attractive also to people living in the Dutch-speaking periphery of Brussels. Due to their mono-Community status, the three hospitals are not legally required to provide services in the other language, with the exception of emergency services (cf. below).

b. Nine (other) public hospitals are obliged to comply with language regulations foreseeing effective bilingualism. They are "dual Community institutions" by law. In the same way as the other "public social welfare institutions" (OCMW's), such as nursing homes or retirement residences, they are considered as decentralised services of the Communities and covered by the Law on Local Services as well as Articles 17 to

22 of the Royal Decree of 18 July 1966. According to Article 19, the language to be used by the service-providers is the language of the user, provided it is French or Dutch. According to the law, staff who have contact with the public must show proof of adequate or elementary oral knowledge of the second language, in accordance with the nature of the function discharged. This proof must be submitted before recruitment. This implies that persons who are regularly in contact with the public, including doctors, nurses and reception staff, must have sufficient knowledge of both Dutch and French. Professional language tests, which according to representatives of both language groups are serious and objective, though sometimes a little too difficult, are administered by SELOR, the staff selection agency of the federal government. The Permanent Commission for Language Supervision has held, however, that bilingualism is not a requirement for temporary staff members, trainees, and independent doctors working in public hospitals on a contractual basis; on the other hand, all emergency service workers must be bilingual.

c. The ten private hospitals in the Brussels region have a choice between mono and dual Community status. Functioning in the legal form of private associations, they are not bound by bilingualism legislation. But as they have chosen accreditation as dual Community institutions and receive subsidies from the Joint Commission for Community Matters' budget, they are held to provide bilingual services. However, their language use is not, so I was told, subject to inspection.

3. Enforcement procedures for the language rules applicable to Brussels hospitals

25. As opposed to the substantial rules, which foresee a high degree of bilingualism in most Brussels hospitals, enforcement procedures are relatively weak. The following "players" are involved in the supervision of the application of the language laws in the public hospitals in Brussels.

a. The Permanent Commission for Language Supervision

26. The Permanent Commission for Language Supervision handles all complaints about the application of the language legislation. It may investigate the background of such complaints and issue opinions either in response to complaints, or upon request by interested parties. The Permanent Commission, whose President, Mrs van Cauwelaert I met during my visit to Brussels, has published a number of opinions on the use of languages in Brussels hospitals, without having the power to sanction local authorities which fail to comply with the rules, or to suspend contrary administrative decisions. The petitioners expressed their frustration as to the limited powers of this organ which they consider to be a well-balanced, neutral body.

b. The Vice-Governor and the United College

27. The Vice-Governor of the Province of Brabant carries out the function of commissioner of the Government of Belgium for the Brussels-Capital Region, whose tasks include supervising the application of the language legislation within the boundaries of that Region, according to Article 6 of the Language Law of 2 August 1963. In this role, the Vice-Governor (currently Mr Nys, whom I met during my visit to Brussels) receives complaints concerning the hiring and promotion of staff in local administrations, including the Public Social Welfare Organisations in charge of public hospitals. When he considers that there has been an infringement of the language laws, he has the power to suspend an administrative decision for a 40-day period. It is then up to two Ministers (one Dutch-speaking, one French-speaking) competent for public welfare matters in the United College of the Joint Commission for Community Matters (the executive branch of the Joint Commission) to annul the administrative decision or not. As every annulment requires consensus between the two Ministers, both of whom I met during my visit (Mr Eric Thomas, and Mr Guy van Hengel), decisions suspended by the Vice-Governor are very rarely annulled, as the French-speaking Minister does not often share the interpretation of the Vice-Governor and that of his Dutch-speaking colleague.

28. As far as the staff of public hospitals is concerned, the control mechanism via the Vice-Governor and the two Ministers of the United College for Community Affairs has been further weakened as a result of the creation of the IRIS "umbrella" to which most public hospitals belong. Since the creation of IRIS, decisions to hire or promote hospital staff are no longer transmitted to the Vice-Governor, who can therefore no longer suspend such decisions.

c. The Council of State (Conseil d'Etat/Raad van State)

29. The Council of State, as the highest administrative tribunal, has the power to annul decisions of an administrative authority that run contrary to the language legislation.

30. I have not been able, so far, to ascertain why this quasi-judicial organ is not more frequently called upon, for example, to resolve the "deadlock" if no consensus can be reached between the Francophone and Dutch-speaking ministers following the suspension of a decision by the Vice-Governor. The supporters of the petition claim

that the judgments of the Council of State are often not executed because no sanctions exist for infringements.

31. In a case concerning bilingualism of hospital staff[6], the Council of State has adopted a position that deviates from that of the Permanent Commission for Language Supervision in that the obligation of bilingualism does not, for the Council of State, depend on the contractual status of the staff member (permanent or temporary contract), but on the function he or she performs.

d. Control mechanisms of the IRIS organisation

32. IRIS, whose President, Mrs Camille Artois, and Director, Mr Dirk Thielens, I met during my fact-finding visit to Brussels, is a management body created in 1996 that runs five public hospitals in Brussels (Brugmann, Saint-Pierre, HIS, Bordet and HUDERF, totalling 2344 beds). IRIS brings together, in the legal form of an association, representatives of the local authorities in the Brussels region, Public Welfare Organisations, doctors' associations and the hospitals concerned in order to manage the latter in a coordinated way that makes the best use of available infra-structural resources. In the general assembly of IRIS and its Board of Directors, the public authorities hold a majority of votes. IRIS is supervised by the United College (the Executive branch of the Joint Commission for Community Matters in the Brussels-Capital Region), or more precisely by three Commissioners (one French-speaking and one Dutch-speaking, and one of the Brussels Government). These Commissioners have the right to attend all meetings of IRIS' administrative bodies, and have the possibility to veto decisions taken by IRIS, and to enjoin decisions that ought to be taken. The IRIS representatives informed me that so far, the commissioners have officially intervened twelve times. In addition, IRIS is subject to audit control by the Brussels-Capital regional government, and to parliamentary-type control by the United Assembly (the legislative branch of the Joint Commission for Community Matters).

33. IRIS, in turn, supervises the hospitals subjected to its control through a commissioner who attends the meetings of the hospital boards and has the right to veto any decisions that are not in conformity with IRIS' decisions. IRIS also exercises budgetary controls over the constituent hospitals, approves the appointment of professional staff and issues guidelines concerning staffing policies in general.

e. The Linguistic Courtesy Agreement of 14 November 1996

34. The perception that administrative and (quasi-) judicial means such as those described above did not lead to a satisfactory level of actual bilingualism in Brussels, the political will on both sides to find a viable compromise led to the conclusion of the Linguistic Courtesy Agreement in 1996. This Agreement confirms that all candidates for posts (including temporary contracts) in the public sector involving contact with the general public should show proof of bilingualism. The Agreement lays down that those contractual employees of the Region of Brussels-Capital who did not comply with the bilingualism requirement at the time of their hiring shall pass the language exam within a period of two years. In turn, SELOR would adapt their exam methods to facilitate the fulfilment of this condition. In a circular letter sent at the end of 1997, the Government of the Brussels-Capital Region and the United College of the Joint Commission for Community Matters each sent a circular letter to the municipal authorities, social welfare agencies and public hospitals in Brussels to inform them of this agreement and lay down a procedure according to which administrative authorities wishing to hire an employee should first refer to a list of eligible candidates having passed the language exam. If there is no eligible candidate on the list, others may be hired for a two-year term during which the person must pass the exam. New circular letters dated 18 and 19 July 2002 represented a softening of this position, in that an initial contract of fixed duration concluded with a non-bilingual applicant can be prolonged by another two years provided the staff member in question has actively participated in a full language course, or participated in a SELOR – exam and earned at least 40% of the points. The application of this circular was, however, suspended by the Council of State on 8 April 2003, which has not yet given its final judgment on the merits.

4. The special case of the treatment of emergencies

35. The treatment of emergencies is a special case for two main reasons:

- Firstly, patients in an emergency situation often do not have any choice of hospital to which they address themselves, or to which the ambulance takes them, as it must be the nearest one.

- Secondly, in emergency situations, the misunderstandings or loss of time caused by communication problems between patients and hospital staff, or by the necessary search for an interpreter, can have particularly dramatic health consequences (as shown by some of the examples provided by the petitioners).

36. The special character of the treatment of emergencies has also been recognised in the legal regulations and their interpretation. The Permanent Commission for Language Supervision has recognised that even private health care

providers that are normally not subjected to the language laws requiring bilingualism must furnish bilingual services insofar as they provide emergency care, which is considered as a public-health task. In practice, this implies that at least the doctors and

nurses who man the emergency rooms and the "Mobile urgency Group" (MUG)[7] of these clinics and who interact with the patient or his family, should be bilingual[8].

37. In Brussels, the Fire Department is charged with organising the emergency ambulance service, reachable through a single telephone number (100). The language rules applicable to the Brussels Fire Department were changed by the Law on Brussels in 1989. Before this date, the Fire Department was attached to the municipality and subject to the coordinated laws on language use in public affairs, meaning that parity between French- and Dutch-speaking staff was required at management level, and all staff members in contact with the public (including ambulance personnel) had to be bilingual. In 1989, the Fire Department was transferred to the Region. As a consequences, the Fire Department became a bilingual service manned by non- (or not necessarily) bilingual staff[9]. Later ordinances adopted by the parliament of the Brussels-Capital region introduced fixed language ratios at all levels, depending on the workload calculated in accordance with the number of calls made in the two languages. This issue has given rise to serious political conflict, lengthy litigation before the Council of State, and the resignation of a Minister. Currently, a ratio of 70.52% of French-speaking staff and 29.48% of Dutch-speaking staff applies. The above-mentioned Linguistic Courtesy Agreement (although its application is currently suspended, see above) may contribute to moving the situation closer to that which existed before 1989, in which all Fire Department staff were expected to be bilingual.

C. Dutch-speakers right to healthcare – the factual situation

38. The Brussels Capital Region consists of 19 different municipalities with a population of around 950,000 inhabitants. It represents 0,54 % of the national territory and about 9,5 % of the Belgian population As the capital of Belgium, of the Flemish Community and of the French Community, Brussels is officially a bilingual city, with a majority of French-speaking inhabitants[10].

39. Numerically, Dutch-speakers in Brussels are clearly a minority also among the patients and staff in the hospitals, even though the "catchment area" of the Brussels hospitals extends far into the Dutch-speaking periphery.

40. A study dating back to 1991 cited in the petition[11] shows that over 25% of patients admitted to public hospitals in Brussels come from outside the Brussels-Capital Region, and 15% of all admissions are from the mostly Dutch-speaking province of Flemish Brabant. The numbers provided by IRIS confirm that about one quarter of the patients come from outside the Brussels region, but the breakdown of the remaining quarter is different (10.8% from Flanders, and 13.2% from Walloon; another 1.9% are of undetermined geographical origin). The petitioners claim that 30% of the patients in Brussels public hospitals are Dutch-speaking, compared to 10% of the doctors working there. According to the figures given by IRIS for the hospitals under its administration, 12.1 % percent of doctors and 30.7% of nurses are of "Dutch" (-speaking) origin, but 48% of doctors and 35% of nurses are in receipt of the language allowance, having passed the language exam. No indication is given as to the breakdown of these bilingual staff members between native Dutch or French speaker. I was told during my visit that generally speaking, more Dutch-speakers than French-speakers receive the language allowance for having passed the exam in the other official language.

41. The petitioners cite a joint research paper published by KUL/ULB[12] according to which 58% of Dutch-speakers referred to public hospitals in Brussels were not properly received in their native tongue and obliged to express themselves in French. By contrast, an "attractiveness study" commissioned by IRIS in April 2000, questioning 604 patients of whom 18 % were Dutch-speaking, concluded that Dutch-speaking patients are generally slightly more satisfied than French-speaking patients with the services provided by the IRIS hospitals.

42. The absolute number of individual complaints is very limited indeed. The petition itself puts forward 13 examples, some of which dating back more than 10 years. The representatives of IRIS, as well as the President of the Permanent Commission for Language Supervision, Mrs van Cauwelaert, confirmed the low number of official complaints received. I was given the complete files of the official complaints treated by IRIS and handed over to the Vice-Governor, and their analysis shows that they were afforded serious attention and follow-up. In September, the petitioners' representatives handed me an additional list of recent complaints collected within a short period of time via a website launched by our colleague Stef Goris.

43. The petitioners' representatives argued that the admittedly small number of official individual complaints could not put into question the seriousness of the problem and its widespread occurrence. The individual complaints were the "tip of the

iceberg" and provided merely examples of the prevailing climate in which Dutch-speaking patients were made to feel like "second-class" patients. Patients and their families were extremely reluctant to file complaints as they feared to lose the "goodwill" of the hospital and the doctors and nurses on whom they depended for their treatment. The situation of extreme dependence typical for the doctor – patient relationship, at least in cases of serious disease or medical emergencies, explains in their view the small number of individual complaints. They maintain that those complaints which are introduced despite this situation are typical examples for the linguistic climate in Brussels hospitals in general, which is in their view characterised by a certain amount of arrogance and intolerance towards those who are unable or unwilling to express themselves in French. The testimonies cited in the petition and the additional memorandum I received go very much in this direction.

44. The existence of a de-facto francophone climate in Brussels public hospitals seems to be corroborated by a written testimonial I received from the IRIS section of the CCOD (Christian Union of Public Service Workers, Dutch-speaking) complaining about the difficulty for Dutch-speaking staff members caused by de facto unilingualism in these hospitals (excepting the Bracops-hospital in Anderlecht which the Union recognises as a truly bilingual hospital). They claim that documents for meetings with the Board of Directors are exclusively in French (translation into Dutch only upon specific request); committee meetings and negotiations are systematically held in French (whilst in theory, everyone shall speak their own language, Dutch-speakers must speak French if they want to be understood); training courses and seminars are held exclusively in French; Dutch-speaking staff are discriminated against in employment and promotion decisions; due to the "Dutch-unfriendly" atmosphere (including child-care for staffers provided only in French), Dutch-speaking staff often leave again after a short time; and palliative care for terminally ill patients is only offered in French.

45. Without having had the possibility, so far, to check on the information provided myself – I did not consider it useful at this stage for example to visit hospitals and interview patients and staff so as to "test" the language situation – I have come to the preliminary conclusion that there can be no smoke without at least some fire. A lot of Dutch-speakers are obviously displeased with the situation that exists in practice, and which contrasts to some extent with the legal rules presented above, prescribing effectively bilingual services and, with the exception of the Fire Department, requiring Dutch/French bilingualism from all members of staff who are in contact with the public.

D. Initiatives to remedy the situation

46. Some initiatives have been proposed for improving actual bilingualism in Brussels hospitals in general, others focus on the area where the problem is perceived as being the most pressing, i.e. ambulance and medical emergency services.

1. Initiatives regarding the language situation in hospitals in general

47. Several initiatives aim at increasing the number of Dutch-speaking or bilingual staff members in the public hospitals. Some focus on changing legal regulations, in particular strengthening the control mechanisms which have so far not succeeded in enforcing the substantive rules providing for bilingualism. Others focus on ways and means to increase the supply of bilingual staff, in view of the fact that hospital administrators complain about the unavailability of bilingual staff, forcing them to recruit monolingual persons in practice, in spite of legal regulations in force.

a. Initiatives involving changes of rules

48. In the Belgian Federal Chamber of Representatives, a proposal was introduced by Flemish parliamentarians to modify the supervision mechanism of the language laws ("annulment procedure") in Article 65 of the Coordinated Language Law. Several interlocutors from the petitioners' side also advocated replacing the current "annulment procedure" (requiring a consensus between the French- and Dutch-speaking Ministers in order to annul a decision, being aware that a consensus is rarely reached) by an "approval procedure" where disagreement between the two Ministers would prevent a decision from being taken.

49. The (presently suspended) "Linguistic Courtesy Agreement" of 1996[13] is another attempt, supported in principle by both language groups in Brussels, to change the legal procedures governing recruitments with a view to increasing the number of bilingual employees. The Agreement would put pressure on all categories of staff members to undergo a language test within a given time limit (two years renewable, in principle, once). Such an approach would provide more flexibility than the introduction of a rigid approval procedure, as it builds on the recognition that it would not be feasible to insist strictly that all new staff members must be bilingual at the time of their recruitment.

b. Initiatives involving other practical measures

50. Pro Medicis Brussel, an independent initiative of Dutch-speaking medical

professionals set up in 1999 with the support of the then Minister of the Brussels-Capital Region in charge of the health sector, the Dutch-speaking Mr Grijp, promotes the development of bilingualism in healthcare.

51. In addition to investigating the reasons for the lack of enthusiasm of Dutch-speaking health-care professionals for practicing in Brussels, it has developed practice-oriented programmes to promote traineeships for Flemish students in Brussels hospitals, to spread information about vacancies to bilingual professionals who may be interested in working in Brussels, and to promote "networking" between bilingual general practitioners and bilingual specialists working in hospitals.

52. The Virtual Health Care Network – presented as an alternative to physically concentrating bilingual health professionals in a new hospital – centralises information on specialist skills of Dutch-speaking and bilingual doctors and other health-care workers in order to facilitate access to such professionals for patients seeking quality treatment in their mother tongue. The network, which also organises training activities, has a permanent structure supervised by an executive committee, and its participants are selected on grounds of their medical and communication skills.

53. Finally, after my visit to Brussels, the (French-speaking) Federal Minister for Social Affairs, Rudy Demotte, expressed himself publicly in favour of improving health service in Brussels for Dutch-speakers. He has proposed to meet up with his colleagues of the Brussels-Capital Region, Mr Vanhengel (Dutch-speaking) and Mr Tomas (French-speaking), in order to discuss ways and means to achieve concrete improvements, in particular through including language training in the curriculum of medical schools. In the reports in the Dutch-language press about Mr Demotte's statements, a link was drawn between my visit to Brussels on behalf of the Council of Europe and Mr Demotte's initiative.

2. Initiatives regarding the emergency services in particular

54. As a matter of fact, among the most vividly expressed complaints I was confronted with were cases of inhabitants of the Flemish region picked up by the MUG services of the mostly French-speaking ULB or UCL hospitals, which are located close to the "language border", whose geographical range of intervention extends well into overwhelmingly Dutch-speaking territory.

55. Bills were introduced in 1999 in the Belgian Chamber of Representatives and in the Council of the Brussels-Capital to bring back the bilingual status of the staff of the Fire-fighting and medical emergency services in the Brussels-Capital region as it existed before 1989.

56. The issue of bilingualism in emergency rooms was also taken up by the Flemish side at the Interministerial Conference on Public Health in September 2000. As a result of the conference, a task force was created to formulate concrete proposals. One of the proposals was to create a central reporting agency for language-related complaints, and another to stipulate, by Royal Decree, that a licensing requirement for MUG's ("Medical Urgency Groups) shall be that every such service should be able to function in the language of the region it operates in.

57. According to the previously-mentioned additional memorandum by the petitioners[14], these proposals have given rise to some optimism among Dutch-speakers worried about ambulances with no Dutch-speaking staff picking up patients from "deep" Flemish Brabant. They are still waiting, however, to be translated into law by the competent Ministers.

IV. Conclusion

58. My preliminary conclusion is that the issue raised by the petition is not, at least not primarily, a legal one, but one that directly concerns other fields, in particular the political, the cultural and the social fields (above B.).

59. My intuition, also in light of my experience with minority issues in other countries, including my own, is to apply legal means as sparingly as possible and to favour practical solutions.

60. Fundamental changes of the legal framework can have wide-ranging repercussions on the existing "modus vivendi" between the different population groups.

61. Belgium is a particularly impressive example of how the elaborate system of "checks and balances" put into place after a laborious search for compromise can lead to the (perceived) artificial stability of the status quo, conserving even some long-standing rules that anyone would agree are or have become irrational. But it is quite conceivable that certain stalemate or blocked situations, however frustrating, are intended or at least accepted by both sides in negotiating a "package deal" that is presentable to their constituents. Nevertheless, it is sometimes difficult to accept that substantive legal provisions remain largely inapplicable because of the weakness of the procedural means put into place for their implementation.

62. To an outsider (and to lawyers such as the members of our Committee), it may seem "cleaner" to reframe the substantive rules in more realistic terms (for example, stipulate bilingualism of the service provided rather than of each staff member dealing with the general public) and in return provide sharp procedural tools to implement the revised rules. But this would require opening the whole package, and I feel that it is not for the Council of Europe to go as far as making this a requirement or even a recommendation. It may be more in line with a constructive approach that is the trademark of the Council of Europe to encourage practical initiatives to improve in concrete terms the situation of Dutch-speaking patients in Brussels hospitals.

63. Having presented the situation as objectively as possible, I want to leave to the discussion in our Committee, and ultimately in the Bureau, what shall be the focus of the future report, and consequently, which Committee of the Assembly shall be mandated.

II. PETITION

Introduction

1. The Assembly has received a petition dated 1 October 2002 from five Belgian local councillors concerning the right of Dutch-speakers to health care in Brussels and the surrounding Dutch-speaking municipalities (see Appendix).

2. The petition satisfies the formal requirements of Rule 62.1 and 62.2 (addressed to the President, signed, legalised).

Admissibility

3. The criteria for interpreting the concept of "admissibility" were approved by the Bureau on 13 March 2001 (see the footnote to Rule 62.3). Applying the criteria to the petition in question provides the following:

a. The petition bears on a matter within the competence of the Council of Europe, i.e. alleged discrimination on grounds of language and access to health care.

b. It bears on a matter of grievance calling for general corrective measures rather than redress of a particular wrong, i.e. the better application of certain language provisions in Brussels and periphery and the ability of Dutch-speakers to be able to use Dutch when using health services in the area.

c. It is of a legitimate interest to the Assembly in its area of competence. Having debated a report on Belgian minorities in September 2002 (see Resolution 1301 (2002) and Order No. 583 (2002)), it would be difficult to argue that this matter is not of legitimate interest to the Assembly within its area competence. Furthermore, the Assembly could be accused of bias if it was seen to reject a Dutch/Flemish request, after having adopted texts perceived by some to be positive towards the French/Walloon population.

d. The matter is not being dealt with by a national court, is not under consideration in the national parliament or the European Court of Human Rights, nor has it been submitted to any other international body.

4. In conclusion, applying the applicable criteria, the petition should be declared admissible.

Reference to committee(s) for report to the Bureau

5. The petition is clearly a mixture of legal and social aspects. However, a close reading shows that it is primarily a question of discrimination on the ground of language. Therefore, the Committee on Legal Affairs and Human Rights could be asked to examine the petition with a view to preparing "its conclusions and recommendations" for the Bureau (see Rule 62.5), possibly as well as the Social, Health and Family Affairs Committee as the right of access to health care is invoked. It would then be up to the Bureau to decide on any further action once it has received the conclusions of the committee(s).

APPENDIX

BRUSSELS PARLIAMENT

Sven Gatz

www.gatz.be

REGISTERED

To Mr Peter Schieder

President of the Parliamentary Assembly

of the Council of Europe

F-67075 STRASBOURG

France

Our reference: br21001bJBA

Brussels, 1 October 2002

Subject: Petition concerning the Dutch speakers' right to health care in Brussels and the surrounding Dutch-speaking municipalities (Belgium)

Dear Sir,

I enclose herewith five copies of a 27-page petition (with each page initialled and dated, and the last page signed by the petitioners and officially validated by the municipality).

The petitioners are:

Herman Mosselmans, alderman of Sint-Genesius Rode

Jean-Pierre Maeyens, alderman in Hoeilaart,

Michiel Vandenbussche, alderman in Etterbeek,

Jan Beghin, municipal councillor in Ganshoren and first Vice-Chair of the Brussels-Capital Regional Council, and

Sven Gatz, municipal councillor in Brussels and member of the Flemish Parliament.

The petition concerns the right to health-care in Brussels and the surrounding municipalities.

Yours faithfully,

Johan Basiliades

Parliamentary party secretary

We the undersigned, members of parliament and local councillors, herewith make an urgent appeal to the Parliamentary Assembly of the Council of Europe. We are acting in the interests of at least 300,000[15] Dutch-speaking people who live, work or undergo hospital treatment in Brussels, the capital of Belgium. For countless years, Dutch-speaking patients have been unable to be treated or receive medical attention in the majority of Brussels hospitals in Dutch, even though Brussels, the capital of Belgium, is by law a bilingual city where both Dutch-speakers and French-speakers are supposed to be able to use their own language on an equal footing. Despite the fact that this problem has regularly been broached throughout this period, there has been no improvement, and yet such a situation contravenes a basic right, the right to health.

1. The fundamental right to the highest attainable standard of health

The right to health is recognised in various national, European and international legal texts and conventions. The fundamental right to the highest attainable standard of health was recognised as early as 1948 in Article 25 of the Universal Declaration of Human Rights. This fundamental right was further developed in Article 12 of the International Covenant on Economic, Social and Cultural Rights, which stipulates:

"1. Th e States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.2.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

b. The improvement of all aspects of environmental and industrial hygiene;

c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

At national level, reference may be made to Article 23 of the Constitution which explicitly acknowledges the existence of a number of economic, social and cultural

rights. One of these rights is the right to health care (Article 23.3 of the Constitution)[16].

The right to the protection of health was also asserted by the Council of Europe in 1961, more specifically in Article 11 of the European Social Charter:

"With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed, inter alia:1.

1. to remove as far as possible the causes of ill-health;

2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

3. to prevent as far as possible epidemic, endemic and other diseases."

At Council of Europe level, further reference can be made to Article 8 of the European Convention on Human Rights (ECHR). This article guarantees the right to privacy. The right to privacy includes, amongst other things, the right to protection from physical and mental injury.

According to the European Court of Human Rights, the right to privacy entails not only negative, but also positive obligations. The authorities must not only refrain from unnecessary interference in the private life of citizens, but must also take the necessary steps to protect or promote the citizens' right to privacy in general and their right to protection from physical and mental injury in particular. This last aspect was strikingly illustrated in the European Court's judgments of 23 November 1995 in the López Ostra v. Spain case and of 2 October 2001 in the case of Hatton and others v. the United Kingdom[17].

Ms López Ostra and her family lived close to a waste processing plant, which caused not only problems of smells, but also numerous physical ailments. Despite their repeated complaints, it was five years before the plant was closed down by court order. This negligence – in breach of Article 8 ECHR – led the Strasbourg Court to rule that Spain was in violation of the Convention.

The case of Mrs Hatton and others concerned Heathrow airport. In 1993 the restrictions on the number of night flights were revised, resulting in practice in a sharp increase in noise disturbance. Eight residents in the vicinity, half of whom had had to move because of the noise, argued before the European Court of Human Rights that the disturbance of their night-time peace caused by the noise of the aircraft was a breach of their right to the protection of privacy, family life and their home. The Court found in their favour.

In the case in question, the UK government had not taken the necessary steps to limit the noise as far as possible, and accordingly had violated the residents' right to the protection of their privacy, family life and home. The UK government had failed to carry out their own critical assessment of the information on the economic interest of night flights provided by the airline companies. Furthermore, the study which had been carried out on the effects of night flights on sleeping patterns had not been sufficiently thorough, in that it had been limited to sleep disturbance alone, whereas it was clear that there was a major problem of sleep prevention, ie the difficulties encountered by those who had been woken up in falling asleep again. Preparatory studies must look at the "impact on human rights" of the various available options and, accordingly, the least onerous option should then be chosen.

2. What the right to health covers in practice

For a long time it was unclear what the right to health actually covered in practice. This situation was changed with General Comment no. 14 on the right to health issued by the UN Committee on Economic, Social and Cultural Rights on 11 August 2000[18].

In its General Comment No. 14, the UN Committee on Economic, Social and Cultural Rights laid down the requirements which must be met by health facilities, including actual health care itself. They must satisfy the conditions of availability, accessibility, quality and acceptability.

Availability implies that health-care facilities and services must be sufficiently available (adequate number of hospitals, trained medical staff, drugs in sufficient quantities, etc).

Further, what is available must be of adequate *quality*. The concept of *acceptability* refers, inter alia, to the fact that health care must conform to medical ethics and due regard must be given to the specific cultural aspects pertaining to individuals, minorities, peoples and communities.

Finally, *accessibility* has four overlapping dimensions:

- *Equal access*: a guarantee must be given that health care is accessible to all, in law and in fact. More specifically, there must be no discrimination on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status, sexual orientation and civil, political, social or other status.

- *Physical accessibility*: health facilities must be as accessible as possible. This means, for example, that the facilities and services available must be evenly distributed geographically.

- *Economic accessibility*: health care must be affordable for all.

- *Information accessibility*.

In our view, there is no reason why any other description should be given of what is covered by the right to health, enshrined in Article 11 of the European Social Charter. Furthermore, like Article 2 of the International Covenant on Economic, Social and Cultural Rights, Article E of the European Social Charter (revised in 1996) and Article 14 of the ECHR prohibit any discrimination on the grounds, inter alia, of language.

Clearly, therefore, the health facilities in Brussels, which serve not only the 19 municipalities of the Brussels-Capital Region[19], but also a large area around it, should be geared to the specific cultural characteristics of both the Brussels urban conglomeration and the Vlaamse Rand[20].

The number of Dutch-speaking people present daily in the Belgian capital, Brussels, is much higher than the effective number of Dutch-speaking people living in the capital. In point of fact, there are some 300,000 Dutch-speaking people who use the health-care facilities in Brussels:

- either as inhabitants of one of the 19 municipalities making up the Brussels-Capital Region;

- or as commuters who travel to Brussels from the Flemish Region every day to work;

- or as patients living in the Flemish Region who are being treated in one of the Brussels hospitals.

There are various ways of guaranteeing everyone's access to health-care facilities. For that reason, the various countries are allowed the necessary margin for manoeuvre in order to develop their own health-care policy in accordance with their own appreciation and in the light of their own resources and possibilities. Furthermore, the right for everyone to have access to health care presupposes that national legislation which stipulates that Dutch-speaking citizens can avail themselves of the Brussels health care facilities in their own language, should in practice be complied with and substantiated, so that Dutch-speaking people can be cared for in the hospitals of the Belgian capital in Dutch and receive the medical treatment they require.

3. The bilingual nature of the Brussels health-care institutions: a *de jure* situation

With regard to the legal situation, the necessary guarantees concerning accessibility in the Dutch language appear to be provided by the Belgian language legislation and the "dual community status"[21] of the Brussels private hospitals.

3.1. The legal situation in respect of public hospitals in Brussels

Public hospitals in Brussels are run by the Public Social Welfare Centres (CPAS-OCMW). In Brussels, these are subject to the **language legislation applicable to local public authorities**[22]. This means that anyone employed by a CPAS-OCMW must have a knowledge of the other national language at a level commensurate with their function. In other words, all staff employed in the public hospitals in Brussels, including the medical staff, must be adequately proficient not only in French but also in Dutch in order to be able to fulfil their duties as a care provider[23].

These legal obligations for the Brussels OCMW hospitals were explicitly confirmed in a unanimous opinion[24] of 30 May 1991 by the Standing Committee for Language Supervision, a standing advisory body monitoring compliance with Belgian language legislation:

"Both Dutch-speaking and French-speaking patients have the right to be seen and cared for in their own language by the medical practitioners of the OCMW-hospitals located in Brussels-Capital" [25]*o*

For these reasons, doctors employed in these hospitals, whether officially

appointed, pursuant to an employment agreement, or as self-employed practitioners, must be bilingual. Public hospitals must ensure *"that doctors can understand and speak the language (Dutch or French) of the patients they are caring for and are able to draw up the relevant medical files in that language"* [26].

3.2. *The legal situation in respect of the emergency services*

Urgent calls for medical assistance are referred to the hospitals via a central emergency service which in Belgium is obtained by dialling 100, and which is usually referred to as "the 100 service". This service is provided for the Brussels-Capital Region and the surrounding area by the Brussels fire-service. The Brussels fire-service often itself takes care of transporting the sick in its own ambulances.

As an institution which belongs to the Brussels-Capital Region, the Brussels fire-service is subject to the **language legislation applicable to central services**[27]. In contrast to the language legislation in respect of local authorities, this legislation does not require each member of staff to be bilingual, but merely requires that the service itself is a bilingual one. This means that the services provided under this legislation must make the necessary arrangements to ensure that all persons in need who turn to them are always given the opportunity to express themselves either in Dutch or in French[28].

3.3. *The legal situation in respect of private hospitals in Brussels*

Private hospitals in Brussels are not subject to the above legislation. However, all private hospitals in Brussels, with the exception of the Brussels university hospitals (the Vrije Universiteit Brussel (VUB), the Université Libre de Bruxelles (ULB) and the Université Catholique de Louvain (UCL)[29]), have opted for what is termed "dual community" status[30]. Establishments having such a status receive public grants from both the Flemish and the French Communities. It is to be expected, therefore, that these hospitals will be open to both communities. Accordingly, these hospitals are at least under a moral obligation to provide reception and care services in both French and Dutch[31].

For some of these private hospitals there is not only a moral but also a legal obligation to be bilingual. Belgian legislation lays down specific rules for cases where a private institution agrees, in conjunction with the authorities, to take on responsibilities which include the carrying out of certain public tasks. In such cases, the establishment in question must make the necessary arrangements for the department to which the public tasks have been assigned to provide its services in accordance with the principle of bilingual service provision, along the lines described above for the Brussels fire-service. Such is the case whenever a private institution is given responsibility for a public task stretching beyond the customary remit of a private concern.

In two opinions on 7 January 1999[32] the Standing Committee for Language Supervision ruled that the running of an officially recognised casualty department and/or medical emergency unit by a private hospital in the Brussels-Capital Region was a public function which went beyond the remit of a private concern[33]. Accordingly, such services must be bilingual. In practice, this means that at the very least, the doctors, nurses and ambulance staff working for the casualty department and/or medical emergency unit in these clinics should be bilingual. When answering emergency calls, they must be able to give patients the requisite emergency health-care and, in addition, be able to contact the patient's family.

The opinions were addressed to the 2 French-speaking single community and university hospitals, the Erasmus ULB hospital and the Saint-Luc UCL hospital. Both hospitals are private ones, subsidised only by the French-speaking community (they are, therefore, so-called "single community" establishments). However, both have a public responsibility as a medical emergency unit and/or casualty department linked to the "100" emergency number. It should also be mentioned here that there is also a Dutch-speaking "single community" hospital in the Brussels-Capital Region, the VUB hospital in Jette. The emergency services of this hospital do, however, comply with the requirements of the aforementioned legislation.

n the above opinions of 7 January 1999, the Standing Committee for Language Supervision also stated that there was an even greater obligation for casualty departments and medical emergency units to be bilingual given that the casualty departments and medical emergency units in these hospitals served not only the public in the bilingual Brussels Region but also the Flemish population in the Dutch-speaking communities of the Flemish Region surrounding the Belgian capital.

3.4. *Medical ethics*

The field of *medical ethics* also offers the requisite guarantees. In 1977, the Belgian Medical Association gave the following opinion with regard to language use in medical practice:

"In the interests of a good relationship between doctor and patient, it is recommended that a doctor be able to speak the language of his or her patients. Wh

Whenever doctors experience communication difficulties in their dealings with a patient, they should take the necessary steps to deal with the situation, for example by having recourse to an interpreter or referring the patient to a colleague who speaks the language of the patient.

Nonetheless, where such an approach is not feasible, for example when on call or on 900[34] *[emergency services] duty, doctors involved in providing such services must be able to speak the language spoken in the region"*[35]*.*

On 15 December 2001, the Belgian Medical Council issued a further opinion on language use in emergency medical assistance:

"In view of the fact that the legislation on emergency medical assistance refers to situations where patients do not have the free choice of health-care provider, the Medical Council regards it as an ethical duty for both medical emergency unit doctors and specialist emergency unit doctors to be able to speak proficiently the language of the region in which they are on duty" [36].

4. Bilingualism in Brussels hospitals: the de facto situation

The actual situation in Brussels hospitals paints a totally different picture, however. Our information is drawn from academic studies, various other publications, individual testimony and official policy documents.

4.1. Academic studies

A study carried out in 1991[37] shows that the catchment area of Brussels public hospitals extends much further than the Brussels Capital Region. Over 25% of patients in public hospital establishments in Brussels come from outside that region. 15% of admissions to Brussels hospitals are from the overwhelmingly Dutch-speaking Flemish Brabant province[38].

It is not surprising, therefore, that 30% of the patients in Brussels public hospitals are Dutch-speaking. Notwithstanding this, a mere 10% of the doctors in those hospitals are Dutch-speaking[39].

At the same time research by the Catholic University of Leuven (KUL) and the ULB at the beginning of the 1990s shows that about 58% of Dutch-speakers referred to public hospitals in Brussels were not properly received and obliged to express themselves in French[40].

This need to switch to French naturally assumes that Dutch-speaking patients have a perfect knowledge of the French language necessary to explain their health problems. However, some 38% of Dutch-speakers referred to public hospitals in Brussels do not master French[41]. Consequently, it is even more of a problem for this group of Dutch-speaking patients.

It is clear from a study by the Catholic University of Brussels (KUB), the VUB and the Brussels Welfare Council in 2000[42] that the situation did not improve in the course of the 1990s. This study maintains that Dutch-speaking patients still come up against unacceptable language problems in Brussels health establishments. They are frequently not understood. Often staff are not willing to make the slightest effort to understand the other language, namely Dutch.

This recent study also reveals that the emergency services (dialled on 100) constitute a major problem. The 100 switchboard operators are not all bilingual. The fire brigade staff who go out on ambulances are often not bilingual either. This has led to misunderstandings on more than one occasion when explaining emergency situations, resulting in delays and/or the wrong services being sent out.

As previously mentioned, the emergency services are provided not only by public bodies but also by private hospitals. In particular, the functioning of the emergency services of the French-speaking hospitals Erasmus (ULB) and St Luc (UCL) have long been a problem. These hospitals assign mostly non-Dutch speaking staff to emergency services in the Flemish municipalities around Brussels, even though the population in those municipalities is nearly exclusively Dutch-speaking. This practice is in flagrant violation of language legislation and medical ethics which, as already explained above, state plainly and clearly that emergency medical staff should understand and speak the language of the communities concerned.

Finally, the recent study by the Catholic University of Brussels (KUB), the VUB and the Brussels Welfare Council demonstrates that communication in the casualty units of Brussels hospitals often goes awry. When asked about communication in casualty units, 57% of the casualty admission patients surveyed were critical. The level of

dissatisfaction among patients who themselves took the initiative of going to a hospital casualty department or doing so on the advice of their own doctor or family was lower (45%) than among patients taken in by the 100 service (62.5%). A number of patients expressing criticism said that the services were French-speaking, there was a lack of comprehensible explanation from doctors and nurses on duty and waiting times were long[43].

4.2. Other publications on the language situation in Brussels hospitals

In addition to the above academic research, numerous other private bodies have analysed and condemned the language situation in Brussels hospitals.

In 1972 the language problem in Brussels hospitals was broached by Dr Robrecht Vermeulen at the time of the Flemish Medical Association's 50th anniversary. He described the language situation in Brussels hospitals as follows:

"In principle patients may freely choose their doctor. … Where clinical care is concerned, this is far from the case, and one can hardly talk of free choice. For the less well-off patients who go to public hospitals … the choice is extremely limited. That also applies to accident victims picked up on 100 calls. They are taken to a public hospital more or less regardless of their wishes. … For patients going to private establishments the choice is also limited and moreover they do not dispose of the necessary information enabling them to make rational choices. In practice, any choices are mostly made through the family doctor.

When patients end up in hospital they very often encounter language situations which are totally unacceptable and which they can do nothing about. In Brussels one can get by everywhere in Dutch but this requires constant and sometimes very considerable efforts. Everywhere, it is becoming increasingly regarded as normal to speak French, with the result that time and time again one must ask for the word in Dutch. This demands repeated efforts, wastes a great deal of time and is likely to result in poorer service. Many Flemish people make such efforts in shops and in dealings with public authorities but how many can and dare make such demands of their doctor or the hospital? A sick person needs above all medical assistance and they are not going to want to delay or complicate the provision of that assistance by making demands concerning language. This means that hospitals and doctors can deal with everything in French and then safely claim that they have not encountered any language problems."[44]

Dr Vermeulen turned up an event from 1962 to support his statement:

"This clinic [the Cesar de Paepe hospital in Bosvoorde] hit the world headlines in 1962 with the Stoffels case, in which a working class Flemish woman underwent a stomach operation instead of having her teeth out as a result of the doctor and nurses speaking only French and the patient only Dutch …"[45]

In 1979 Dolf Cauwelier, chairman of the Brussels Welfare Council, posed the problem as follows:

"Dr Emmerechts' statistics show that virtually 30% of the patients in public hospitals in Brussels are Dutch-speaking while the figure in private hospitals is nearly 35%. That means that, overall, something like one in three hospital patients in Brussels is Dutch-speaking.

The language ratio of the doctors is in stark contrast to the patient numbers: in private hospitals there is barely 1 Dutch-speaking doctor for 18 French-speaking ones; in public hospitals, the figure is 1 for every 16.

Of course a number of these French-speaking doctors can make themselves understood in Dutch, some of them even fairly well. But that does not alter the fact that the everyday environment in virtually all public and most private hospitals is plainly and simply French-speaking. The Flemish patients are the second language people; they feel like second-class patients.

It used to be said that the further down the hierarchy one looked, the more one found Dutch spoken. Nowadays that too no longer seems the case. Among nursing and maintenance staff too, the number of monolingual French-speakers seems to be on the increase. This applies even to telephone receptionists whose job is dealing with the public! In a recent spot-check in which 29 hospitals were telephoned, 7 switchboard operators spoke no or virtually no Dutch and another 5 could answer calls in only very halting Dutch.

Unless they are in the Flemish VUB hospital in Jette, Flemish patients who are not bilingual themselves have no absolute guarantee anywhere of being able to explain what they feel or what they are suffering from in Brussels hospitals."[46]

In 1998 Reej Masschelein, coordinator of the Brussels Welfare Council, appraised the situation as follows:

"It is naturally to be expected on humane grounds that any healthcare worker will turn their attention to any persons requiring care, regardless of their background, race or language, or financial status. …

Yet it often appears less self-evident that a Flemish patient will be addressed in their own language in non-municipal facilities. Language is undeniably an important requisite for quality care in these eminently personal circumstances. What is needed here above all is respect, a little goodwill and a little effort. It is not the carer's free choice of language that should take precedence here; the patient must be the central concern as the ethically and legitimately interested party. Structural measures have brought about little change in recent decades. Incentives have been given, circumstances sometimes make things possible but there is also reluctance."[47]

In 2000 Sven Cockx, coordinator of Pro Medicis Brussel, an officially recognised voluntary association working to develop Dutch-speaking care provision in Brussels, described the situation of emergency medical teams as follows:

"If a Dutch-speaker in Brussels urgently requires specialised care, it may be the case, for instance, that an emergency medical team from, say, the Erasmus or St Luc hospital comes out with exclusively French-speaking paramedics on board. Language problems in such emergency situations are not unheard of. There is also a very real chance that a Dutch-speaking patient will be taken to one of those two French-speaking university hospitals, and an equally high chance that pretty well no one on the nursing and medical staff can speak to them in Dutch."[48]

Yet the emergency medical teams from the Erasmus and St Luc hospitals cover large parts of the Dutch-speaking area: the radius of action of the Erasmus hospital team reaches well into Pajottenland[49], while the St Luc hospital team goes as far as Leuven[50].

4.3. Individual testimony

The structural problem of the lack of Dutch-speaking personnel in emergency services and hospitals is also clear from accounts given by various individuals.

Back in 1978 Mrs De Ceuninck had the following experience when her young daughter was taken by ambulance to the supposed bilingual St Pieter public hospital in Brussels:

"I stood there with my child in the hall of the hospital. She was lying unconscious on a stretcher. A woman came up and asked me if I spoke any French. I replied quite truthfully that I could not speak French and understood only a little. Then another woman, who seemed to be a doctor, came up. The same thing happened. She did not speak a word of Dutch either. Then a police officer happened along and asked in Flemish what had happened. But after three minutes he moved on and I was left all alone again.

Then another woman doctor came along and asked if I spoke German to which I replied no, and then if I perhaps spoke any English. I said a little bit.

They then examined my daughter and a doctor came up afterwards to tell me in broken Dutch that she had food poisoning and that she had better stay another day in hospital. But our daughter did not speak any French either. I did not want to imagine what she might experience there as some kind of foreigner. So we simply went home."[51]

In 1990 the following account of the mishaps of a terminal AIDS patient was given:

"Mr H, a terminal AIDS patient, was brought into St Pieter hospital in an emergency. A psychiatrist was called up and appeared to speak only French. Mr H. refused any further hospitalisation because he could not be treated by Dutch-speakers. Eventually he allowed himself to be admitted to the university hospital of Jette where he died a few days later."[52]

The following experience was related in March 1995:

"The D. family from Dilbeek dialled the 100 services early yesterday morning because their child, Jetje, was suffering from convulsions and high fever. The Brussels 100 services switchboard sent out the fire brigade ambulance from Asse, which has a station in Dilbeek, a medical team from the Anderlecht Erasmus hospital and a resuscitation unit from the Brussels fire brigade. The ambulance team from Dilbeek were quickly on the scene and cooled the child down immediately in a bath. Using their radio they found out that the two other ambulances could not find their way. One of the Dilbeek team had to give directions to the other crews by radio. An additional problem was that the medical team spoke only French, which made communication more difficult. The medical team arrived over twenty minutes after the call (normally it

takes less than ten minutes to drive from Anderlecht to Dilbeek), followed five minutes later by the resuscitation ambulance. Not a single member of the team could speak Dutch. The child's mother had to interpret. Jetje was taken to the university hospital of Jette and is now well again."[53]

On 9 May 1998 Dr Patrick Bastaerts, chairman of the Brussels General Practitioners association gave the following account at a colloquy on the Dutch-speaking care provision in the Brussels Capital Region:

"I had a patient from a muslim country who spoke only Dutch besides his own language. The man had to be rushed to hospital and ended up in a bi-community establishment. Three hours later I received a call from him asking me to contact his daughter and tell her to go and sit with him in the ward, since no one could talk to him. The patients could not and, to his amazement, nor could the nurses and doctors. That man could not make himself understood, could not explain what he was suffering from and could not even say that he wished to drink, because the people around him quite simply did not understand."[54]

At the beginning of April 2000, Dr Luc D'Hooghe, deputy chairman of the Brussels General Practitioners association and a GP in Vorst, related the following:

"A patient who was hyperventilating was brought in by the emergency services. He had tingling in his mouth and fingers, with palpitations and occasional fainting. These are symptoms of a heart attack. After questioning in halting Dutch, the patient was taken up to cardiology whereas five minutes' questioning in his own language would have shown that this was unnecessary."[55]

In the same interview Dr D'Hooghe said that communication problems often caused misunderstandings in paediatric and psychiatric treatment too:

"Once your file is drawn up in French, you generally stay within the French-speaking circuit. A child who had suffered an oxygen deficiency at birth struggled with the consequences for years. Since the file was drawn up in French, the patient was referred to French-speaking physiotherapists and speech therapists. By chance he came into contact with Dutch-speaking doctors, with the result that the child made swifter progress, not because of poor or incorrect treatment but simply because everything was taking place in the child's language."[56]

One patient with a speech impediment was treated by a speech therapist who did not understand the patient's language.

In June 2000 the case came to light of a Dutch-speaking woman with a head injury. The woman was redirected by a Brussels public hospital because the French-speaking staff did not understand the woman:

"Barbara had hit her head, and the wound needed stitches. … We reported to reception in the Etterbeek-Elsene hospital casualty department and spoke Dutch because my girlfriend comes from Antwerp. The reply we received beggared belief. The receptionist said: 'This is a French-speaking hospital. I cannot understand you'. If we wanted assistance we had to go to another hospital."[57]

In the wake of this case, other similar cases surfaced in the press. Peter Van Breusegem, a Flemish GP in Brussels, said the following of private hospitals in the newspaper *De Standaard* of 3 August 2000:

"Private hospitals are not obliged to comply with the language legislation. But for emergency medicine, ie emergency cases and the ambulance services, they really must provide a bilingual service. That legal obligation is not complied with everywhere. The Erasmus ULB hospital, on the border between Flemish Pajottenland and Anderlecht, has a bad reputation. The Erasmus ambulance teams go a long way into the Pajottenland area and not always with Dutch-speaking staff."[58]

The same article mentioned the following attempt at a solution:

"Some hospitals are trying to make up for the lack of Dutch-speaking staff in another way: the radiography department of a hospital in the centre of Brussels puts on a cassette giving instructions when a Dutch-speaking patient comes in."[59]

In *De Standaard* of 7 June 2001 Mrs Jaklien Vandermeulen related the following experience:

"One of these days a Dutch-speaking child will come into the casualty unit of a Brussels hospital and the doctor will not be able to find out from his young patient exactly what the matter is.

'I have experienced this kind of difficulty myself', says Jaklien Vandermeulen from Home-Info. 'My little boy once had to be taken to a Brussels hospital and none of the nurses understood a blessed word of Dutch. That in itself was not a problem because I

was with him but imagine that that had not been the case. My son hardly spoke or understood any French. I was very angry. Had there been a telephone line to make complaints on, I would certainly have called it'."[60]

Furthermore the bench of mayors and aldermen of Overijse, a municipality on the edge of Brussels in the Dutch-speaking Flemish Brabant province, sent the following letter to the ministers responsible for public health in March 2002:

"Following the referral of a specific case to the recent municipal council sitting on 12 March, we are writing to draw your attention to a longstanding and ever more pressing problem.

The following events recently occurred in Overijse. An old lady required assistance following a fall. An ambulance was called immediately. When the lady was picked up, she asked to be taken to a hospital in Leuven because her medical file was there and she wished to be treated by Dutch-speaking staff. Instead, she was taken to St Luc hospital in Woluwe. There, in all the different departments, she was spoken to only in French. This resulted in a total lack of communication as regards her medical condition, care and treatment. When her medical file came from Leuven, she had to translate it herself!

Such unacceptable situations are worthy of complaint. This particular complaint is only one of many. It is only a matter of time, therefore, before this state of affairs causes a tragedy.

Freedom to choose the place of one's medical treatment is a fundamental right for any person. The argument that a person can be taken elsewhere later on does not stand up, since this right must apply at any time and particularly at the time of an accident. Therefore, the legislation concerning the ambulance transport of injured or ill people on the basis of the single-number "100" system has to be amended. If this fundamental right is not recognised, another right applicable in Belgium needs to be recognised in any case, namely that people must be able to receive treatment in Dutch in Brussels."[61]

Finally, to underline the urgent nature of the problem, a number of Flemish Brussels residents made the following complaints about the inadmissible language situation in Brussels hospitals at the end of January 2001:

Gerrit Six, journalist, St Gillis: *"… I remain insistent that our children be schooled in Dutch and that in hospitals we can say what we are suffering from in our mother tongue. …"*

Staf Nimmegeers, parish priest: *"… How can it happen that a Flemish Brussels resident dies because the doctor does not understand him?"*[62]

4.4 Official political acknowledgement of the problem

Moreover, a number of responsible ministers have explicitly acknowledged that Dutch speakers' right to adequate access to Brussels hospitals is not guaranteed.

As long ago as 1973, the then Minister of Health, Mr Jos De Saeger, agreed that the language situation in Brussels hospitals was problematic:

"… It is also a fundamental rule of medicine that there should be no language barrier which could impede or prevent confidential contact in the personal relationship between doctor and patient. It is not the patient who must know the doctor's language, but the reverse. It should not just be assumed that most Flemish people admitted to Brussels hospitals know a little French. When the health of a patient is at stake, "a little French" cannot suffice for close personal contact between doctor and patient. It is not the patient who must be expected to make a great effort, but the doctors who work in the hospitals of the Brussels metropolitan area." [63]

In 1975, Mr De Saeger confirmed what he had said previously:

"As we, in spite of the awful imbalance where doctors are concerned, receive so few individual complaints, although there are some, this is, in my opinion, largely due to the ability of the nursing and medical staff to speak more than one language." Q[64]

The following description of the situation was given in 1979 by Mrs Rika Steyaert, at that time Dutch-speaking Secretary of State for the Brussels-Capital Region:

"The French-speaking dominance of Brussels hospitals is adequately recognised. In the private sector, there are 60 Dutch-speaking doctors as against 1,182 French speakers. Yet the proportion of Dutch-speaking patients is 35%. The situation is no better in the public hospitals, where conditions are similar. One typical example is enough: the Bordetinstituut, where only four Dutch-speaking doctors work, as opposed to 38 French speakers, whereas virtually 44% of patients are Flemish.Su

Such imbalances are typical where Flemish patients are concerned. And, from the

strictly medical point of view, they are inexcusable, for the psychological aspects of every therapeutic process are disregarded."[65]

The problem in the public hospitals was described in the following terms in 1998 by Mr Rufin Grijp, Minister of the Brussels-Capital Region with responsibility for emergency medical services:

"The statutory requirement for bilingual reception and care applies to the public sector. There is no doubt that there is as yet no guarantee that this requirement will be met.Bu

But what is the actual position? According to some recent data available to me, the Dutch-speaking representation at levels 3 and 4 (lower-ranking staff) is more than satisfactory. The pinch begins at levels 2 and 2+ (nursing staff), and the situation is very imperfect at level 1, which is the level of senior paramedics and doctors".[66]

Likewise, at that colloquy, Mrs Brigitte Grouwels, at the time Minister of the Flemish Community[67] with responsibility for Brussels affairs, acknowledged that the reception of Flemish patients in Brussels hospitals was problematic:

"Of course, it is impossible to lump all establishments together. And naturally, it is the case that in the establishments which serve both communities there are plenty of bilingual doctors and nurses, who treat all patients in a professional and exemplary way, regardless of mother tongue. It is, nevertheless, an unmistakable fact that there are Flemish patients every day who experience difficulties in obtaining treatment in their own language in what are called 'dual community' establishments. This is of course unacceptable". [68]

Individual members of parliament have also frequently voiced their concern. At a May 1998 colloquy, for instance, Mr Jan Béghin, vice-president of the Brussels parliament - the directly elected regional assembly of the Brussels-Capital Region - recognised that there was a constant need to champion the use of both languages in private hospitals, even in the very same private hospital of which he was vice-chairman:

"I am sitting at this table today as vice-chairman of the Europa-Sint-Michielskliniek, created by a merger of the Europa-kliniek and the larger Sint-Michielskliniek, in Etterbeek. It serves both communities, and I endeavour to make and to keep it as bilingual as possible, but that is not an easy task". [69]

Bert Anciaux, Minister of the Flemish Community with responsibility for Brussels affairs, writing in 2000, expressed his view in the "Beleidsnota Brusselse Aangelegenheden 2000-2004" that:

"In municipal administrative departments and non-profit-making organisations, in establishments serving both communities and even in regional authorities, the application of the legislation on language often leaves a lot to be desired. Nor is there effective supervision of compliance. For the sake of convenience, firms and establishments base themselves on the false premise that Brussels is a uniformly French-speaking city. This is expressed in both their service provision and their communication. Not only is there a risk from this attitude for Dutch speakers - if they need emergency services in private hospitals - but it also goes against the grain for Flemish people in less vulnerable situations."[70]

On 1 Aug 2000, Bert Anciaux introduced an action plan for better compliance with the language legislation. In his press release, the minister made it clear that the law states that hospitals, where emergency medicine is concerned, and public hospitals in every respect, must provide services in both languages. He urged his responsible federal colleagues to oblige hospitals to organise themselves so as to provide services, at least, in two languages. He also complained that it was still the case that Dutch-speaking patients in the "Vlaamse Rand" around Brussels are always transported by single-language Brussels-based French services to hospitals which also work only in French.[71]

The latest acknowledgement by a responsible Minister came from Mr Jos Chabert, Minister of the Brussels-Capital Region with responsibility for health policy. He agreed, in December 2001, that there were far too few Dutch-speaking staff in certain hospitals in Brussels.[72]

The concern of various Dutch-speaking ministers is shared by the Parliament of the Flemish Community. On 21 February 2001, the Flemish Parliament passed a motion asking the Flemish government:

"… to place on the agenda for the interministerial conference on health and drug policy the language problem in the health sector in Brussels, and particularly the problem of a bilingual service at the public hospitals in Brussels, the bilingual nature of the emergency services at all Brussels hospitals and the bilingual nature of the

emergency medical services in Brussels and the 'Vlaamse Rand'." [73]

5. Why is an urgent improvement of the situation desired?

It is not only because of the fundamental right to health, which should be guaranteed without discrimination, and the positive obligation for the authorities to protect and promote their citizens' right to physical and psychological integrity, that rapid improvements are required to the unacceptable situation of Dutch speakers in Brussels health facilities. Speedy improvements relating to the unequal access of Dutch speakers to Brussels hospitals are also necessary in order to avoid the potentially fatal consequences of misunderstandings. Human dignity is also at stake, ie the proper care of patients and the respect with which patients deserve to be treated.

Good communication between doctor, nurse and patient may sometimes be literally vital. MUGs (emergency medical groups) have to provide very rapid assistance to people in need. Sometimes a few minutes can be crucial. It is in some instances important for patients, their families, their friends, or witnesses, to be able to provide extra information. If the people questioning them cannot speak Dutch, the consequences for the patient may be serious. But there are also other situations in which clear communication between doctor, nurse and patient is very important. Dialogue between those providing care and the patient is essential in the health service. Only through dialogue can all those involved, doctor, nurse and patient, fully grasp the health situation or the clinical picture. Only when they have been fully and properly informed can patients gives their informed consent to certain medical treatments. And medical jargon is highly specific, making even more important a comprehensible explanation in ordinary language. It may be extremely doubtful whether a patient who cannot be understood can be properly treated. If language is a real obstacle to communication, something is very wrong in the health care sector.

Often, patients are in great need. Their need is all the greater if they have to use a language other than their mother tongue to express themselves. Relations between, on the one hand, the patient and, on the other, doctors, nurses and hospitals are indeed first and foremost a relationship of dependence. Patients come to the hospital in pain or needing urgent treatment. Their main objective is to obtain assistance. If that cannot be done in their own language, they often dare not make any comment, fearing that they will not receive good treatment. As they cannot express themselves in their own language, their feeling of dependence is merely further accentuated.

Policy documents also acknowledge that it is essential, and sometimes even vital, to promote or to make possible good communication (relations between doctor and establishment, doctor and patient, patient and emergency services...). It is likewise agreed that language plays an even greater role in some forms of care (care of the elderly, rest homes, psychotherapy, dementia, childcare, emergency services).[74]

Moreover, language problems often lead to unnecessary examinations, and therefore to wasted expenditure:

"The quality of medical treatment largely depends on the extent to which information is exchanged between doctor and patient. In order to exchange this information, it is important for each to know the other's language. Where a doctor does not know the language of the patient and family circle, it is impossible for him or her to communicate with them. A doctor who cannot communicate with the patient and his or her family circle cannot write an accurate case history. And an accurate case history is simply vital if complete and high-quality treatment is to be given.Th

Thus language problems are a significant obstacle to high-quality medicine. If a doctor writes an inaccurate case history, this might well lead to an incorrect diagnosis and unsuitable treatment. Incorrect diagnoses, again, lead to unnecessary examinations, so money is wasted, often large amounts.

Where the patient is concerned, language problems may, again, give rise to misunderstandings. It is always important for the patient to understand as fully as possible why he or she is being treated in a certain way, and how, for example, any medicines are to be taken. If you cannot understand your doctor, there is a real risk of misinterpreting his or her advice. Such misunderstandings can lead to unsuccessful treatment, resulting in both time and money being wasted.

Language problems and the costs that they entail are not confined to doctor or patient. There is also a social dimension. Society has to foot most of the bill for these avoidable costs. Costs which can mount up if a patient has suffered damage as a result of incorrect treatment or misinterpretation of the doctor's advice."[75]

After all, a nurse shows little respect it he or she fails to use patients' own language when speaking to them. In this context, there is an appropriate quotation from the book "Arm Brussel", by the celebrated Flemish author, Geert Van Istendael:

"The language legislation is clear: anyone in contact with the public must have an

elementary grasp of both languages. Those doctors and nurses who are bilingual do much more than just comply with the law. They understand a problem that is actually very commonplace, very fundamental: that of trying to explain to a doctor exactly where it hurts, and what kind of pain it is, in a language which is not your own." [76]

6. Why are we addressing ourselves to the Parliamentary Assembly of the Council of Europe?

De jure it seems that the necessary guarantee of access to Brussels hospitals does exist for Dutch speakers. Medical ethics and the current language legislation, in particular, may give this impression. Instead, the situation on the ground shows that Dutch speakers' access to health establishments in Brussels, the capital of Belgium, is anything but guaranteed. This has already been the situation for decades, and in spite of the language legislation, medical ethics and the fact that Brussels private hospitals are supposed to serve both communities, no significant improvement can be detected, as emphasised by the latest study, conducted in the year 2000.

Systematic discrimination against Dutch speakers at health establishments in the capital of Belgium is not a recent phenomenon. For decades, attempts have been made to solve the fundamental problem through negotiations between the two main linguistic communities of Belgium, the Dutch and the French speakers. Nevertheless, a legislative framework does exist. The problem resides firstly in getting the French-speaking community to acknowledge that the problem exists, and secondly in an unwillingness of the controlling authority to enforce application of the laws concerned.

Belgium's language legislation developed under a procedure which differs from that used for other Belgian legislation. It requires a dual majority, ie among both the Dutch-speaking and the French-speaking members of the federal parliament. It is more the Brussels-Capital Region which is responsible for supervising application of the language legislation by local government, and among Public Social Welfare Centres (OCMWs). The Brussels-Capital Region can take a decision about supervision of the OCMWs only if that decision is supported by both a Dutch-speaking member of the Brussels-Capital regional government and a French-speaking member of that same government. In other words, if an OCMW takes a decision which contravenes a law, its decision can only be annulled by the government of the Brussels-Capital Region if a consensus exists about it between the responsible Dutch-speaking minister and the responsible French-speaking minister.[77]

This consensus rule was intended to protect the Dutch-speaking minority. The interests of the Dutch-speaking minority in relation to matters affecting both linguistic communities, both the Dutch and the French-speaking, were to be protected against damage resulting from any decision taken by the French-speaking majority, as the Dutch-speaking group does have a right of veto. In practice, the consensus rule tends to have more of an inhibiting effect. The inequality between the responsible Dutch-speaking minister and the responsible French-speaking minister in respect of compliance with the language legislation in the OCMWs generally leads to the absence of one of the two signatures required to give a decision legal force.[78]

There is one practical example in the shape of appointments to public hospitals in Brussels which do not comply with the language legislation. Staff can only be taken on by a Brussels public hospital if they have proved in a language examination that they have a satisfactory knowledge of the other national language, Dutch or French. If a public hospital does recruit somebody who cannot prove in such an examination that he or she has a satisfactory knowledge of the other national language, its decision is suspended for 40 days by the deputy governor of the Brussels-Capital Region. The deputy governor is a federal government official appointed by the King. The main power he or she holds is precisely that of supervising compliance with the language legislation in the Brussels-Capital Region.[79]

The deputy governor can only suspend implementation of a decision which contravenes the language legislation, meaning that implementation is prevented for a specified period. Such a decision can only be annulled, and therefore definitively blocked, if both the Dutch-speaking and French-speaking ministers responsible agree to annulment. In practice, it tends to be the responsible French-speaking minister who systematically refuses to sign annulment decisions relating to appointments of French speakers who have not demonstrated their knowledge of the Dutch language by taking a language examination, although the language legislation explicitly requires such a demonstration in respect of all persons recruited to work at OCMWs, thus encompassing recruits to the public hospitals of Brussels.

Between 1995 and 1999, Mr Rufin Grijp was the Dutch-speaking Minister of the Brussels-Capital Region responsible for application of the language legislation in OCMWs. Mr Gosuin was his French-speaking counterpart. Whereas the deputy governor of the Region suspended one recruitment process which contravened the language legislation, and Mr Grijp did sign an annulment decision, Mr Gosuin did not countersign it, preventing annulment, the contravention of the law notwithstanding. As Mr Grijp put it himself, *"On this point, it is Mr Gosuin who is obstructing me"*.[80]

Asked whether Mr Gosuin's signature rendered him powerless, Mr Grijp replied: "*Not so much powerless, it is more a question of being frustrated*".[81]

In Belgium as a whole, the specific national language legislation protects the numerically smaller French-speaking population, but, in contrast, it does not offer sufficient guarantees to the minority Dutch-speaking population which forms 9,3% of the population of the Belgian capital.[82] Furthermore, the number of Dutch speakers who live in the Brussels-Capital Region, are employed in that Region, or are potential patients of Brussels hospitals has to estimated at a minimum of 300 000.[83]

And, as already indicated, the Brussels authorities are given insufficient encouragement by their French-speaking superiors to apply the language legislation effectively. Application is frequently deliberately obstructed by these local and regional authorities themselves.

For these reasons, we find ourselves obliged to take this matter to a higher level, namely to the Council of Europe, so as at last to obtain a full guarantee of the right to equal treatment for Dutch speakers in Brussels hospitals, a fundamental right enshrined in various Council of Europe human rights treaties.

The signature below, validated in accordance with the provisions of Belgian law, confirms my explicit agreement with the content and purpose of this petition.

Date of signature: 26 September 2002

Signature (*preceded by the personally handwritten confirmation "read and approved"*)

Sven GATZ, member of Jette municipal council, of the Brussels-Capital regional council, and of the Flemish Parliament

Validation of the signature: L Vermeiren

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[1] Approved by the Committee on 3 November 2003. At its meeting on 25 November 2003, the Standing Committee ratified the proposal of the Bureau to refer the Opinion and the Petition to the Social, Health and Family Affairs Committee for report and to the Committee on Legal Affairs and Human Rights for opinion (Reference No 2906).

[2] Isolated reports of patients who were "refused" treatment unless they addressed the hospital staff in French were disputed on factual grounds by the hospital administration in charge. They made it very clear that such behaviour would not be tolerated in any circumstance.

[3] The medical, human and legal reasons given above logically apply also to patients whose native langue is neither French nor Dutch. The figures given by IRIS representatives show that patients (mainly immigrants) speaking more than 100 languages are treated regularly in Brussels hospitals. But in my view, their situation differs in that they have chosen to live in a foreign country and can therefore be expected to learn a local language to the point that they can meet practical requirements connected to their stay. For those who have not (yet) reached this stage, the hospitals go through considerable lengths to provide interpretation into French. These efforts can only be welcomed whole-heartedly. From the point of view of patients' rights, it is regrettable that one of the Dutch-speakers quoted in the above-mentioned study was apparently annoyed about the efforts made by Saint-Lucas hospital in Woluwe to interpret for an Arabic patient and his family, with whom her child shared a room, whilst no similar effort had been made for her to enable her young child to communicate in Dutch.

[4] I do not wish to comment on those statements from radical elements on the sides who talk about "re-conquering" Brussels, which used to be the capital of (Flemish) Brabant, or on the contrary, wish to eliminate the remaining Dutch-speaking character of Brussels and its surroundings as a first step towards "redressing the balance" at the national level.

[5] Interhospitalenkoepel van de Regio voor Infrastructurele Samenwerking/Regional Organisation of Hospitals for Infrastructural Cooperation.

[6] Decision no. 24.982 of 18 January 1985, quoted from the above-mentioned memorandum, p. 38

[7] A "Mobile Urgency Group" consists of at least one doctor and a nurse specialising in emergency medicine, assisting the ambulance staff in caring for the patient on-site and during their transport to the nearest hospital.

[8] decision of the Permanent Commission cited in the above-mentioned Memorandum,

p. 32

[9] study by J. Tyssens, cited in the Memorandum, p. 28

[10] as there are no language-based "sub-nationalities" in Brussels, the best way to estimate language affiliation of Brussels residents are the election results. In the first election to the Brussels parliament, held in June 1989, the French-speaking parties won 84.7 % of the vote. The Flemish parties totalled 15.3 %. According to the study by R Janssens on Language use in Brussels (VUB Press, 2001, p. 34, cited in the Petition in footnote 68), 9.3% of the population of the Brussels Region live in households communicating exclusively in Dutch at home, and in another 10.1% of households, both Dutch and French are spoken at home)

[11]

footnote 38

[12]

the (Dutch-speaking) Katholieke Universiteit Leuven and the (French-speaking) Université Libre de Bruxelles – Study by A. Laurent and A. Prims – Investigation into the quality of the reception of and assistance provided to users from different communities in the bi-community general hospitals of the Brussels region, Leuven/Brussels 1992

[13] see above p. 7

[14] page 33

[15] The underlying premise in all of the Flemish Community's policy texts is that the public authorities providing education, culture and health services in the Dutch language in the Brussels-Capital Region are at the service of 300,000 Dutch-speaking residents, not only "Flemings" but also anyone who has recourse to the amenities and facilities in question in order to obtain the required provision of services (see the policy paper "Gezond en wel" (Healthy and well), submitted by Mr J. CHABERT, Minister of the Brussels-Capital Region with responsibility for health, 13 December 2001, *Gedr. St.*, Raad van de Vlaamse Gemeenschapscommissie, 2001-2002, 229/1, 6).

[16] Article 23: Everyone has the right to lead a life in conformity with human dignity. To this end, the laws, decrees, and rulings alluded to in Article 134 guarantee, taking into account corresponding obligations, economic, social, and cultural rights, and determine the conditions for exercising them. These rights include notably: 2) the right to social security, to health care and to social, medical, and legal aid;

[17] E. BREMS, "Nachtvluchten kunnen mensenrechten schenden" (Night flights can violate human rights), *De Juristenkrant*, 24 October 2001, 1 and 12.

[18]

"The right to the highest attainable standard of health. CESCR General Comment 14", 11 August 2000, E/C.12/2000/4. See also, B. TOEBES, "Het recht op gezondheid: geen recht om gezond te zijn" (The right to health, not a right to be healthy), *Ars Aequi*, 1999, 912-915.

[19] Brussels, as the capital of Belgium constitutes, within the federal structure of the country, a special Brussels-Capital Region with its own specific powers and responsibilities.

[20]

The "Vlaamse Rand" is an unofficial name for a number of municipalities in the Flemish Region which are situated close to Brussels and which depend on the capital's facilities for a number of public services, such as health-care.

[21]

The "single community" establishments depend for their financial resources on one of the two language communities. There are also a number of establishments in Brussels which are subsidised by both language communities; these are the "dual community" establishments.

[22]

Sections 17 to 22 inclusive of the laws on the use of languages in administrative matters, as co-ordinated by the Royal Decree of 18 July 1966. Language legislation comes under the competence of the Belgian federal level. Monitoring of the application of federal language legislation, on the other hand, falls under the competence of the regional authorities.

23

A. DETANT, "De toepassing van de taalwetgeving in de OCMW's" (The application of language legislation in the OCMWs), in A. DETANT (ed.), *De toepassing van de taalwetgeving in de Brusselse gemeentelijke instellingen* (The application of language legislation in the Brussels municipal institutions), Brusselse Thema's nr. 2, Brussels, VUB Press, 1995, 129.

24

This means that both the Dutch-speaking and French-speaking members of the Standing Committee for Language Supervision **unanimously** supported the text of this opinion.

25 Standing Committee for Language Supervision, nr. 22.004, 30 May 1991, 3.

26

Standing Committee for Language Supervision, nr. 22.004, 30 May 1991, 8.

27

Sections 50 and 54, the first paragraph of Chapter V and Chapters VII and VIII of the laws on the use of languages in administrative matters, co-ordinated by the Royal Decree of 18 July 1966.

28

J. TYSSENS, "Conflicten rond het taalkader van de Brusselse brandweer" (Conflict over the language situation in the Brussels fire-service), in E. WITTE, M. DE METSENAERE, A. DETANT, J. TYSSENS and A. MARES, *Het Brussels Hoofdstedelijk Gewest en de Taalwetgeving* (The Brussels-Capital Region and Language Legislation), Brusselse Thema's nr. 5, Brussels, VUB Press, 1998, 60.

29

In Belgium, institutions set up by religious or ideological groups are deemed to be not "public" but "private" institutions, even though they derive the majority of their financial resources from public grants. This is true in particular of the Katholieke Universiteit Leuven (KUL) and the hospitals belonging to the VUB, the ULB and the UCL. There are also other private hospitals set up following special private initiatives (eg monastic/convent orders, health-care funds).

30

See footnote 21.

31

A. DETANT, "De toepassing van de taalwetgeving in de OCMW's" (The application of language legislation in the OCMWs), in A. DETANT (ed.), *De toepassing van de taalwetgeving in de Brusselse gemeentelijke instellingen* (The application of language legislation in the Brussels municipal institutions), Brusselse Thema's nr. 2, Brussels, VUB Press, 1995, 126.

32

Standing Committee for Language Supervision, no. 29.336, letters of 7 January 1999 from the Standing Committee for Language Supervision to the Erasmus and Saint-Luc hospitals.

33

Section 1, § 1, 2° of the legislation on the use of languages in administrative matters, co-ordinated by the Royal Decree of 18 July 1966.

34 In 1977 the emergency services number was "900", subsequently being changed to "100".

35

The opinions of the Belgian Medical Council can be found on their website: www.ordomedic.be.

36

Ibid: www.ordomedic.be.

37

M. TAYMANS, *Invloedzone van de Brusselse ziekenhuizen* [Brussels hospitals catchment areas], Dossier BRES nr. 1, Brussels, BRES, 1991, p 53.

38

A. DETANT, *"De toepassing van de taalwetgeving in de OCMW's"* [The application of language legislation in public social welfare centres], in A. DETANT (ed.), *De toepassing van de taalwetgeving in de Brusselse gemeentelijke instellingen* [The application of language legislation in Brussels municipal establishments], Brusselse Thema's nr. 2, Brussels, VUBPress, 1995, 123 and 135.

39

J.F. VAN GYSEL, *De aanwezigheid van de artsen in Brussel* [The availability of doctors in Brussels], Brussels, study under the auspices of Minister Rufin Grijp, p 125, quoted in A. DETANT, *"De toepassing van de taalwetgeving in de OCMW's"* [The application of language legislation in public social welfare centres], in A. DETANT (ed.), *De toepassing van de taalwetgeving in de Brusselse gemeentelijke instellingen* [The application of language legislation in Brussels municipal establishments], Brusselse Thema's nr. 2, Brussels, VUBPress, 1995, 123 and 135.

40

A. LAURENT and A. PRIMS, *Onderzoek naar de kwaliteit van het onthaal en de begeleiding van de gebruikers uit verschillende gemeenschappen in de bicommunautaire algemene ziekenhuizen van het Brussels Gewest* [Investigation into the quality of the reception of and assistance provided to users from different communities in the bi-community general hospitals of the Brussels region], Leuven/Brussels, KUL/ULB, 1992, p 189.

41

See footnote 39.

42

M. VERKOUTER, Kwaliteit van de communicatie in de contacten van de patiënten en van de huisartsen met de Brusselse verzorgingsinstellingen [Quality of communication in dealings of patients and GPs with Brussels care establishments], Brussels, Brusselse Huisartsen, 2000, p 214. See also G. TEGENBOS, *"Brusselse gezondheidszorg is nog altijd taalziek. Nooit zeker of een patiënt die door de 100 wordt opgehaald, ook zal worden begrepen"* [Brussels health care is still language-impaired: it is never certain whether patients will be picked up by the 100 services or understood when they are], *De Standaard* newspaper, 23 June 2000.

43

M. VERKOUTER and L. D'HOOGHE, *"De opvang van (Nederlandstalige) patiënten uit Brussel en Vlaams Brabant door de spoeddiensten van het Brussels hoofdstedelijk gewest"* [The reception given to (Dutch-speaking) patients from Brussels and the Flemish Brabant by the emergency services in the Brussels Capital region], Nieuwsbrief-VGV, January-February 2001, 8.

44 R. VERMEULEN, *"De taaltoestand in de Brusselse ziekenhuizen", Taaltoestanden in de Geneeskundige Sector te Brussel, Vlaams Actiecomité voor Volksgezondheid, najaarsvergadering van het Vlaams Geneesherenverbond* [The language situation in Brussels hospitals – situation in the medical sector in Brussels, Flemish Action Committee for public health, autumn meeting of the Flemish medical association], 8 October 1972, 1-2.

45

R. VERMEULEN: op. cit: 6.

46

D. CAUWELIER, *"Welzijns- en gezondheidszorg voor Nederlandstaligen te Brussel, Gezondheidszorg voor de Vlaamse Patiënt te Brussel, najaarsvergadering van het Vlaams Geneesherenverbond"* [Welfare and health care for Dutch-speaking Brussels residents, Health care for Flemish patients in Brussels, autumn meeting of the Flemish medical association], 29 September 1979, 9.

47 J. DEGADT and A. MONTEYNE, *Het Nederlandstalig Zorgaanbod in het Brusselse Hoofdstedelijke Gewest* [Care provision for Dutch-speakers in the Brussels Capital region]. Report at the colloquy of 9 May 1998, Brussels, K.U.B., 1998, 15-16.

48

S. COCKX, *Pro Medicis Brussel: project ter bevordering van het tweetalig zorgaanbod in het Brusselse hoofdstedelijke gewest. Stand van zaken op 1 november 2000* [*Pro Medicis Brussel* [Pro Medicis Brussel project to promote bilingual care provision in the Brussels Capital region. Progress at 1 November 2000], Brussels, Pro Medicis, 2000, 20.

49

Pajottenland is an area in the Flemish Brabant province. This province is in the Dutch-speaking Flemish Region and borders on the bilingual Brussels Capital region.

50

R. MASSCHELEIN, *"Het bestaande zorgaanbod"* [Existing care provision], in J. DEGADT and A. MONTEYNE (ed.), *Het Nederlandstalig Zorgaanbod in het Brusselse Hoofdstedelijke Gewest* [Dutch-speaking care provision in the Brussels Capital region]. Report at the colloquy of 9 May 1998, Brussels, K.U.B., 1998, 13.

51

De Standaard newspaper, 9 November 1978, quoted by D. CAUWELIER, *"Welzijns- en gezondheidszorg voor Nederlandstaligen te Brussel, Gezondheidszorg voor de Vlaamse Patiënt te Brussel, najaarsvergadering van het Vlaams Geneesherenverbond"* [Welfare and health care for Dutch-speaking Brussels residents, Health care for Flemish patients in Brussels, autumn meeting of the Flemish medical association], 29 September 1979, 10.

52 G. VAN BELLE, *Aids en discriminatie, Brussel* [Aids and discrimination in Brussels], The Foundation, 1990, 2 p., quoted in S. COCKX, *Pro Medicis Brussel: project ter bevordering van het tweetalig zorgaanbod in het Brusselse hoofdstedelijke gewest. Stand van zaken op 1 november 2000* [Pro Medicis Brussel project to promote bilingual care provision in the Brussels Capital region. Progress at 1 November 2000], Brussels, Pro Medicis, 2000, 31.

53

"Language problem hampers medical assistance", *De Standaard* newspaper of 16 March 1995, quoted in S. COCKX, *Pro Medicis Brussel: project ter bevordering van het tweetalig zorgaanbod in het Brusselse hoofdstedelijke gewest. Stand van zaken op 1 november 2000* [Pro Medicis Brussel project to promote bilingual care provision in the Brussels Capital region. Progress at 1 November 2000], Brussels, Pro Medicis, 2000, 54.

54

J. DEGADT and A. MONTEYNE, *Het Nederlandstalig Zorgaanbod in het Brusselse Hoofdstedelijke Gewest* [Dutch-speaking care provision in the Brussels Capital region]. Report at the colloquy of 9 May 1998, Brussels, K.U.B., 1998, 50-51.

55

S. ISHAQUE, *"Een krop in de keel is geen schildklier"* [A lump in the throat is not a thyroid gland], *Knack* magazine, 5 April 2000

56 S. ISHAQUE: op.cit.

57

"Geen Frans, geen verzorging" [No French, no care], *Het Nieuwsblad* newspaper, 20 June 2000, quoted in S. COCKX, *Pro Medicis Brussel: project ter bevordering van het tweetalig zorgaanbod in het Brusselse hoofdstedelijke gewest. Stand van zaken op 1 november 2000* [Pro Medicis Brussel project to promote bilingual care provision in the Brussels capital region. Progress at 1 November 2000], Brussels, Pro Medicis, 2000, 14. Also see *inter alia* F. VERHOEST, *"Anciaux komt op voor Vlaamse patiënt in Brussel. Vlaamse minister pakt uit met actieplan om taalwetten te laten naleven"* [Anciaux stands up for Flemish patients in Brussels. Flemish minister unveils action plan on compliance with language laws], *De Standaard* newspaper, 2 August 2000.

58

P. DEJAEGHER, *"Anciaux maakt van naleving taalwet ziekenhuizen testcase. Nederlandstalig? Luister dan naar het cassettebandje"* [Anciaux makes test-case of hospital language law compliance. Dutch-speaking? Listen to the cassette.], *De Standaard* newspaper, 3 August 2000.

59

P. DEJAEGHER, op.cit.

60

M. VANDERSMISSEN, *"Nauwelijks taalklachten over Brusselse rusthuizen"* [Hardly language complaints about Brussels rest-homes], *De Standaard* newspaper, 7 June 2001.

61 This letter was published in the local newspaper *De Serrist*.

62

G. FONTEYN and T. ROCK, *"Vraag van de week: Vlaanderen laat Brussel los, en dan?"* [Question of the week: Flanders lets Brussels go – and what then?], *De Standaard* newspaper, 27 January 2001.

63

Question of 28 February 1973 from Mr ELAUT to Mr DE SAEGER, Minister of Health, on the now intolerable language situation in the teaching and other hospitals of Brussels, Senate, *Hand.*, 1972-73, 530.

64

Question from MR R VANDEKERCKHOVE to Mr DE SAEGER, Minister of Health and Family Affairs, on the intolerable language situation in Brussels hospitals, 22 May 1975, Senate, *Hand.*, 1974-75, 2216.

65

R Steyaert, *Verslag aangaande de niet-discriminatie tussen Nederlandstaligen en Franstaligen* (Report on non-discrimination between Dutch and French speakers), Brussels, State Secretariat for the Dutch Community, 1979, 8, quoted by P. DESLE, in *Het cultureel statuut van de Brusselse ziekenhuizen. Een juridisch-politiek onderzoek naar de communautaire aspecten van het Brussels ziekenhuiswezen* (The cultural status of Brussels hospitals. A legal/political investigation of community aspects of Brussels hospitals), K.U. Leuven, Thesis on the subject of the medical and social sciences and hospital administration, written for a master's degree, 1980, 82.

66

J DEGADT and A MONTEYNE, op cit, 7.

67

The Flemish Community is one of Belgium's federal states with responsibility for what is termed "personal welfare" (matters such as education and culture) in the single-language Dutch-speaking Flemish Region and among the Dutch-speaking inhabitants of the Brussels-Capital Region.

68

J DEGARDT and A MONTEYNE, op cit, 109.

69 J DEGARDT and A MONTEYNE, op cit, 86.

70

Beleidsnota Brusselse Aangelegenheden 2002-2004 (Policy note on Brussels affairs, 2000-2004), by B ANCIAUX, Flemish Minister with responsibility for culture, youth, urban policy, Brussels affairs and development co-operation, 29.

71

A press release from the office of Bert ANCIAUX, Flemish Minister with responsibility for culture, youth, Brussels affairs and development co-operation, dated 1 August 2000, announced that Mr Anciaux was launching an action plan to have language laws enforced.

72

"Gezond en wel" (("Healthy and well"), a policy paper submitted by Mr J CHABERT, Minister of the Brussels-Capital Region with responsibility for health and welfare, 13 December 2001, *Gedr. St.*, Council of the Flemish Community Commission, 2001-2002, 229/1, 6.

73

Motion with reasons from Messrs S PLATTEAU, L PEETERS, E GLORIEUX and S GATZ on the language situation in emergency services in and near Brussels, Flemish Parliament, *Gedr. St.*, 2000-2001, No 562/2.

74 "Gezond en wel", policy paper submitted by Mr J CHABERT, op cit, 5 and 6.

75

S COCKX, *Pro Medicis Brussel: project ter bevordering van het tweetalig zorgaanbod in het Brusselse hoofdstedelijke gewest. Stand van zaken op 1 november 2000 (*Pro Medicis Brussels project to promote bilingual care in the Brussels-Capital Region. Position as at 1 November 2000*)*, Brussels, Pro Medicis, 2000, 9.

76 G VAN ISTENDAEL, *Arm Brussel (Poor Brussels)*, Antwerp, Atlas, 1992, 126.

[77] A DETANT, "Tussen taalwet en werkelijkheid: interpretatiegeschillen en politieke bezwaren" (Between the language legislation and reality: differences in interpretation and political difficulties), in E WITTE, M DE METSENAERE, A DETANT, J TEYSSENS and A MARES, *Het Brussels Hoofdstedelijk Gewest en de Taalwetgeving* (The Brussels-Capital Region and Language Legislation), Brusselse Thema's nr. 5, Brussels, VUB Press, 1998, 85.

[78]

A DETANT, op cit, 85.

[79] A DETANT, op cit, 82.

[80]

Interview with Mr R GRIJP conducted by Mr S VANERMEN on 25 February 1997, in E WITTE, M DE METSENAERE, A DETANT, J TEYSSENS and A MARES, *Het Brussels Hoofdstedelijk Gewest en de Taalwetgeving*, Brusselse Thema's nr. 5, Brussels, VUB Press, 1998, 150.

[81]

Interview with S VANERMEN, op cit, 152.

[82]

R JANSSENS, *Taalgebruik in Brussel (Language use in Brussels)*, Brusselse Thema's nr. 8, Brussels, VUB Press, 2001, table 5, p 34: the term "minority Dutch-speaking population" refers to those households resident in the Brussels-Capital Region and communicating exclusively in Dutch in the home (in 10.1% of households in that region, both Dutch and French are spoken in the home).

[83]

See footnote 15.